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Executive Summary

Child and Adolescent Mental Health Services (CAMHS) in South Australia are governed by the Women’s and Children’s Health Network (WCHN) which provides the inpatient unit and oversees community and outpatient services as well as the Postnatal Unit located at Glenside. Previous to July 2013 the service was split between Southern Adelaide Local Health Network (Southern CAMHS) and the WHCN (Northern CAMHS). These services operated under very different models of care and in July 2013 there was a merger of the Northern and Southern CAMHS teams to all come under the one umbrella of WHCN. Despite the merger on paper, little changed in the way that services were delivered until recently, when new policies and procedures began to be implemented and an acting CAMHS Director and acting Psychiatrist Clinical Director were appointed to manage the integration of the service.

In addition to the changes to the service itself, the overarching mental health system in South Australia is in a process of change with a new structure which will impact on CAMHS. This will see CAMHS community teams deal only with children and young people up to 15, and a new Youth Mental Health Service (YMHS) established to cater for 16 to 25 year olds.

Overlying these changes, have been a number of youth suicides related to CAMHS clients over the past four years. Two of these suicides were the subject of recent Coroner’s inquests and there are a series of recommendations from the Coroner in regard to these. The Coroner’s recommendations strongly advised changes in the approach to care and service delivery adopted by CAMHS.

All of these issues and events resulted in a decision to conduct an overarching review of CAMHS to make recommendations for systems improvement in the following areas:

- Overarching clinical governance including clinical risk management policies and procedures
- Models of care including pathways, integration with other bodies, staffing model and transition to youth services in the new strategy
- Consumer engagement
- Standards of documentation

A CAMHS Review Team of external professionals with CAMHS expertise and including consumer and carer representatives was engaged to work together to review CAMHS and make recommendations for improvement. The review team members came from four different jurisdictions and two team members also had backgrounds in UK CAMHS services.

It is noted that since the review of CAMHS commenced there have been a number of changes which have impacted on various aspects of CAMHS and these are referred to throughout the report.

The process of review included a series of interviews. These involved staff from many locations and all professions, consumers and carers, CAMHS executive management, chief psychiatrist, external stakeholders who share CAMHS clients and professional bodies and unions. In addition, submissions were invited from interested parties and over forty of these were received from individuals, professional bodies and staff groups. A variety of documentation and data was also reviewed.

The full CAMHS Review Team visited South Australia on three occasions, with additional visits by the team coordinator. During the review the team members met frequently to compare notes. They wrote up their impressions and communicated by email to develop and refine identified themes and to contribute to the report. The review team also met with a group of CAMHS managers with the
penultimate draft of the report in a formal workshop structure to discuss the report and recommendations, amend factual errors and gain input on aspects of the report. The final report was completed following the workshop and incorporates relevant information from this workshop.

Throughout the process of review, the CAMHS Review Team was impressed with the openness and honesty of all of those interviewed, the professionalism and commitment of staff working in CAMHS and the clear dedication to patient care amongst individuals and staff groups. The submissions from individual staff and staff groups similarly were clearly concerned with issues that related to making improvements in care and service delivery.

It is noted that the CAMHS Review Team did not visit all CAMHS locations, but from those that they visited, consumer and carer feedback and feedback from external stakeholders, a number have been referred to in the report as specific strengths and delivering consistent, contemporary, consumer focused services.

The key findings outlined in this report focus on systems which require improvement to better support staff in consistent delivery of care, and the CAMHS culture which at the time of the review still showed a split between the previous geographic services including low staff morale amongst significant numbers of staff. The fragmented change strategy and the recently released coroner’s reports contributed to this, but during the review concerted efforts were being made to address some of these issues and improvements were evident by the time of the workshop with managers.

Recommendations relate to specific areas that will require addressing in a structured, well led and professionally facilitated change process. The recently appointed CEO of the Women’s and Children’s Health Network has commenced driving this change with some effect. A change facilitator is required as part of the new CAMHS executive team to engage staff and work with them on an enhanced service delivery model supported by a series of frameworks and an accountability structure. A rebranding of CAMHS with a new name may also assist to drive cultural change.

Governance (corporate and clinical) and leadership were two themes that permeated many discussions. The first step in strengthening corporate governance and leadership is to confirm the interim organisation structure with a Co-Director team of an Executive Director and Clinical Psychiatrist Director reporting to the CEO, and to put in place transparent process to permanently fill these two executive positions. CAMHS should then be led by the Co-Directors with a small executive team representing all of the professions and including the change facilitator and finance support. This highly strategic team will work to implement the change process over the next two years in a structured and supportive way. This will ensure that CAMHS delivers care consistently and that all staff are clear on both the role of CAMHS and the way in which services are delivered in a CAMHS-wide approach.

Clinical governance in CAMHS requires strengthening with a new framework, with the Psychiatrist Clinical Director functioning as the clinical lead and overseeing a number of CAMHS-wide committees. These committees will not only ensure that review of risk, morbidity and mortality and case review are consistently managed, but will also oversight a quality and innovation strategy aimed at building CAMHS into a contemporary, high level service continually striving to benchmark itself against other services.

As part of the enhanced service delivery model, a key focus must be on clarifying the role of CAMHS and how it will work with external stakeholders to provide the most appropriate care for its clients. For many years, CAMHS staff and external providers have been unclear on the boundaries of CAMHS’ responsibility for clients. Relationships have been inconsistently defined and often based on
relationships between individual professionals rather than a CAMHS-wide strategy. CAMHS is a very complex service and the clientele means that many external stakeholders have a role in provision of care and services. Best practice care can only be delivered if there are clear communication mechanisms between the stakeholders and CAMHS and mutual respect between the organisations to provide a client focused approach. Building these relationships will take considerable time and require a specific resource to put in place the structures and processes so that there is a CAMHS-wide modus operandi. An Integration and Relationship manager will be required to carry out this function for a time limited period. Once the systems have been set up and are operational, this role can be subsumed into operational management.

Multidisciplinary functioning needs to be clearly defined and embedded in the service delivery model so that structures and processes are understood and adhered to by staff. This lack of clear definition and the inconsistency of practice throughout CAMHS has caused a lack of shared understanding of what the aims of multidisciplinary care are and how such practices should be implemented. Added to this is a general lack of clarity around the role of the psychiatrist in the multidisciplinary team and the lack of a job description for this role. The report has provided definitions and references in relation to multidisciplinary team functioning and the importance of having appropriate access to all relevant professions so that care can be tailored to the individual client.

The report identifies some benchmarking which indicates that staffing mix requires addressing. In particular, there is more limited access to clinical psychologists than is the norm in other similar services and strategies need to be developed to address this lack of access so as to ensure that clients who require this service have care appropriate to their specific needs. An important strategy is the development and implementation of a documented workforce strategy aimed at ensuring that over time the most appropriate workforce is available with the right mix of professions, to provide tailored care for CAMHS clients.

With the advent of the National Standards for Safety and Quality in Health Services, there has been a marked change in mechanisms to better involve consumers and carers in health service delivery and innovation. CAMHS has involved consumers and carers over many years, but the mechanisms used have changed little and more innovative ways should be explored to gain the most value from input and advice from these groups. A consumer and carer representative on the CAMHS executive is recommended to ensure leadership of innovative engagement at executive level and communication with other jurisdictions will be useful to further this involvement.

CAMHS still has two different data systems and the use of data requires a CAMHS-wide strategy, so that accountability is embedded at all levels. This will enable CAMHS to monitor and measure its service delivery and develop strategies for improvement across the service. CAMHS must develop a single data system to enable this to occur and it will need some external support to determine which system will best meet the needs of both staff and clients.

The CAMHS review team has considered the recommendations made by the Coroner at the two recent inquests. These have been commented on in the report to indicate which can be practically implemented and which may require a different approach to achieve the intent of the specific recommendation. The development, implementation and monitoring of the new service delivery model which clearly defines the roles of CAMHS and the multidisciplinary team, will be integral to meeting the intent of all of the Coroner’s recommendations.

The CAMHS Review Team is confident that with appropriate support, an integrated service built around an enhanced service delivery model will be fully implemented over a two year period and that this
integrated service will deliver the contemporary, consistent and high quality care and services, expected by all stakeholders.

Summary of Recommendations

Organisation structure, executive team and key staff roles

1. Confirm the reporting structure of CAMHS to the CEO of the Women’s and Children’s Health Network
2. CAMHS to be led by a partnership of an Executive Director and Executive Clinical Director
3. Recruitment and selection of the two executive positions to be an open and transparent process following best practice in human resource management
4. Establish two clinical leads (Country and Metropolitan) for each of Clinical Psychology and Mental Health Social Work at AHP 4 level
5. Pending a review, establish interim clinical leads for Occupational Therapy (AHP4) Speech Pathology (AHP 3) in CAMHS followed by and a formalised reporting structure once these roles have been defined
6. Once the model of care has been developed, review and confirm the nursing structure to ensure that it follows contemporary mental health practice
7. Review roles and titles of the Aboriginal Mental Health workers as part of the enhanced Model of Care
8. Include in the definition of the role of the Executive Clinical Director that this position is the professional lead for psychiatrists in CAMHS and the lead in clinical governance for CAMHS
9. To ensure continuity in both clinical and clinical governance leadership, establish a part time Deputy Clinical Director position to be filled by an existing psychiatrist
10. Develop an appropriately classified and resourced administrative structure to support the clinicians in CAMHS in the provision of an efficient and effective services to clients
11. Establish a small management team as the CAMHS executive with representation from all key professional groups and from consumers/ carers

Clinical governance structure

12. Set up a clinical governance structure and appropriate processes, led by the Executive Clinical Director to incorporate:
   a. A clinical governance framework linked to the WHCN clinical governance framework
   b. A clinical governance committee with an appropriate accountability structure
   c. An education strategy and process for CAMHS staff
   d. A set of reporting committees to support management of risk, case review and quality and innovation

Overview of Model of Care

13. Develop and implement a comprehensive Model of Care that clearly identifies the philosophy and role of CAMHS and is a valuable guide for staff working in the service
14. Agree on a more descriptive name for the new Model of Care document that focuses on its function as a useful guide for staff and stakeholders
15. Establish a set of principles as a basis for clearly defining the role of CAMHS
16. Clarify the role of the psychiatrist in the various CAMHS services and develop a job description for each of these roles
17. Based on the role of the psychiatrist in each of the CAMHS services, review the requirement for increasing numbers of psychiatrists and work towards this requirement over time in accordance with the workforce strategy.

18. Clearly define the process of multidisciplinary care from end to end and the roles of all of the staff working in this process.

19. Develop and implement a mechanism to monitor and report on how effectively this process supports care and service delivery.

20. Develop and implement standardised processes for assessment, management and escalation of clinical risk and educate all staff in these processes.

21. Adopt standardised clinical documentation which includes risk assessment, mental state examination, bio psychosocial assessment etc.

22. Review the use of clinical pathways and evidence based guidelines and build these into the new Model of Care to support standardisation of practice.

23. Once agreement has been reached on modes of service delivery, develop detailed descriptions of each of the services that make up CAMHS to include how each of these services will fulfil its service objectives and link to other services.

24. As part of the process of defining the roles of CAMHS services, ensure that the role and care processes of Boylan Ward are well defined to support the objective of consumer focused care and with clear linkages to services provided by community teams.

25. Review the support required by Country teams and develop and implement a strategy to provide the necessary support to staff and clients in country areas.

Allied health staffing mix

26. Develop and implement a strategy to increase the numbers of experienced clinical psychologists in CAMHS and concurrently change the social worker/clinical psychology mix.

27. Ensure that AHPRA approved clinical psychology supervisors are able to assume a role in clinical supervision of junior staff.

28. Consider establishing a team of lead psychiatrists who will be accountable for the clinical service functions of the different CAMHS service areas.

29. Review the roles of occupational therapists and speech pathologists in CAMHS in line with their roles in other Child and Adolescent Mental Health Services in Australia.

Model of Care Frameworks

30. As part of the development of the Model of Care develop a clinical supervision framework.

31. As part of the development of the Model of Care, develop and implement an orientation framework to assist new staff in their transition to CAMHS.

32. Consider the appointment of a Training and Education Coordinator with responsibility for education and training for the whole of CAMHS.

33. As part of the development of a Model of Care, design and implement an education strategy to include in-service, onsite training, external training opportunities and regular visits to CAMHS services in other jurisdictions.

34. Clarify the role of research and evaluation in the development of the Model of Care.

35. Further develop the CAMHS accountability framework and embed this in CAMHS operations.

Internal and external relationships and communication

36. Ensure that there are appropriate communication processes in place so that staff feel informed and confident about the transition of clients to the Youth Mental Health Service.
37. Establish a position for an Integration and Relationship Manager to develop, monitor and report on the formal relationships with all internal and external CAMHS stakeholders

38. Establish a working group with the Medicare Local (or its successor body) to develop and implement a strategy for shared care with interested General Practitioners

Strengthening consumer and carer relationships and therapeutic processes

39. Explore new ways of involving consumers and carers in CAMHS by discussions with consumers and carers and benchmarking mechanisms used in other health service organisations

40. Implement expanded therapeutic models to support clinical care and service delivery including an appropriate balance of individual, family, group and systemic therapies, and working more closely with private providers

Process of change and use of data

41. Appoint an experienced change facilitator to work with CAMHS management, staff, consumers and carers on developing an appropriate Model of Care, building a whole of CAMHS culture and focussing CAMHS on the future

42. As part of the focus on the future consider a name change for CAMHS to more clearly reflect its role

43. Review the data systems presently used in CAMHS and develop one robust data system to support clinical services and operations of the integrated service

44. Develop the CAMHS’ capacity to utilise and interrogate existing data to improve quality of patient care and outcomes and better manage services

45. To boost momentum for change, support staff on visits to other jurisdictions and foster discussions on innovative service delivery in the Quality and Innovations Committee

Reply to Coroner’s recommendations

46. Utilise the comments that the CAMHS Review Team has made in response to the recommendations in the Coroner’s reports in the development of the Model of Care and in the development of the specific processes that should be part of the Model of Care
1. Background

Child and Adolescent Mental Health Services (CAMHS) in South Australia are governed by the Women’s and Children’s Health Network (WCHN) which provides the inpatient unit and oversees community and outpatient services as well as the Postnatal Unit located at Glenside.

CAMHS services consist of 304 FTE staff distributed amongst the following services:

- Community teams in both metropolitan and country areas, with a variety of staff who have different professional backgrounds
- Country outreach services
- Inpatient units at WHCN (Boylan Ward for up to 18 years of age) and Glenside (Helen Mayo House for mother/baby dyads)
- Emergency Mental Health Team at WCHN
- Specialist Services including:
  - Adolescent Services Enfield Campus for young people 12 to 17 to receive more intensive support and therapy on site and Behavioural Intervention Services for children aged 5 to 11 and their families
  - Adolescent Sexual Assault Service
  - YouthLink
  - Early Psychosis Prevention Service
  - Secure Care Services
- Consultation and Liaison Services at both WCHN and Flinders Medical Centre

Previous to July 2013 the service was split between Southern Adelaide Local Health Network (Southern CAMHS) and the WHCN (Northern CAMHS). These services operated under very different models of care and in July 2013 there was a merger of the Northern and Southern CAMHS teams to all come under the one umbrella of WHCN. Despite the merger on paper, little changed in the way that services were delivered until recently, when new policies and procedures began to be implemented and an acting CAMHS Director and acting Psychiatrist Clinical Director were appointed to manage the integration of the service. These positions are interim and await the outcome of this review.

During the review, the reporting structure of these senior managers has also changed with the disbanding of the Division of Primary and Population Health at WHCN. Whereas CAMHS used to report to the Executive Director of this division, it now reports to the CEO of WHCN and this will remain so until the review is completed and recommendations are adopted.

In addition to the changes to the service itself, the overarching mental health system in South Australia is in a process of change with a new structure which will impact on CAMHS. This will see CAMHS community teams deal only with children and young people up to 15, and a new Youth Mental Health Service (YMHS) catering for 16 to 25 year olds. The inpatient unit at WCHN will continue to admit up to 18 years of age. A Model of Care has been developed for this service and there is also a documented up to date SA Suicide Prevention Strategy and a documented Mental Health and Wellbeing policy that extend to 2015.

Overlying these changes, have been a number of youth suicides related to CAMHS clients over the past four years. Two of these suicides involving Southern CAMHS clients which occurred in 2010 and 2012 and prior to the integration of Northern and Southern CAMHS, have been the subject of recent Coroner’s inquests and there are a series of recommendations from the Coroner in regard to these.
The Coroner’s findings identified a number of issues including:

- Lack of a multidisciplinary team approach
- Lack of access to psychiatrists

The Coroner’s recommendations strongly advised change in the approach to care and service delivery adopted by CAMHS.

All of these issues and events resulted in a decision to conduct an overarching review of CAMHS and to make recommendations for systems improvement. The scope of the review included:

- Overarching clinical governance including clinical risk management policies and procedures
- Models of care including pathways, integration with other bodies, staffing model and transition to youth services in the new strategy
- Consumer engagement
- Standards of documentation

A steering committee (CAMHS Review Advisory Committee) was established to oversee the review under the chairmanship of the Chief Public Health Officer. A CAMHS Review Team of external professionals with CAMHS expertise and consumer and carer representatives were engaged to work together to review CAMHS and make recommendations for improvement.

Terms of Reference: Attachment One

It is noted that since the review of CAMHS commenced there have been a number of changes which have impacted on various aspects of CAMHS. These will be referred to throughout the report, but include:

- The YMHS was to have been implemented commencing September 1, but this has been delayed to ensure that all of the requirements are in place so that clients and services are transferred in an orderly and sensitive way.
- The Division of Primary and Population Health at WCHN has been disbanded and so CAMHS now reports directly to the CEO
- The interim CAMHS executive structure is making some positive inroads to develop more consistent and supportive services
- Increased levels of reporting have commenced under the interim governance structure with reporting of CAMHS to the CEO
- Improvements have been made in delegations and complex administrative processes
- Clarification of the governance and roles of the services remaining at Flinders Medical Centre
- Commencement of a Competency Framework for CAMHS based on the NSW model

Note 1: Throughout this report, reference will be made to psychiatrists. Unless otherwise specified, in the context of this review, “psychiatrist” means Child and Adolescent Psychiatrist. Where an adult psychiatrist is referred to this will be specified as Adult Psychiatrist.

Note 2: The timeframe for the review did not allow every service to be seen or discussed. The aim was to gain an overall understanding of CAMHS and the diversity of its services and to describe some of those services to illustrate some of the issues and the strengths of the service as a whole.
2. The CAMHS Review Team

The CAMHS Review Team comprised:

- Dr Lee Gruner: Team leader, Director Quality Directions Australia, Health management consultant and President Royal Australasian College of Medical Administrators
- Dr Michael Gordon: Child and Adolescent Psychiatrist, Unit Head Child and Adolescent Psychiatry Monash Health, Victoria
- Dr Nick Kowalenko: Child and Adolescent Psychiatrist, Head of Infancy of Early Childhood Studies, Institute of Psychiatry NSW
- Ms Margaret Jones: Consultant Clinical Psychologist, Child and Adolescent Mental Health WA
- Ms Carolyn Rae: Senior Nurse Advisor, Child & Adolescent Mental Health, NSW Health
- Ms Delia O’Shea: Team Manager Mental Health Service Southern Table Lands NSW
- Ms Ingrid Broekx: Carer Consultant
- Jason Cutler: Consumer Consultant

The CAMHS Review Team conducted interviews, reviewed documentation on site, submitted benchmarking information, reviewed data and provided reports to the team leader.

The CAMHS Review Team met regularly as a group during the time on site to discuss issues and compare perspectives and corresponded by email throughout the review.

3. Methodology

It was important for the CAMHS Review Team to gain a shared understanding of a variety of factors. These included:

- The history of CAMHS in South Australia, service delivery, key people and issues
- The present situation including process of integration and progress towards integration, barriers to successful integration, culture of the service, comparison with other CAMHS services in Australia, strengths and deficits of the present service
- Agreed contemporary practice for a CAMHS based on the expert knowledge of the team in both other states and overseas
- Impact of the recent Coroner’s cases on staff
- Consumer and carer views and opinions about the service

The means of doing this was a series of in-depth interviews with both individuals and groups of staff, a process to accept and review submissions from a variety of interested stakeholders, a review of documentation from the service and a review of documentation from other CAMHS in Australia that had relevance to contemporary practice.

Full list of those interviewed: Attachment two

Full list of submissions: Attachment three

List of documents reviewed: Attachment four

The aim was to speak to and/or receive submissions from as many people as possible to gain a clear picture of the present situation, the operation of the service, what services were delivered, specific concerns about the service and how consumers and carers viewed these services. There were also specific questions for all those interviewed that related to the strengths of the present service.
Large numbers of staff attended interviews. Some were seen on site at WCHN and others were seen at some of the community sites, either face to face or by videoconference. In addition, over 30 submissions were received from a wide range of stakeholders including staff, the public, mental health professionals, unions, other health services and community organisations.

In addition to staff interviews, there were meetings with other stakeholders whose clients, patients or consumers accessed CAMHS services. Many of these stakeholders had regular contact with specific areas of CAMHS and CAMHS staff.

### 3.1 Interviews conducted

Interviews were conducted over six days in August 2014, with the lead consultant conducting an initial set of one on one interviews with key senior staff at WHCN and at Department of Health over two days and the full team being present for the further four days. When the full team was present, some interviews were organised with the whole team and others involved pairs of team members with specific groups of staff either on site at community teams or with staff groups coming together from diverse parts of CAMHS at WHCN. The full team met with the steering committee, with senior CAMHS staff and the executive and with groups of consumers and carers.

Initial interviews focused on:

- Identifying the strengths of CAMHS
- Identifying any concerns with service delivery
- Understanding how CAMHS operated
- Understanding relationship of CAMHS with other stakeholders
- Understanding relationships of CAMHS with the health service executive
- Exploring CAMHS organisation structure
- Exploring the impact of the recent Coroner’s reports on staff
- Clarifying what staff and other stakeholders sought as the outcome of the review
- Understanding corporate and clinical governance processes

The second set of interviews aimed to:

- Further explore some of the issues that arose during the first set of interviews
- Identify any other themes that arose

From these interviews a list of themes was developed which underpin this report.

### 3.2 Review of documentation

Documents examined on site included present organisation structure, proposed organisation structure, Model of Care, staffing levels, risk register, Coroner’s reports, committee minutes, consumer feedback and adverse events. Comparative Model of Care information was collected from the team members and various research literature was also examined.

The information from the documents was used to support the themes that had been identified from the interviews.

### 3.3 Review of submissions

The submissions were divided up amongst the team members according to their areas of specific expertise with a view to identifying any new themes and/ or supporting the themes that had already been identified. Very few new themes were identified from the submissions and these mainly confirmed what the in-depth interviews and documentation had already provided. There were
however some useful details provided in some of the submissions which added to team understanding of the issues. Quotations that relate to some of these submissions (in addition to those from interviews) are provided throughout the report to illustrate some of the themes identified.

Team members provided both written reports and verbal reports to the team leader and these form the basis of the draft report.

4. Findings and Themes Identified

This section of the report identifies issues that relate to a broad range of CAMHS culture, strategy, operations, and service delivery. The key issues are developed to provide an overview of factors which need to be considered in building on the present strengths of CAMHS, working to eliminate gaps in service delivery and taking advantage of opportunities. These themes have been identified as a common thread through many of the stakeholder discussions and submissions including both internal and external stakeholders. They reflect the perceptions of significant numbers of stakeholders and are thus what they see as real issues that impact on their work and how they feel about the work environment. It is acknowledged that some of these issues may have been addressed by management, but that nevertheless stakeholder feelings about the issues remain.

It is noted that even though interviews were arranged at short notice that large numbers of staff attended as they all wished to put forward their views. In addition, all stakeholders contacted attended for interview so that the broadest range of internal and external stakeholders was able to be canvassed. The team was impressed with the honesty of opinion put forward and the willingness to share both operational and sensitive issues. Quotes from those interviewed are used in this section to gain a better understanding of stakeholder issues.

4.1 General comments

4.1.1 Focus on systems issues throughout the review

The CAMHS Review Team was clear at the outset that the aim of the review was to identify issues relating to systems rather than individuals and that the process of the review and the questions asked were all developed to meet this objective. The outcome was to report and make recommendations in line with the Terms of Reference. This involves identifying systems strengths and gaps and recommending how both staff and consumers could be better supported so that care and service delivery would be enhanced. The best way to identify systems that are not working optimally is by talking to stakeholders of a service and to understand what is not working for them: in their day to day work, in their relationships with other stakeholders, in the outcomes they wish to achieve and in their expectations of the service and of each other.

Stakeholders will not say “the systems isn’t working”, but they will indicate what isn’t working for them, what barriers there are to efficient and effective service delivery, what makes their working life more difficult or in the case of consumers and carers, what makes accessing an appropriate service more difficult. It is only by putting all of the individual comments, observations and expectations together, that a picture is formed of what appears not to be functioning optimally for a large number of stakeholders and which systems are involved. This is often not recognised by management as they only see a small part of the system, in the same way that staff only see the part of the system that affects them personally or affects their individual work environment.
The Coroner’s reports identified a number of systems issues and the stakeholders confirmed these and provided more detail and also identified further areas that were fragmented, inconsistent and did not support stakeholders well.

All of the CAMHS Review Team have significant experience in health as clinicians and senior managers and they understand the commitment, dedication and professionalism of staff who work in the health field. Health in general suffers from burgeoning demand, inadequate resources and is subject to many external influences. Despite this, the overwhelming majority of staff who work in health always do the best that they can for the patients and clients in their care, irrespective of the circumstances pertaining in the environment of the organisation they work in.

Through all of the interviews conducted with stakeholder groups it was clear that CAMHS staff are no different to those working in health organisations all over Australia. They continue to do the best they can for their patients, even when systems are unclear or unsupportive. However, systems issues cannot be fixed by staff. Staff can identify problems then it is up to management to work out ways to address these to improve staff efficiency and effectiveness and satisfaction in work.

4.1.2 Perceptions of being regularly reviewed
Many commented on what they perceived as the large numbers of reviews in the South Australian health system in general and mental health in particular, and that these reviews came up with recommendations which were never implemented. There was a common plea for a commitment to be given that relevant recommendations arising from this review should be implemented to deliver long-lasting effects for patient care and/or service delivery. It was emphasised that a clear mandate and expectation for sustainable change and improvement would need to be given from the highest levels.

4.1.3 Impact of perceived budget cuts
There was a view amongst many of the staff that CAMHS has been differentially allocated savings targets when compared to other acute services over many years and that this impacted on the standards of care. Allied with this, was that the resourcing levels did not provide for capacity building and health promotion which they regarded as integral to providing a good service. The Review Team did not validate what the historical budgets of CAMHS services had been over previous years, but received a management report for 13/14 which evidenced that the savings contributions for CAMHS was 4.5% (or $538K) of the total savings target for the Network.

4.1.4 CAMHS reputation and role
The other issue which seemed to be a theme from external stakeholders was that CAMHS did not have a good reputation as a service. A variety of those interviewed indicate that CAMHS did not have respect from adult mental health and appeared to have a culture of “super-confidentiality” so that other clinical units and external stakeholders often did not have access to relevant clinical information for shared clients. External services were often not clear on CAMHS’ specific role, bemoaned lack of access to specialised metropolitan services and carers felt that GPs in general knew little about CAMHS. General Practitioners themselves stated that they were uncertain about the appropriate service to refer a particular problem to, how to make the referral, and who was able to refer to CAMHS. External stakeholders in general were concerned about long waiting lists for many CAMHS services.

4.2 Strengths of CAMHS
There are a number of specific strengths of CAMHS, noted by both internal and external stakeholders and agreed by the team. These relate to:
4.2.1 Perinatal and Infant Mental Health (PIMH)
This integrated service provides treatment for mothers with mental illness and also works on mother child attachment issues and is located at two sites:
- Helen Mayo House (HMH) at Glenside Hospital, providing inpatient care for 6 mother/ child dyads for children 0 to 3.
- The Women’s and Children’s Hospital (consultation/liaison) which provides services to expectant mothers antenatally and to infants under paediatric care
- The service also includes a community outreach team which is based at HMH.

This service provides high intensity medical input with psychiatrists fully integrated into the service, well developed multidisciplinary care and clinical monitoring and a high degree of support from experienced staff who are readily available for consultation across the community, mental health inpatients and Women’s and Children’s Hospital Services. PIMH has been internationally recognised and the clinical leader has the role of National President of the Marcé Society. There are best practice partnerships and innovation in clinical practice with development of networks of care with NGOs and partnerships with obstetrics, paediatrics and adult mental health. There is also a phone help line.

The annual HMH conference is well subscribed. HMH has a role in education in Southern Australia and nationally and staff are encouraged to seek training opportunities. Developments are regularly showcased and promoted both nationally and internationally.

The clinical leadership of the unit is high profile, supports clinical innovation and a culture of research and education. There is reliable and valued support from senior clinicians including medical staff with higher numbers of medical staff than in the rest of CAMHS and it is reported that access to psychiatrists is excellent.

4.2.2 The BART information system
This information system has been used for the Northern CAMHS and was commented on not only by staff but also by a number of external stakeholders as being a high level system. This is a computerised case information system useful for day to day management as well as being able to provide collated data and reports. It is designed to identify relevant clinical data review, processes, workload and other management tools. There are opportunities to analyse and interrogate this data better and improve available reporting to improve services. There were many comments from various staff groups about the BART system.

Staff indicated that the CBIS system which is used in the Southern part of CAMHS does not fit the purpose as well and there were fewer comments in general about this system. As one submission described this: “CBIS, our data entry system is a ‘clunky’ inefficient system which is time-consuming to use. In addition each clinician is required to print off, sign and keep paper notes as well as entering data to maintain electronic case notes”.

The CAMHS Review Team does not recommend either of these systems and which (if any) should be used can only be determined by a review of the needs of CAMHS as indicated in Section 5.8.
4.2.3 Mental Health Nurses in the Emergency Department

These nurses receive accolades from all those who work with them including ED staff, paediatricians, adults clinicians, the Adolescent Unit and Boylan Ward staff. The mental health nurses are available 7 days a week between 8 am and 2 am and assess patients together with the ED team to come up with a combined decision on management. Those who worked with them believed that they carried a large workload and were always busy with 14-18 contacts per day, including face to face and telephone contacts.

This is a specialised service as indicated in their submission:

“At a wider state level, the EMHN service performs clinical functions over and above those which are generally seen in adult emergency departments in SA. Adult mental health has a dedicated, 24 hour centralised telephone triage system to manage phone calls.”

In addition these nurses are at Level three in recognition of their expanded responsibilities:

“The clinical role does not only encompass triage and risk assessment and then deferral to a trainee registrar for a more detailed assessment; rather it encompasses a full clinical assessment, care planning, referral and ultimately discharge, with the scope for consultation by phone with a psychiatrist for situations which require this due to complexity or perceived risk.”

The detailed submission from the EMHN Team indicates that they require consideration in the development of the Model of Care to ensure that they can continue to provide an efficient and effective service and engage in continuous quality improvement.

4.2.4 Adolescent Services Enfield Campus (ASEC) and Behavioural Intervention Service (BIS)

This service was highly regarded by external stakeholders, consumers and carers. ASEC is a service for 12-17 year old young people, usually referred through the school or clinical sector providing a state-wide tertiary tier of service delivery. There is a high staff to consumer ratio and there are a variety of group programs to suit individual young people. Consumers talked about the more supportive group environment at ASEC. They formed close relationships with the staff and felt respected by the staff. The group environment was less threatening and far more therapeutic in many cases than one on one counselling. They particularly liked the group outings and activities and being assisted to adopt a different approach to life.

Carers whose children had been at ASEC, talked about how positive it had been for their child when nothing else seemed to work for them. The discussion with carers clarified that this was seen as a last resort when everything else had failed and they were desperate for new approaches. Some persisted for considerable periods to gain admission for their child as they feared the consequences of what might happen if ASEC was not made available to them.

Comments from carers included, “one on one therapy doesn’t get a young person back into life and improve relationships” and in relation to one on one therapy “an adult tells them how to feel and think”. However at ASEC, their confidence is improved and “every day is a new day”. Staff are flexible “it’s not a job for them” and young people are given some autonomy over what they do. Carers feel that young people are able to gain a better understanding of their emotions and control these more effectively.
4.2.5 Therapeutic and Family focus

Staff in some CAMHS teams discussed this as a key philosophy that underpinned their service and this was confirmed by some of the external stakeholders. Some external stakeholders also mentioned that CAMHS did have a range of interventions and approaches available and was able to assertively engage in a crisis. The CAMHS review team agreed that this was a clear modus operandi in some of the teams and services visited.

4.2.6 Programs to Aboriginal Communities

The CAMHS review team did not visit any of the specific programs but was impressed with the commitment of the staff involved in these programs. In addition the submission from the Aboriginal Health Council of South Australia (AHCSA) highly commended a number of these programs as a result of work the council had carried out in 2014. The programs commended were:

- Ngartunna-Patpngga at Onkaparinga and Marion
- Nanko-WatunPorlar Nomawi at Murray Bridge
- CAMHS APY Lands
- Journey Home and Sista Girls at CAMHS Eastern

The specific reasons for commendation included:

- The emphasis on consultation with Aboriginal people in program development and support for young people
- The flexibility of service delivery
- The employment wherever possible of Aboriginal workers

In addition it is the intention of AHCSA to showcase these programs at a forum early in 2015.

4.2.7 Innovative and high level practice

During the round of interviews the CAMHS Review Team noted some areas of innovative practice and high level service, although these related to specific teams rather than the service as a whole. These included:

- Youth/ early psychosis service in Southern CAMHS.
- Adolescent Outreach and Drug and Alcohol Morbidity service. (Staff from within both of these services are in scope to transition to the new Youth Mental Health Service, but the functions will still need to be undertaken, largely from within the remaining CAMHS community teams.)
- The Port Adelaide team has very good multicultural services and relationships with other organisations such as DECD, and a focus on cultural and linguistic diversity, as there is such a large multicultural community

Note: this is not an extensive list as it only refers to those services the team actually visited during the review

4.3 Outcomes desired from the review

The terms of reference clarify what SA government and WCHN expect from the review and the CAMHS Review Team believed that it was also important to understand the outcomes desired from the review by stakeholders. The reasons for this are that as with any review, some of these will be achievable, others will not be possible, and some may not be regarded as desirable after team deliberations. In addition, it is important to understand differing expectations so that the rationale for recommendations can be clearly described.
4.3.1 Staff
The overriding issue was the development of a clear governance structure. This included both the executive structure and the structure of the professional disciplines that responded to this. There was disagreement in relation to the executive structure, with two opposing opinions i.e. the clinical director position should be open to any discipline as opposed to the clinical director being a psychiatrist. All professional groups indicated that a clear structure needed to be in place for senior clinicians with the grades of senior clinicians being equivalent. There were similar comments from administrative staff. In addition the governance structure needed to have clear lines of accountability, be underpinned by client needs and to ensure that country services had a clear place, were treated equitably and did not just have a metropolitan model imposed. There needed to be a strong consumer/carer line management voice at both divisional and state level.

Staff of CAMHS wished to see the positives of the present service clearly identified with the report not just being focused on gaps in the service and they wished the team to gain an understanding of the diversity of the service.

Staff also supported CAMHS being represented at higher levels of the organisation so that it was more influential given its size, complexity and scope, and able to influence resourcing decisions and priorities directly. They wanted a clear way forward with strong clinical leadership, an integrated service and a focus on education. Many indicated that they wished to have enhanced psychiatric support in their teams.

Many staff indicated that they wished to have the role of CAMHS clarified so that there were guidelines on what their core business should be and what the vision was for the future. The interviews confirmed that staff simply took calls and referrals from all comers and while some teams did refer to other services, other teams allocated these to their staff as they believed this was their role. A clear delineation of the role and function of CAMHS was sought as an outcome, including those roles which could be more appropriately delivered by other providers.

The rural and remote teams wished to see a focus on improving these services and having access to specialised services more easily.

4.3.2 Consumers and Carers
Carers indicated that they wished to have a more accessible, consistent and flexible service delivery model and consumers particularly wanted increased aged appropriateness of facilities and more group type services than were presently available. Carers were also keen to be able to maintain their relationships with private providers while they accessed CAMHS for specialised services.

4.3.3 External stakeholders
External stakeholders were seeking better relationships, adoption of clearer information sharing protocols for consumers who access a number of services and direct access to CAMHS involvement.

4.4 Governance matters
As referred to in 4.2.1., governance, and particularly organisation structure, was a major concern of staff and also of the unions involved in the consultations. Much of the discussion related to corporate governance but underlying issues relating to clinical governance were also identified by the team. It is also noted that some of the corporate governance issues impact on appropriate clinical governance.
4.4.1 Corporate governance and organisation structure

There was no agreement on what the executive structure should be with disparate views being put forward. There was however very clear agreement on what the structural problems were amongst all staff groups. The CAMHS Review Team has provided a recommendation on options for the design of an organisational structure in Section 5.

4.4.1.1 Organisation Structure

It is noted that the present structure of a Director CAMHS and Clinical Director CAMHS was put in place temporarily when an acting CEO was in place earlier in 2014, after an approach from the CAMHS psychiatrists. In the past there had been a clinical director who was a psychiatrist but this lapsed following their resignation. One of the senior CAMHS psychiatrists was subsequently requested to take on this role by the Acting CEO and the Acting Director is an experienced manager who has come from adult mental health. These two temporary positions were to be replaced more permanently as part of the integration process of Northern and Southern CAMHS, shortly before the review but it was determined that no changes would be made to this structure so that it could be informed by the Review findings.

The planned integration, based on the documentation provided, had:

- one director, reporting to the Executive Director of Primary and Population Health, to be selected from any profession and all the professional leads including psychiatrist reporting to the director. This has now been overtaken with the previously mentioned change in executive structure. Allied health clinical leads at an AHP4 level with a number of AHP3 positions below this. The various unions and professional groups and the staff were in favour of this as one of their main issues was the very flat structure which meant that they had no one to go to with management or high level issues and which also impacted on the clinical supervision process.
- operational managers of metro, country and day and inpatient, reporting to the Director CAMH;
- The Aboriginal mental health lead, the Clinical Director, a Projects Consultant and a Business Manager reporting to the Director.

Many staff commented that they would like CAMHS to be “more in control of their own destiny”. There appeared to be some dissatisfaction about reporting to the Executive Director of Primary and Population Health and a feeling that they did not have full executive support and that they often had to act in a way not compatible with CAMHS philosophy. They particularly felt that the Coroner’s findings had had a significant impact on their modus operandi and that this directive had come down from above.

4.4.1.2 Administrative processes

There was feedback about both inadequate processes, as well as non value-adding processes: the former related to the policies for an integrated service, and the latter related to delegations for recruitment and procurement being at too high a level, creating bottlenecks and disrupting service delivery. During the review period, work had already begun to improve this, with the introduction of new delegations to streamline and devolve decision making, and the CAMHS Director introducing a set of business rules and access to management information. This also started to address the concerns about access to timely management information such as financial and activity data.

Another issue referred to was that staff from the Northern and Southern Teams are on different pay cycles until the new pay system is introduced, which creates rostering inefficiencies. It is understood
that resolution to this is part of the transition to a new state-wide payroll solution, but the concern remains that this may take a considerable period of time

4.4.1.3 Committee Structure
A number of comments were made about committees: particularly that many committees had the same people resulting in considerable duplication. With people already time poor, many felt this was not an appropriate use of time, and that a more streamlined and relevant committee structure was needed. The new committee structure was regarded by those who mentioned this as unwieldy, a duplication of effort and inconsistent with the objectives of good governance.

4.4.2 Clinical Governance System
“Clinical governance system” includes everything that contributes to ensuring high standards of care i.e. the leadership, structure, the policies and processes and the people. Each of these factors needs to be robust and the various factors need to be well integrated to produce a system that fully supports a high standard of patient care.

The aspects of clinical governance of significance relate to clinical leadership, clinical processes, risk management and evaluation of care. Although the term clinical governance was not used by many of the stakeholders interviewed, there was considerable discussion about aspects of clinical governance that they considered suboptimal as well as some that they believed were functioning effectively or had recently improved.

4.4.2.1 Clinical leadership
It is acknowledged that CAMHS is in a process of change and so while some of the old Northern and Southern structures and systems have been abandoned, new structures and systems are not yet consistently in place or adequately embedded. Nevertheless staff described issues that pointed to longstanding instability in clinical leadership. This instability was attributed to turnover, the nature of the organisation structure, lack of adequate accountability for performance, and until very recently, unclear discipline specific leadership. Some suggested that it was not previously clear how to get issues resolved, or how to escalate clinical or service delivery issues for effective resolution.

The CAMHS Review Team identified disengagement of psychiatrists as an issue. However it was noted that the reinstatement of a Clinical Director in Psychiatry, albeit temporarily, has begun to alleviate this situation and has provided psychiatrists with a focus for discussing the service more broadly. In addition, the new clinical leadership has begun to foster a team approach that is valued by staff. Other clinicians did however state that they had not had as much access to the Clinical Director.

4.4.2.2 Safety and Quality
It is noted that the Northern CAMHS had a long time Clinical Safety and Risk Committee which reported to the Northern leadership group and that the Southern had a quality meeting every months. It was unclear what had replaced these in the attempted integration or where any new committees reported.

There are a variety of aspects in relation to quality and safety that could be improved and some areas that have recently been addressed. It is noted that until recently there has been no specific CAMHS morbidity and mortality committee and there is now a CAMHS committee that focuses on mortality. A number of staff mentioned that there was no appropriate complex case review process and in the past such cases had gone to the Executive Director of Primary and Population Health instead of being discussed at a clinical level. However, other staff said there was a complex case review process but
they didn’t know what the outcomes of the discussions were. From this it appears the system is unclear to staff.

The adverse event process is also not robust and review of incident documentation revealed that documentation and analysis needed improvement and that evaluation and follow up were also suboptimal. The recommendations made were often not clear.

On the other hand it was noted, that a CAMHS representative now attends the Department of Health Quality Committee chaired by the Chief Psychiatrist and attended by the Executive Directors of all of the Adult Mental Health Services. This is regarded as a very positive step providing access to discussions and quality activities in mental health generally, not just CAMHS.

4.4.2.3 Clinical processes

There was a continuing focus by staff on the differences between the previous Northern and Southern CAMHS, but the differences relate more to the individual teams than to any specific strategy of Northern and Southern. Where Northern and Southern differences could be clearly identified, these related to:

- Safety and Quality Committees as alluded to above
- The different information systems with BART- a home grown product in the North and the use of the system developed by the Department of Health (CBIS) in the South
- More robust data being collected and collated and available in the North with more useful breakdown of where specifically staff were located and evidence of file audits over many years. There was no evidence that file audits had been a regular event in the South, from the documentation provided to the team
- A major drive to reduce waiting lists in the North
- A single phone number for a number of the Northern country teams where the caller is triaged to a specific CAMHS or another service depending on need and location

It appeared from this that there was a more definitive overarching strategy in the Northern CAMHS, but this did not extend to the individual teams all of which operated fairly autonomously.

A number of those interviewed referred to variability of services available where clients received a different service depending on where they lived. The visits to the various community teams confirmed this view. For example:

- The degree of psychiatric support varies from no access to a psychiatrist, to very limited access with some telemedicine to close to a full time psychiatrist in some teams
- One team adopts a very specific psychotherapeutic model which was not seen in any of the other teams
- The mix of professional staff is very variable, with social workers predominating in many teams and with no or minimal access to clinical psychologists in some teams
- Country patients having limited access to either psychiatrists or services external to CAMHS
- Some teams indicated that country patients were sent back from Boylan Ward with no handover and follow-up therefore needed to be arranged at short notice
- The multidisciplinary Model of Care being very variable ranging from therapists appearing to be individually responsible for clients with virtually no multidisciplinary review or input, to regular meetings of the multidisciplinary team to review clients

It is noted that the Coroner referred to some of these issues in the one team involved in the two inquests, but that the issues are much wider than just one team. These inconsistencies are across the
whole of CAMHS. There are also inconsistencies in referral processes, management processes and discharge processes as identified in the process mapping exercise with staff from a diversity of community teams.

Referrals come from a very wide number of sources, but there are more common referral patterns for each of the services. For community teams the most common referral sources are self or carer, schools, non-government organisations, general practitioners and Families SA. For Boylan Ward referrals are mainly from within the hospital, the Emergency Department, community teams and other hospitals. For the Consultation Liaison team referrals are from within the hospital, either inpatient or outpatient. In addition a Consultation Liaison team also remains at Flinders Medical Centre, but its relationship to the rest of CAMHS post integration was not clear to the CAMHS Review Team at the time of the review. Action has now been taken to clarify these issues.

As indicated, the Northern teams had a major focus on waiting lists, with a clear expectation of discharge management. In the Southern area there are significant waiting lists with one of the Southern teams having recently made a concerted and successful effort to reduce its 300 referral waiting list through pro-active audit and referral processes. There was little evidence of a standardised approach to referral management or client allocation process across CAMHS community teams as identified from those that were visited or who attended the process mapping workshop some did review and change the clinician allocation post initial assessment and allocation. One team had recently reformed its referral management, with a significant attempt to provide a best fit clinician, but this process had not yet been evaluated. The ISBAR process for clinical handover has only been introduced very recently.

There were general comments that there was increasing complexity of cases, however there was no documented evidence of this acuity, due to a lack of data and also no clear criteria for admission to CAMHS. This results in inappropriate referrals to the Service, and valuable clinical time being spent on re-directing clients. In the absence of clear referral management and client allocation principles, there is little consistency in how clients are allocated, and therefore how the waiting list is managed to ensure those most in need are supported as a priority. This is also impacted by one-off assessments for other agencies.

The other issue put forward strongly by carers was the necessity to choose between public and private providers i.e. if CAMHS was to be used, the client was expected to stop seeing their private provider. This differs to the philosophy of the Adult Mental Health services, where public and private providers work closely together to provide the most appropriate care and where a mix of one on one clinical psychology support, group psychology and public services were often used.

There was also evidence of lack of documentation or inadequate documentation in that only one team visited was able to provide assessment/referral/supervision forms which they had developed themselves. There appeared to be no standardised documentation for the service as a whole. One of the submissions indicated that there were no clarity around case note recording, and the Review Term observed a vast inconsistency in the recording of case notes by different individuals, which creates risks for both staff and patients.
4.4.2.4  CAMHS Policies

Although the integration of Northern and Southern CAMHS took place on July 1 2013, effectively the integration was only commencing at the time of the review and policies were in the process of being developed and implemented. There was some feedback that these policies were not user-friendly, e.g. “There are ways to write procedures that mean they are more likely to be read, but there was no allowance made for exploring which format might work best when the procedure merge process was started.” Having reviewed some of these newer policies, the Review Team agrees that there is room for improvement, simplification and greater ownership by CAMHS.

4.4.2.5  Professional Education and Continuing Professional Development

There were many comments relating to a lack of basic education and orientation in areas such as development of appropriate core skills and following of protocols such as on case assessment, review or suicide risk. There was no orientation in clinical practices such as intake and assessment. It was noted that nursing had less resources in education than other clinical units.

There was however evidence of quite good access to professional development funding for teams through the PSA award. Although this fund can be used for travel to conferences, this is mainly used to buy in educators from outside Australia whilst they are on their lecture tours here. Nursing staff also join in these sessions, which are organised at team level. However one of the side effects of this is that clinicians do not need to leave the state to undertake professional development which restricts knowledge of contemporary processes.

4.5 The CAMHS Culture

It is difficult to know what the culture of CAMHS was prior to the integration process in July 2013, but as there were two separate services each belonging to a different parent organisation, and as culture is significantly impacted by leadership, each service would have had a different organisation culture. The review team however, was exposed to the culture as it is today with the two services brought together in a somewhat ad hoc way. In addition there was the significant overlay and anxiety caused by the release of the Coroner’s reports and this review. Social workers in particular were anxious and upset and felt the subject of the Coroner’s inquest had been poorly supported. The report can only describe the situation it found at the time of the review.

Staff commented in many of the interviews about how they felt and why it was they felt this way. They were concerned that the review team would spend its time focusing on the Coroner’s findings and recommendations instead of gaining an understanding of the service and its strengths. A number of observations were made by staff in many of the interviews including a feeling of being “micromanaged” and always feeling that the “coroner was in the room”. There was also the comment that CAMHS had “an accreditation culture rather than an education culture” and things were “all about throughput not patient care”. Staff previously from Southern CAMHS indicated that it felt “like a hostile takeover” with all Northern CAMHS’ processes being adopted and the loss of all of the positive services in the South. It is noted that the quotes reflect many of the staff groups interviewed and these are not from isolated interviews.

They believed that decision making was crisis driven, they had lost their staff in management and there was the comment that morale amongst significant numbers of staff was low. Staff stated that they felt unprepared to speak out due to fear of repercussions and also felt completely unsupported in the management of change, which they felt had been imposed without consultation. They were unhappy that the review was not implemented in the way originally planned i.e. led by a CAMHS
clinician. They did not believe the review would be transparent and would focus on individuals who had already been traumatised by the Coroner’s inquests. They believed the organisation structure had been determined and the clinical director selected.

There were many instances where staff indicated that “they were unsupported by management”.

There were clearly tensions between some clinical staff and CAMHS and Clinical Governance senior management, about the role of each post Coroner’s findings, with a view that management had become “increasingly risk averse” and “was stepping into issues which were the province of clinicians.” The psychiatrists expressed concern that up until recently, there had been no psychiatrists on any key committees they were positive about interim management structure, but concerned that it might not continue after the review.

External stakeholders viewed the culture of CAMHS as not working in collaboration with other bodies, and often inflexible. The submissions received expressed similar views from both external stakeholders and staff.

It needs to be noted however that morale issues were not universal, many were not concerned about the review, and were very proud of the services being provided, despite working in difficult circumstances with large workloads.

4.6 Relationships with stakeholders

A diverse number of external stakeholders were interviewed and/or provided submissions including the Health Complaints Commissioner and Public Advocate, Families SA, Department of Education and Child Development, external psychiatrists and other clinicians, unions and professional associations and consumers and carers.

The objective was to understand how they worked with CAMHS, what were the strengths and deficits of these relationships and what could be improved. Again there were some consistent themes from all of those organisations that shared CAMHS clients mainly around communication, duplication of care and lack of consistent processes of entry to CAMHS and exit from CAMHS. Some of these stakeholders also stated that they did not completely understand CAMHS operations. On the other hand external stakeholders did not believe their own operations were well understood by CAMHS staff.

4.6.1 External Stakeholders

There was little in the way of a structured and regular meeting process with external services to build relationships, mutual respect and understanding, nor formal ways to handle communications, transfers and sharing of information about clients. Some teams had Memoranda of Understanding with some services, but this was not a CAMHS wide strategic approach. There was no formal way to recognise duplication of service and this was picked up serendipitously if at all. Some described ineffective or inefficient relationships with CAMHS. Many indicated that once a client entered CAMHS, the referring body had no idea what had happened to them, unless they made strenuous efforts to find out and even then there might be no information forthcoming. It is noted that the Coroner’s reports also identified this duplication of effort, with little communication regarding CAMHS relationships with school counsellors, private clinicians and general practitioners.

Those who worked well with CAMHS often did this through building relationships with individual CAMHS workers rather than using any formal pathway. This became a concern if the CAMHS contact left the service. Families SA was complimentary about the way in which CAMHS prioritised young
people under guardianship, but indicated, as did a number of other stakeholders, that “every region did things differently” and some workers were not prepared to share information.

The role of the Department of Psychological Medicine is also unclear to external stakeholders and they do not know how this fits with CAMHS.

Consumers and carers also mentioned problems with communication. Both the carers and consumers indicated that ASEC worked closely with schools and involved both the young person and the carer in all significant discussions. However this was not always the situation with community teams. Carers agreed however that if the counsellor had a flexible approach, was prepared to meet where the young person was comfortable, tried to make school less frightening and interacted with the school, the outcomes were more positive.

Discussions with Department of Education and Child Development (DECD) indicated that as from the commencement of 2015, there would be a new approach in schools:

- An Integrated services model will be incorporated into the schools and be related to school partnerships. These will employ a variety of professionals and will have capacity to buy in services if needed.
- DECD believes that this service will impact on CAMHS and improve the delay in service that young people experience at present
- CAMHS referrals in the future will come from the team manager and psychologists in the integrated service for schools will provide direct care so CAMHS can provide higher level services
- Children in trouble will be identified by teachers working with the integrated service. There will be constant liaison relating to placements and transitions in and back to the school environment

This could have a positive impact on the CAMHS workload or it could increase complexity or referral numbers. The importance of working with DECD on the introduction of this new service is highlighted to ensure a streamlined system of care.

4.6.2 Internal Stakeholders

Internal stakeholders refers to other clinicians within the WCHN who share patients with CAMHS. This includes paediatricians, obstetricians, Clinical Liaison Psychiatry, relationships between community teams and Boylan Ward.

Some described very poor relationships and others highly beneficial relationships such as the mental health nurses in the ED and other ED staff. Some community teams described the discharge processes from Boylan Ward as poor and lacking in handover information. Community teams also identified concerns where psychiatrist visits were irregular and inadequate documentation made transition of care difficult.

4.7 Issues relating to CAMHS staff

A variety of consistent themes were identified at the outset in the interviews with staff and were confirmed in further interviews and in the submissions. These themes are of considerable concern to staff and areas that they are very keen to address as outcomes of this review. Some of these have been alluded to briefly previously. The themes identified relate to:

- Staffing mix
- Generic roles for many of the professional staff
- Clinical supervision
4.7.1 Staffing mix

Staffing mix was mentioned by some staff groups, unions and professional associations as an issue and some staffing data was provided to the review team. The different professions in CAMHS are psychiatrists, clinical psychologists, social workers, nurses, occupational therapists and speech therapists. The types of professions are those one would expect in a mental health team.

SA CAMHS has a preponderance of social workers in its community teams and nurses many of whom are located in the ED and in Boylan Ward. There are some occupational therapists and speech therapists in the community teams, but none who are permanent in Boylan Ward. Psychiatrist numbers are low in South Australia and most work mainly in the public system. Clinical psychologist numbers are also low and it was stated that it is difficult to keep a sustainable and experienced clinical psychology workforce. Most of the clinical psychologists working in CAMHS are newly graduated and there is a significant number of more experienced clinical psychologists who are nearing retirement. When the new graduates become more experienced they move into private practice where there is more autonomy and more income.

There seems very little rationalisation of team composition and no clear workforce plan or guideline about this. The numbers and distributions of the professional staff have been benchmarked and will be discussed and analysed in Section Five.

4.7.2 Generic roles for professional staff

This was a major concern for professional associations and a concern for staff themselves. Some staff felt that they had been de-professionalised and did not use their profession specific skills to assist clients, operating as generic clinicians. A significant number of occupational therapists occupied generic positions, a small number managerial positions, and a small number profession specific positions. The small number of speech pathologists in SA CAMHS occupied profession specific positions also providing generic services to teams, profession specific positions not providing generic services, and in managerial positions. All speech pathologists on community teams also perform duties as rostered duty officers. Some social workers were also concerned about their scopes of practice, particularly in the context of the Coroner’s reports.

This was also a comment from the nursing group in that many nursing positions when advertised but not filled became generic positions and never reverted back to nursing. They also reported that the nursing structure mitigates against them applying for certain positions due to salary levels.

4.7.3 Clinical supervision

All professional groups believed that clinical supervision was a major deficit, although there were some individual examples in specific teams where this was regarded as adequate. The lack of appropriate clinical supervision has a number of causes including the flat structure with inadequate numbers of senior staff to supervise more junior staff, inability to recruit staff at appropriate levels and increased patient loads as a result and an implication in some areas that it is just too difficult to organise. In addition, it had been difficult in some of the disciplines to increase the numbers of senior staff through criteria progression over a long period of time, although this had been supported by professional associations.
4.7.4 The role of the CAMHS psychiatrist

As alluded to above, due to a number of historical factors and the lack of access to significant psychiatry resources in community teams, and lack of appropriate role definition, psychiatrists have become disengaged. However, this is improving with the interim structure. The other factor that relates to the access to child and adolescent psychiatrists is that South Australia has very low numbers of these professionals and no obvious workforce strategy to redress this.

Psychiatrists were asked about what they thought their roles should be and staff groups were also asked about what they considered to be the psychiatrist’s role. It is noted that initially psychiatrists were not members of community teams and this has been evolving over the past ten years, with numbers slowly increasing. As a result it is not known how many are needed and their roles have not been clarified. There was discussion about which cases required Psychiatry input, and how this was transparently determined or whether this was left to the discretion of individual Psychiatrists.

Staff reported that there were often requests from GPs for a young person to see a psychiatrist, but there were not sufficient psychiatrists for this to happen, let alone fitting in with the CAMHS allocation process and this was an issue with external referrers, especially if the young person had to relinquish their private psychiatrist in order to access other CAMHS services.

Some psychiatrists also reported that they felt devalued, were not sure what their roles on the teams were and needed a clear job description to describe this. It is noted that this is not the case in the inpatient services where their roles are more clearly defined. It was also clear from the Coroner’s reports that the psychiatrist in one team was regarded as a generic member of the team and interchangeable with others. In some teams, the psychiatrist is not fully integrated into the teams and in teams where there has been no psychiatrist available for many years, the need for a psychiatrist is not recognised. Patient management plans are not consistently signed off by psychiatrists in any of the CAMHS teams as a general rule.

As with many other aspects of CAMHS operations, the role of the psychiatrist was inconsistent across the various outpatient teams. From interviews, medical and non-medical staff indicated that psychiatrists were required to:

- Provide second opinions
- Support the risk and back up staff
- Understand emerging Mental Health issues
- Provide collegial exchange
- Undertake group supervision of the team
- Prescribe and monitor medications where this is appropriate
- Get things done where authority is needed e.g. with Emergency Department
- Use of credibility with patients i.e. telling patients that treatment is appropriate and they don’t need drugs

This is not necessarily how psychiatrists in a contemporary service would see their role if this was better defined. There is a lack of consistency across the various teams as to whether the psychiatrist and team leader or the multidisciplinary team hold the clinical risk and accountability about the patient’s treatment and progress. The psychiatrist is not consistently consulted about patients needing review across the community teams. In both coronial inquiries, it was reported that the patient was not brought to the attention of a psychiatrist for consultation or review. In one case, the young person did not see a psychiatrist and in the other case, the young person saw a psychiatrist but this was as a generic team member, rather than as a specialist psychiatry consultation.
It is noted that the Coroner’s recommendations clearly stated that:

- The number of psychiatrists employed in CAMHS needs to increase
- All services provided by CAMHS should be under consultant supervision
- All triage should be by the most senior therapist in the service
- All clients with suicidal ideation should be immediately referred to a CAMHS psychiatrist
- All risk assessments and management plans should be referred to a psychiatrist

Comments on the feasibility of these recommendations will be made in Section Five of this report, but it is noted that there have been changes in operations to attempt to comply with these recommendations.

4.7.5 Administrative Staff

While the focus of much of the discussions in previous sections has related to professional staff, it is clearly important to acknowledge that competent and knowledgeable administrative staff are essential if any service is to operate efficiently and effectively. As a result, administrative staff were also interviewed to understand their concerns and improvements required.

Similar to other areas of CAMHS, administrative processes across the service are not consistent and there is no clear administrative hierarchy within CAMHS.

One submission indicated “As there are no senior administration staff, the administration staff have no structure for support or supervision other than regional team managers. This increases the load on the regional manager and may decrease the efficiency and accountability of the administration staff”.

Administrative staff mentioned the difficulties of dealing with the two different payroll systems of the North and South, the lack of training in the new procurement system, inconsistent practices across many teams in relation to case notes, managing understaffing both administratively and in relation to clinical staff, staff with no training in mental health administrative issues, lack of cover for leave, internal communication processes and no managers on site for some teams.

4.8 Specific CAMHS areas of operation

There are a number of services which require an individual focus because of concerns expressed and/or aspects that are individual to their operations. Inpatient services, indigenous CAMHS operations and country services in particular are identified as requiring specific comments.

4.8.1 Inpatient Services

There are two specific inpatient services, Helen Mayo House for perinatal services located on the Glenside Campus and Boylan Ward located within the Women’s and Children’s Hospital.

4.8.1.1 Helen Mayo House

The integrated PIMHS at HMH has been referred to in 4.1.1 as an innovative and high quality service and was reviewed by the psychiatrist on the team who specialises particularly in this area. The inpatient facilities are world class, being modern, welcoming of families and well designed. They also house the community team, and education and training functions. Clinical leadership is at a high level and the following positive attributes were noted:

- High profile clinical leadership
- Culture of innovative clinical service delivery and of models of care
- Range of multi-disciplinary staff leading and contributing to clinical innovation
- Culture of research and evaluation
- High degree of staff motivation
• High level function by medical and multi-disciplinary staff in consultancy, partnership, clinical and liaison roles
• High degree of continuous learning organisation type behaviours. However these are now challenged by fiscal, administrative and bureaucratic restrictions
• Clinical staff hold the view that they are experienced, have developed roles where they have been able to extend and expand their clinical functions because of the reliable, accessible senior clinical support they receive from medical staff and other senior clinicians that can be relied upon
• Staff perceive their multi-disciplinary team functioning, team meetings, and roles to be nurturing, supportive, well-developed, collaborative and effective

Access to services including adult mental health and CAMHS for children under five may also impact on care delivery.

4.8.1.2 Boylan Ward
This inpatient unit is located in the Women’s and Children’s Hospital and was not purpose built for mental health patients. Patients admitted range between 12 and 18 years and there are 12 beds in the unit. This unit in contradistinction to HMH does not appear to have enough psychiatrists to cover the work, however this will need to be assessed during the clarification of the role of the psychiatrist and requirement for changes in allocation of psychiatrist hours, as recommended in Section five. A number of issues were identified including:

• The referral template not being used by referrers and so many different modes of referral
• Many staff in acting positions over long periods
• Inability to discharge to some community teams due to long waiting lists
• Large numbers of enquiries requiring investigation and reply
• Lack of clarity of what core business is
• Sub-optimal relationships with some community teams
• Little use of planned admissions where the outpatient clinician, the young person and their family meet with the ward staff to discuss admission goals and enable the consumer and family to gain and understanding of the ward and ward processes, prior to a formal admission

It is noted during interviews with consumers and carers and reference to complaints data that Boylan Ward is the service where there are the most complaints from consumers and carers and also the most complaints to the Health Complaints Commissioner. The Health Complaints Commissioner indicated there were not a large number: 3 over the past 3 to 4 years. These complaints related to the culture of the ward, the therapeutic nature of the staff and adversarial relations and processes of discharge. Some community teams commented that Boylan Ward was refusing admissions, making unrealistic recommendations and changing the patients’ management.

Consumers and carers were more forthcoming, with very few positive comments (although these were specifically requested) about Boylan Ward and many negatives including lack of a therapeutic service and too early discharge.

4.8.2 Indigenous services and APY lands
There is a small group of Aboriginal Mental Health consultants with a role in patient counselling, assessment, welfare, brokerage, group work, education and as consultants to clinicians. The
community would prefer “Aboriginal well-being counsellors” because mental health is not a concept that is understood in the Aboriginal world view. There is significant variation in the roles and functions

This was also seen as a complex issue as it was reported that some had tertiary qualifications and others did not, so this impacts on the range of roles undertaken. In addition, supervision of work and the role is limited because while clinical and liaison functions are supervised, cultural supervision is not provided. Staff believe that supervision of both roles is warranted because they work within a “culture first” model. Some expressed the view that this orientation required they have supervision in cultural issues as a first priority. Others expressed the view that cultural skills were equally important as clinical skills and consideration should be given to recognising them equally.

Concerns were raised regarding the small number of permanent staff in Aboriginal mental health consultant roles. The ratio of temporary to permanent staff was reported to be much higher with Aboriginal versus other staff. The reasons for this are not clear. A number of issues were identified including some staff reporting that they felt that they were working beyond their scope of practice, inappropriateness of the current award and a high temporary to permanent staff ratio. Further exploration of these issues is required in the CAMHS change process referred to in Section five.

The APY lands are very remote in the far North of South Australia. In this area, English is not the first language and this creates a potential barrier to establishing trusting relationships. There are a number of staff whose positions are program funding dependent, and most staff are on contracts so there is considerable turnover resulting in a fragmented process of care. Phone and internet services are unreliable and safety for staff is a concern. The staff who work with these communities are highly dedicated and committed.

Although the population is small, the need for CAMHS is significant and the manager has a house on site. Team workers visit for a week at a time and indicated that they need to live in the manager’s house as there is no other accommodation. There is an opportunity to collaborate with Country Area Health Network to access other accommodation in the community for this purpose. A room in the school is used for interviews of clients. The administrative part of the service is situated on the ground floor in the Health Promotion office area with staff from different services and this causes some concerns in relation to confidentiality and sensitivity in the open office area.

A number of other stakeholders noted that not only CAMHS but other services also visited APY lands, and that there is potential for greater co-ordination to ensure optimal impact. Since the visit of the review team a strategy has been developed to address these issues.

4.8.3 Country CAMHS community teams

Although there are inconsistencies and systems issues in all of CAMHS, country CAMHS experiences specific difficulties related to size, more difficulty in attracting professional staff, especially clinical psychologists and psychiatrists, limited access to non-government services and lack of support from metropolitan services. This was a common theme in many of the services interviewed.

This is expressed cogently in one of the country submissions:

“Access to psychiatry is limited, particularly in country sites. There are unrealistic expectations (e.g. from GPs & hospitals) about how much psychiatric support CAMHS can provide.”

“Backup from WCH in terms of assessment and/or admission for high risk clients is often difficult to negotiate e.g. clients who have phoned WCH for mental health crisis support being told to contact CAMHS or even that CAMHS will see them, without first checking that there is a clinician available.”
The remoteness of some of the services also makes training and professional development for staff difficult and there are limited funds and travel makes funding education very expensive.

It is noted that some services use limited telemedicine for psychiatrist input, but this is not yet widespread. Some teams have many non-English speaking clients.

Country teams will be contacted by local hospitals when they have young people in distress and will generally provide support for this. The teams close to the Victorian Border will refer to Victorian hospitals and have close relationships with Warrnambool and Mildura but no memoranda of understanding with these hospitals.

4.9 Consumer and Carer impressions of CAMHS

Consumer and carer impressions have been referred to throughout this section but overall they have some specific issues relating to their experiences of the service. It is noted that all of the consumers seen had experienced ASEC services and that some of the carers had also experienced ASEC services. However some carers had neither had experience of ASEC n had they heard of ASEC. All of the consumers and carers had had experiences of community team care and some had had experiences of Boylan Ward.

4.9.1 Consumer experiences and expectations

Consumers were not sure of the differences between psychiatrists and clinical psychologists and did not know if they had seen a psychiatrist in most cases. They believed CAMHS would provide a more therapeutic experience for them if:

- There was a more relaxed approach
- Someone listened to their full story without interruptions
- They were kept informed about what was happening, particularly on Boylan Ward
- Facilities were more age appropriate in fit out
- There were more age specific services
- There were given more time to provide answers as some took time to think things through
- Home visits by CAMHS staff were an option
- Transport services could be provided to get to services more easily
- There were more ASEC like services for better access

Consumers were especially negative about inpatient services particularly if they were sent home, shortly after admission.

4.9.2 Carer experiences and expectations

Carers described the inconsistency of services they had experienced. This related to both staff and processes:

- Some workers wonderful and others judgemental
- Repeating of the same story was very frustrating
- Some were not told about ASEC and did not know it existed
- GPs did not mention CAMHS to most carers as an option for care
- Services were different in different locations
- Carers believed time alone with the CAMHS therapist was very important
Where young people were admitted to Boylan Ward, many carers indicated that they were being discharged too early and that the discharge process was not oversighted by a psychiatrist. Problems remain unresolved and referral back to CAMHS is needed.

With discharge from ASEC, it was not clear what preparations would be made for discharge to support this process and what further follow up there would be, so carers and young people could be left feeling in limbo.

Improvements sought by carers included:

- More ASEC type services and more ability to access ASEC
- Better continuity of care
- More education about mental health issues, prognosis and treatment for both carers and teachers, including in private schools where there seems to be a major gap
- More service flexibility
- More parenting programs
- Maintain focus on schooling as well as improving mental health

### 4.10 Availability and use of data

The review team spent time trying to understand what data was available and how this was used. As referred to previously the data systems of the North and South are different and have not yet been combined as decisions have not been made which to adopt.

The review team was given access to data relating to:

- Staffing numbers and breakdowns for all clinical staff except psychiatrists
- Incident and adverse events data
- File audit results (Northern CAMHS)
- Some outcome data that was routinely used in some services but not others

There appeared to be little other data collected, collated or reviewed to provide information for improvement of clinical service delivery of more efficient management of the services. Despite direct questioning, staff from different geographic areas did not indicate that they regularly used data to improve their services or for accountability purposes.

It is acknowledged that with the integration of Northern and Southern CAMHS, some of the existing systems may have been lost as is common in any change process, but the CAMHS Review Team focused on what was available at the time of the review.

### 4.11 Proposed new Model of Care

A CAMHS Model of Care document was provided. It is noted that this document was prepared in June 2013, presumably for the integration of the Northern and Southern services which at that time was in the process of occurring, and to take into account the implementation of the Youth Mental Health Service planned for 2014. The Model of Care for YMHS was also accessed. The aim of reviewing these documents was to gain an understanding of the directions of service delivery for young people with mental health concerns in South Australia, to determine if these were appropriate in relation to goals, objectives, strategies and guidance to staff and to determine if they provided a clear picture not only of what services would be provided by an integrated CAMHS (and the YMHS), but how such services would be provided, monitored and evaluated.

It was noted that the document is still in draft and had not yet been adopted. An analysis of the limitations of the draft Model of Care has been documented in Section Five.
The Youth Mental Health Services document is described as a set of Operational Guidelines and is therefore far clearer on what the YMHS will do, its philosophy and how it will do this. Notable is the establishment of operational governance structures including a central coordinating committee of which WCHN is a member and a set of network coordinating partnerships, one of which incorporates CAMHS. During the review, no-one mentioned these committees. However information was received that this committee was previously attended on behalf of WCHN by the Executive Director PPH and is now attended by the CAMHS Director. In addition the document has an implementation chart of committees showing a CAMHS – Youth Mental Health Implementation Steering Committee. This was not mentioned to the review team during its time at WCHN. The committee has been set up and is a Department of Health Committee chaired by the Chief Psychiatrist.

The YMHS Operational Guidelines also clearly document a System of Care approach based on Tiers:

- Tier 1: Primary care;
- Tier 2: Specialist care with mental health expertise;
- Tier 3: Specialist mental health services

For each of the tiers, the role of the YMHS is clearly outlined.

The section on transition is brief and there is little detail on processes to be used. There are some useful flow diagrams to illustrate processes of care and these clarify how the service will operate.

4.12 Autism Spectrum Disorder (ASD) and CAMHS

Whilst not intending to detail all of the specific groups of clients CAMHS may have referred to it, a number of staff brought up ASD and the role that CAMHS had to play in the treatment of this disorder. Generally staff believed that this was not within their professional scope of practice, but there was often nowhere else for the consumer to go. One of the submissions refers to this:

“Other agencies continue to refer clients to CAMHS for assessments for Autism Spectrum Disorder. Most CAMHS clinicians are not trained nor have the experience to assess ASD or provide the specialised treatment for children and adolescents with ASD. Other health, education and welfare agencies and professionals continue to refer children and adolescents to CAMHS for ASD assessments and/or treatment because of the long waiting times for the agencies who do provide assessments and treatment for ASD and because of the cost.”

In other jurisdictions, ASD is clearly the role of paediatricians with psychiatrists being involved in secondary consultations where needed. This is a whole of South Australia issue and again indicates how the lack of service delineation for CAMHS means it can become an inappropriate default option for referral management.

However, mental health comorbidities with Autism spectrum disorders are very common, particularly in community patients. CAMHS staff should develop the skills, expertise and the experience to assess, manage and treat these common mental health comorbidities in partnership with other appropriate services. It may not be appropriate for initial diagnostic assessment of such developmental disorders to be undertaken by CAMHS, but the treatment of common mental health comorbidities, when appropriate, could be considered a core CAMHS function, providing SA CAMHS is adequately funded to undertake this expanded role.
5 Discussion and Recommendations

Note: recommendations will be confirmed and numbered following feedback from stakeholders

The terms of reference for this review focus on improving systems relating to CAMHS and seeking recommendations on:

- Overarching clinical governance including clinical risk management policies and procedures
- Models of care including pathways, integration with other bodies, staffing model and transition to youth services in the new strategy
- Consumer engagement
- Standards of documentation

The discussion and recommendations will reflect these objectives and extend to a variety of strategic issues identified which have an impact on the functioning of the organisation and standards of care. It is noted that documentation standards were limited to a review of policies and as part of development of the integrated CAMHS model of care, standards for staff documentation in client/patient records should be clearly defined.

5.1 Understanding services and systems and their effect on culture

5.1.1 Definitions of mental health services and systems

A definition for “mental health services” is to be found in a recent University of Queensland Report. This definition is:

“Refers to services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non-government sectors, where such organisations may exclusively focus their efforts on mental health service provision or provide such activities as part of a broader range of health or human services.”

This is a useful definition for CAMHS as a mental health service providing a broad range of services for consumers and involving carers, and providing activities as part of a broader range of services.

Another useful definition is:

“A group of government, professional, or lay organizations operating at a community, state, National or international level to aid in the prevention and treatment of mental disorders.”

This definition is helpful as it refers to a group of organisations and CAMHS has a number of different professional services under its umbrella, which need to function as a group or as a system. Taking this into account, the definition of “system” is also of value:

“A set of things working together as parts of a mechanism or an interconnecting network; a complex whole” and “A set of principles or procedures according to which something is done; an organized scheme or method.”

1 Defining mental health services for classification purposes, Definition and Cost Drivers for Mental Health Services project, University of Queensland, March 2013
3 www.oxforddictionaries.com (September 2014)
The reasons for referring to these definitions is to clarify the accepted purpose of a mental health service and to emphasise the importance of such services working in a coherent and systematic way to provide a consistent, efficient, effective and high quality care for its consumers and carers. This means that even the best professionals working with absolute commitment to their consumers and community, cannot deliver the best service that they are capable of without an appropriate and robust system. Such a system must fully support their work, build capacity and capability, nurture and grow internal and external relationships, build mutual trust between management and staff, and provide the security that if things go wrong they will be attended to in a timely, supportive and consultative way.

As referred to in 4.1.1, the focus throughout the review has been on systems and understanding the impact of systems that need improvement on all stakeholders. Although senior management can point to systems which are in place, if these systems are not perceived by staff, or are inaccessible to staff or if different parts of the organisation are seen to be doing things differently, then the systems are fragmented and not providing the support and guidance staff require to deliver optimal care and service delivery.

It is not unusual for systems to break down, particularly in times of change as is the case with CAMHS at present. In the neutral period of the transition process as described by Bridges⁴, old systems are breaking down and new ones have not yet taken their place. This he states is the most dangerous time in the transition to change and causes:

- Staff to become overloaded, systems to become unreliable, priorities to get confused and information to be miscommunicated
- People to become polarised, consensus to break down and teamwork to be undermined

Even with Northern and Southern CAMHS, some systems were not effective. With the transition process and the overlay of the Coroner’s reports, these difficulties have been exacerbated. It will be very important that when new systems are established, including the new Model of Care, that these are regularly evaluated. This is the only way to ensure that systems continue to provide support to all stakeholders in the context of a continuously changing environment.

# 5.1.2 Delivering a whole of CAMHS system

From the beginning of the review, it has been defined by discussions of Northern and Southern CAMHS, with staff in their two separate systems with differing organisational cultures, each group being certain that their system was best and attempting to provide evidence that this was so. Although the two different parts of the service had been integrated on paper, this had not made any significant change in the way that CAMHS operated and staff still were to all intents and purposes in two separate services. In fact bringing together these two disparate parts of CAMHS without a carefully planned and implemented change strategy, is likely to have impacted negatively on both service delivery and staff morale, with some previous systems disappearing and no new systems to take their place.

Overall the conclusions of the CAMHS Review team were that there is a need to:

- Establish a whole of CAMHS strategy and consistent clinical leadership to overcome the fragmented, variable delivery of care
- Proactively disseminate innovative practice in areas where this was evident
- Provide consistent support for country teams from metropolitan services

Address the variability in the use of data for monitoring and improving service delivery and care

Acknowledge that some staff felt that they received ineffective support in the difficult period following the release of the coroner’s reports

Build trust and mutual respect between management and staff, as this was at a low ebb at the time the initial interviews were conducted

It needs to be stressed that the recent changes in reporting structures and interim senior management for CAMHS have started to make inroads into this situation, but this will take time and a comprehensive overarching change management strategy to resolve.

Despite this, the individual staff who deal with consumers and carers continue to do their work professionally and to the best of their ability. The service continues to function as well as it can under the circumstances and this is a credit to staff at the front line. However overall, there is no overriding CAMHS culture or a consistent CAMHS way of doing things and this provides an opportunity for the future, to integrate in the right way, for the right purpose, led by the right people and supported in the right way so that the service is contemporary, consistent, efficient and effective and valued by clients and the community.

This means that a number of areas need to be addressed and it requires all of these to ensure a sustainable high quality, integrated CAMHS in future years.

- An appropriate organisation structure, with appropriate people in key positions
- A contemporary and comprehensive clinical governance framework
- A contemporary and comprehensive Model of Care that defines staffing mix, staff roles and team functions, underpinned by evidence based policies and procedures
- A commitment to ongoing robust orientation, education and clinical supervision and resources and systems put in place to implement and monitor success of these
- A clear accountability system including performance indicators, oversighted by the leadership of CAMHS and reporting into the WHCN performance system
- A professionally developed and implemented change strategy aimed at developing a whole of CAMHS culture, based on a clear mission, vision and values
- Integrated consumer and carer strategies
- A focus on building and nurturing a whole of CAMHS collaborative and structured relationships with all CAMHS stakeholders
- Allowing CAMHS as a service to have a more direct influence in its strategy, structure and systems within a defined performance framework, so that staff, stakeholders, consumers and community are engaged in the delivery of consistent care.

It is essential that this is an active process. A whole of CAMHS system will not be built by simply changing an organisation structure, developing policies and procedures and imposing performance measures. This will only change if staff and management are engaged and involved in a professionally led and resourced change process, are educated on mission, vision and values and in clinical governance, and, are supported to make the change.

This can be exemplified by a quote from one of the submissions: “when two different organisations face the challenge of merging, then misunderstandings re appropriate practice and priorities between people from two different working models/cultures are likely and almost inevitable. This is compounded when there is a significant power differential between the combining groups, and the larger, more well-resourced group is already part of the designated governance structure.”
There have been many health services that have attempted amalgamations where there has been a clash of cultures and which have not implemented an engaging and professional change process. This has led to decades of repercussions as old grievances have never been addressed and have been allowed to fester, with the result that effectiveness of service delivery and quality of care continues to be compromised.

5.1.3 Developing a positive organisation culture for an integrated CAMHS

The organisation culture of any service is intimately connected with its leadership and strategy and the importance of the right people to lead, develop and nurture this new integrated service cannot be minimised. The prevailing culture in CAMHS, and the reasons for this have been alluded to in Section four.

The Service now requires an injection of energy, optimism and collegiality to launch itself as a rebranded service for children and young people from 0 to 15. The focus for this cultural change should be what is agreed by all working in CAMHS, i.e. providing the best possible care and service delivery (within appropriate funding parameters) based on the needs of the South Australian community, so that young people are provided with the optimal opportunity to improve and sustain their mental health.

The integrated CAMHS should cease reference to “Northern” and “Southern” and concentrate on a new way forward that is geographically unaligned. This may mean a new name for the service and this will be referred to later in the section on managing change. Since the review team visited considerable efforts have been made to begin addressing these issues.

5.2 A workable organisation structure for an integrated CAMHS

A variety of perspectives have been put forward and for structure there are only limited options:

- No change: this has been discarded as it will not support change
- One Director selected from any discipline
- One Director who is a child and adolescent psychiatrist
- Present temporary structure confirmed with a Psychiatry Clinical Director and a Mental Health Executive Director working in partnership as Co-Directors

There are also limited options in relation to reporting relationships;

- Report to another executive on the WCHN team, now that the Division of PPH has gone
- Retain the present interim situation and continue to report to WHCN CEO

Report outside the WHCN altogether: this has been discarded as it is unlikely to be adopted

5.2.1 Reporting structures for the CAMHS executive

The review team has examined these options from a variety of points of view including benchmarking with mental health structures in Australia, research relating to clinician engagement and how this might best be fostered, structures that would best support the strategy of a new CAMHS i.e. one that is fully integrated, supports and respects all professions, is better defined in relation to mission and services delivered and one that is state-wide.

Considering all of these matters, it is clear that the accepted most common model for large mental health services is direct reporting to the CEO of the health service. This is the typical regional and metropolitan model in all jurisdictions. It becomes even more appropriate in South Australia with CAMHS being a large state-wide service and now a different type of model from the previous “clinical department” model when there were Northern and Southern CAMHS. It is no longer appropriate for
an integrated CAMHS to report to an executive at WCHN and if real change is to be developed and sustained, this will provide the best opportunity for this to occur.

It is difficult to envisage any disadvantages for continuing this reporting structure. This will however mean that either the single director or the co-directors will need to be Executive Directors of CAMHS.

### Recommendation:

1. **Confirm the reporting structure of CAMHS to the CEO of the Women’s and Children’s Health Network**

#### 5.2.2 CAMHS executive leadership

Leadership structures for mental health services do vary and there is no consistent model. Some are led by a psychiatrist, some by a professional in another field with extensive management experience and some have a co-director model similar to the interim structure at CAMHS at present. The pros and cons of these models have been considered by the review team, with reference to the present culture of the service, the best ways to integrate the service and engage all clinicians, the intent behind the Coroner’s recommendations and the means to a contemporary and consistent service.

##### 5.2.2.1 The Co-Director Model

The CAMHS Review team noted that there had already been many positives from the implementation of the present interim structure although acknowledging that the individuals had only been in these roles since June 2014 and that more work had been done with psychiatrists than with the other clinical disciplines. Having a professional and experienced manager in the Director role meant that there could be an immediate focus on some of the gaps, procedures and accountabilities albeit limited somewhat as definitive CAMHS operations and integration awaited the outcome of the review.

The team approach of a part time Psychiatrist Clinical Director and full time Director appeared to be working well and this is a model successfully adopted in many health services not just in mental health. This sort of approach engages medical staff as there is a medical clinician equal to the manager, allows medical input into key decision making, but allows the professional manager (who may come from any discipline) to assume a full time role that is both strategic and operational.

Research in the UK, Canada and the USA has focused on the importance of engagement of medical staff and in physician leadership both in improving quality of care and in reducing costs of health services. There has also been considerable work in Australia on building partnerships with medical staff so that they are engaged and involved in all health service activities to improve organisational operations. The work of McKinsey in the UK is one area where there has been considerable research. The advantages of physician leadership include “acting as role models for medical staff and being able to attract talented medical staff” 5, a heightened sense of “professional identity and a sense of accountability” 6 and “high performing medical groups typically emphasise clinical quality” 7.

Implementing a Co-Director model where the co-directors are half time psychiatrist and full time manager from any discipline, should in fact be acceptable to all groups of professional staff and

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5 Goodall Amanda, H: *Physician Leaders and Hospital Performance: Is there an Association*, IZA and Cass Business School, July 2011


associations. Both of these should work with the whole of the clinical workforce to ensure a true multidisciplinary strategic and operational approach.

The disadvantages of the Co-Director model are that it is more expensive than a single director appointment and that the model will not be successful if the two people appointed cannot work as a team with shared responsibilities and accountabilities.

5.2.2.2 Single Director Model

The single director model has the advantage of being less expensive for WHCN and having a single point of accountability rather than having to work in conjunction with another executive. It gives the senior executive that CAMHS reports to at WCHN, one single person to deal with in any CAMHS issues. However, the single director model will be acceptable to only part of the workforce and part of the professional associations, depending on what sort of person is chosen.

In addition, if the single director is not a psychiatrist, there is a significant risk that the fragile re-engagement process which has commenced with psychiatrists is likely to stall as this part of the workforce again feels devalued. This could be extremely detrimental to forming an enhanced CAMHS with fully engaged psychiatrists.

On the other hand if the single director is a psychiatrist, other professional staff may feel that this will result in the adoption of a medical model rather than the true multidisciplinary model which CAMHS requires. Past history will be remembered by many staff with concerns that history will repeat itself and they will feel excluded from decision making. The advantages of the single director being a psychiatrist are identical to those outlined in the Co-Director mode.

5.2.2.3 Recommending a structure

Whatever executive structure is approved, this will only satisfy a proportion of the stakeholders and the objective is not to satisfy stakeholders but to determine what will be the structure that will provide CAMHS with the best opportunity for making the needed changes at the present time in its history. Ultimately any structure is only a vehicle for appropriate people to effectively carry out their roles and the selection of the right people will be paramount, once the structure is confirmed.

The CAMHS Review Team was unanimous in its view that the interim structure that has been put in place (full time Manager and half time Psychiatrist Clinical Director) provides considerable advantages to move CAMHS forward and that these advantages far outweigh any added costs. Also in accord with the other reports to the CEO, the two directors should be “Executive” in title i.e. Executive Director and Executive Clinical Director. It is however essential that with the clear intent of developing a culture based on transparency and trust, it is imperative that the recruitment and selection processes for both the Director and Clinical Director observe the highest standards of HRM practice.

**Recommendation:**

2. **CAMHS to be led by a partnership of an Executive Director and Executive Clinical Director who will be a psychiatrist**

3. **Recruitment and selection of the two executive positions to be an open and transparent process following best practice in human resource management**
5.2.3 Leadership in the clinical disciplines and administration

Both the interviews and the submissions from the professional groups provided views on leadership in the clinical disciplines presently existing in CAMHS. The review team engaged in benchmarking to support a robust organisation structure that would be consistent with services in other jurisdictions. Some of the positions are already in place in the CAMHS structure and others will be new positions.

The submissions, discussions and benchmarking confirmed that the organisation structure should have clinical leads in all the professions to provide professional leadership and management support for each profession, including overseeing education and supervision strategy and monitoring, performance monitoring, recruitment and orientation and administration issues.

The largest groups in CAMHS are clinical psychologists and social workers with a smaller number of occupational therapists and a very small number of speech pathologists. There are 75 FTE social workers. There are 49 clinical psychologists with an FTE of 37. It cannot be assumed that the proportions of these will remain the same, as discussed under staffing mix later in this section, but these will always be the largest groups among the allied health professionals. The suggested structure for these groups (based on benchmarking with other jurisdictions) is to have two clinical leads in each of social work and psychology at AHP 4 level with an operational role in metropolitan or country for each profession.

**Recommendation:**

4. Establish two clinical leads (Country and Metropolitan) for each of Clinical Psychology and Mental Health Social Work at AHP 4 level

Occupational therapy may warrant one AHP 4 across both metropolitan and country, with a similar role for speech pathology but at AHP 3 level as the numbers are very small (4.2 FTE). However, these should be considered interim measures for a number of reasons further referred to in 5.4.2. The review team believes that these positions should be specialised rather than generic i.e. Occupational Therapists and Speech Pathologists with a competency in mental health work, rather than generic mental health workers. These would then report in a line management context to the relevant operational director and professionally to their professional lead at WCHN.

**Recommendation:**

5. Pending a review, establish interim clinical leads for Occupational Therapy (AHP4) Speech Pathology (AHP 3) in CAMHS followed by and a formalised reporting structure once these roles have been defined

The nursing structure with a nursing director also needs to be reviewed. The CAMHS DON will be responsible for all nursing staff in CAMHS and will report to the Co-Directors as a line role and professionally to the WCHN Executive Director of Nursing and Midwifery.

**Recommendation:**

6. Once the model of care has been developed, review and confirm the nursing structure to ensure that it follows contemporary mental health practice

Aboriginal Mental Health workers will report to an Aboriginal Mental Health Lead. It is noted that these workers request a change of title to Aboriginal Well Being Counsellors as this better reflects their role and is more meaningful to the community they serve.
**Recommendation:**

7. **Review roles and titles of the Aboriginal Mental Health workers as part of the enhanced Model of Care**

The Executive Clinical Director will be the professional lead for all psychiatrists in the service and psychiatrists will report to operational managers in relation to line responsibilities. In addition it is suggested that the Executive Clinical Director is the lead in clinical governance for CAMHS. The Psychiatrist Executive Clinical Director will also require a deputy as this position needs to be filled in case of leave and there may need to be some delegated activities.

**Recommendations:**

8. **Include in the definition of the role of the Executive Clinical Director that this position is the professional lead for psychiatrists in CAMHS and the lead in clinical governance for CAMHS**

9. **To ensure continuity in both clinical and clinical governance leadership, establish a part time Deputy Clinical Director position to be filled by an existing psychiatrist**

Administrative services will also need to be well organised to provide the optimal support to the clinical services. Having a competent administrative team with consistent processes can make a significant difference to efficiency and to effectiveness of a complex service and can take a considerable load from clinical staff. The review team is of the opinion that resourcing adequate administrative support will allow clinicians to focus on their clinical work and will ensure that systems are maintained and improved. This is supported in two of the submissions:

“Clinicians are required to complete large amounts of paperwork and spend time doing administrative tasks.”

“Increasingly, therapists are finding they are needing to do more and more Administration work, previously undertaken by Admin, e.g. typing of letters, making of client labels, photocopying.”

The administrative area requires leadership and although overall leadership has been vested in the Finance Manager in the new organisation chart, operational leadership for day to day coordination of activities needs someone whose focus is on this area to the exclusion of all others. An administrative manager is suggested, with experience in managing complex and geographically diverse services. This manager will ensure that there are always well trained administrative staff available at CAMHS sites, that there is a consistent system to support their work, that staff are appropriately orientated and have further training on new systems and processes and will field any concerns with administrative service delivery.

An administrative structure will need to be developed to ensure that all sites have administrative support at an appropriate level.

**Recommendations:**

10. **Develop an appropriately classified and resourced administrative structure to support the clinicians in CAMHS in the provision of an efficient and effective services to clients**

5.2.4 CAMHS Operational Structure

There was considerable discussion about what was needed to form what will be a new integrated service from 0 to 15 with a focus on change and building relationships both internally and externally.
The structure proposed takes all of these factors into account and acknowledges that the structure may need to be reviewed in two or three years as the new service matures. **One possible structure is outlined below.**

This structure is based on a number of principles:

- Keeping the CAMHS executive small so that it functions as a high level strategic body, that supports a consistent contemporary service
- Having a number of key roles that will lead collaborative relationships and processes both internally and externally
- Integration of consumer and carer input at the highest level of governance
- Having change management acknowledged as integral to success of a state-wide CAMHS
- Keeping key committees small and focused to function more as peak bodies with quality and accountability delegated to the lowest possible operational levels

**Recommendation:**

11. Establish a small management team as the CAMHS executive with representation from all key professional groups and from consumers/carers

5.2.4.1 Reporting to the Co-Directors or Single Director

- **Director of Nursing:**
- **Allied Health Chair:** this position would be elected from amongst the AHP clinical leads to chair combined CAMHS allied health meetings and be the representative on the CAMHS executive. This would be a rotating position of 2 or 3 years
- **CAMHS Director Operations:** responsible for operations across the whole of CAMHS with a key role in providing an integrated and contemporary service, and building collaborative partnerships with internal and external stakeholders
- **CAMHS Finance and Business Support Manager:** responsible for finances and overall performance data and monitoring for the CAMHS as a whole
- **CAMHS HR Consultant:** responsible for all HR functions in the service
- **CAMHS Change Facilitator:** responsible for developing and implementing the change strategy with the executive over a period of two years. This person needs to be an expert in change facilitation and contracted for two years to embed change and an enhanced culture
- **Consumer/Carer Consultant:** This needs to be a carefully recruited and appointed paid part time position who will work with the executive to keep them constantly aware of consumer and carer views so that the service is consistent in its patient care. This position will continuously canvass consumers, assist in education of staff, assist with complaints management and be a resource for staff.

This creates an executive of nine people whose role should be highly strategic.

5.2.5 CAMHS Committee Structure

- **Executive Committee:** peak CAMHS strategy committee chaired by one of the Co-Directors or Single Director or by the CEO of WCHN

Reporting to the executive Committee
Operations Committee: members will include operations managers, integration and relationship manager, allied health clinical leads, director of nursing, business manager. Chaired by the Operations Director

Consumer and Carer Advisory Committee: Chaired by Psychiatrist Clinical Director/ Lead to include all appointed consumer and carer members of this committee

Change Facilitation Team: this is the operational team of the change strategy and will include the Director CAMHS and staff recruited to the team. Chaired by the Change Facilitator

Clinical Governance Committee: to be described in the section on Clinical Governance

5.3 The Clinical Governance Committee

As indicated in 5.2.3, the Executive Clinical Director will be the clinical governance lead in CAMHS and will require a small support staff for efficient and effective strategy and oversight of the clinical governance strategy and to develop, implement and maintain the clinical governance system.

Because of the limitations canvassed in 4.4.2, the Executive Clinical Director working with the CAMHS executive will need to develop an appropriate clinical governance framework document that describes the philosophy and principles that underlie CAMHS clinical governance, the policies and processes that will support clinical governance and roles of the people in CAMHS i.e. staff, consumers and carers. The framework will be linked to the overall WCHN clinical governance framework.

The clinical governance framework will include the identification and management of risk, the identification and management of adverse events, credentialing and scope of practice systems, a strategy for ensuring staff skills and competencies are maintained and enhanced, processes for ensuring contemporary evidence based practice and processes for monitoring clinical effectiveness.

It will be important to establish a clinical governance committee and accountability structure this will require education of staff on their roles and responsibilities in continually improving standards of care by use of evidence based practice, identifying and managing risk and a focus on quality. The staff in the clinical governance area of CAMHS will need to be competent to conduct this education and to support CAMHS staff in their journey towards contemporary clinical governance. It is noted that as a first step a CAMHS clinical governance committee has recently been established.

A clinical governance committee (CGC) will need to report to the CAMHS executive and also provide its minutes to the WCHN Safety and Quality Committee. The CAMHS clinical governance committee should be the peak committee for quality and risk in CAMHS. It will monitor and implement strategy for strategic risk and monitor action taken on high level risk in CAMHS. In addition it will approve and support innovative practice based on ability to resource and consumer need. A number of committees are suggested to report to the CGC:

- CAMHS Morbidity and Mortality Committee: this committee will not only examine deaths but will have reported to it all serious adverse events and will assess Coroners’ reports from SA and other jurisdictions. This committee will be chaired by a psychiatrist and with membership from CAMHS staff and other non-psychiatric staff in the hospital such as paediatrics, surgery and the Emergency Department. It would also be worthwhile considering a psychiatrist who does not work in CAMHS as a member of this committee.

- Clinical Review Committee: this committee will assess all complex cases and provide recommendations to the CGC about changes in practice that should be considered.

- Quality and Innovations Committee: this committee will focus particularly on better practice within CAMHS, by putting forward improved practice gleaned not only from other services nationally and internationally but from its own services. This committee will be of key
importance in driving better practice and its membership should encompass staff at all levels who wish to contribute to this

- **Operations Management Quality and Risk Committees:** each of the operations areas will have their own quality and risk committees aimed at assessing and improving quality and risk identification and management in their own areas and monitoring improvements identified. Although these committees could be embedded in operations management committees, there would be added value in involving staff outside senior management, who would enhance their skills in this area and be able to educate other staff. In addition a quality and risk portfolio for an enthusiastic staff member in each operational area is a common model.

**Recommendation:**

12. **Set up a clinical governance structure and appropriate processes, led by the Executive Clinical Director to incorporate:**
   
a. **A clinical governance framework linked to the WHCN clinical governance framework**
   
b. **A clinical governance committee with an appropriate accountability structure**
   
c. **An education strategy and process for CAMHS staff**
   
d. **A set of reporting committees to support management of risk, case review and quality and innovation**

### 5.4 Implementation of a comprehensive, contemporary Model of Care

#### 5.4.1 Analysis of the Draft Model of Care June 2013

A new Model of Care has been developed, but not yet implemented and this provides the opportunity to review this with a view to ensuring that it is contemporary, addresses the issues and recommendations in this report and takes advantage of the knowledge and views of the CAMHS Review Team in further development of the model. The CAMHS Review Team is of the opinion that there are limitations with this document and these are described by one submission:

“the process was somewhat constrained by the derailment of previous attempts to do this, meaning that the pressure to find a consensus led to harder issues (e.g. re resourcing, workload benchmarking, and possible change to some programs or practices) not being able to be addressed by this group. This resulted in the development of an aspirational document, with no real clarity re priorities in a time of constrained resourcing,”

The review team has not undertaken a re-write of the Model of Care, nor is that within its scope. The question that needs to be answered is what is a Model of Care? What is its purpose? What should it contain? There are some useful references including:

- Understanding the Process to develop a Model of Care: NSW Agency for Clinical Innovation, May 2013
- Child and Adolescent Mental Health Service Model of Care, ACT Government May 2012
- Early In Life Mental Health Services Mental Health Program Service Manual, Monash Health, December 2011

There was discussion in the team about what a Model of Care should contain and the view that it should provide both a philosophy of care and service delivery and clear guidance to staff about how to implement this in their day to day work. To enable this to occur a Model of Care needs to include:

- Strategic objectives of the service including a clear role definition and how the service will be accountable for meeting its objectives
- Description of the different parts of the service and how they contribute to overall care
This will include service definitions, communication mechanisms and stakeholder relationships

- Roles and mix of the professions in CAMHS and how they work together in a multidisciplinary team environment to support patient care
- Support for clinical staff including orientation, training, education, continuing professional development and supervision
- A clear description of what multidisciplinary care consists of and how it is monitored
- A process for support of country services
- Description of how the clinical governance system supports provision of high quality care and accountability of staff for clinical governance
- The role of research in CAMHS
- The processes of transition to the Youth Mental Health Service and to Adult Mental Health
- Support of the processes of care delivery with flow diagrams, organisation charts and care process diagrams, clinical pathways and frameworks

**Recommendation:**

13. Develop and implement a comprehensive Model of Care that clearly identifies the philosophy and role of CAMHS and is a valuable guide for staff working in the service

The Service Manual for the Early in Life (ELMHS) Service for Monash Health in Melbourne is one example of a very detailed Model of Care. Any staff member working in the ELMHS will be able to pick up the service manual and understand not only the philosophy of the service, but what has been done to underpin this philosophy, what the aims and strategic objectives are of the service, how its values underpin the philosophy and the objectives of each part of the service and how each part operates.

The manual is full of useful diagrams with organisation structures, flow charts and processes that clarify how the service operates. In addition this manual is valuable in that it demonstrates what can be evaluated to ensure that there is progress towards strategic objectives and areas for improvement. In addition, the manual clearly identifies streams of care and breaks down these streams to specific services.

It is clear from the ELMHS service manual that this was developed in close consultation with staff during the structured change strategy introduced to develop a new service for the 0 to 24 age group. The difficulties faced at Monash Health with these changes are no different to those which are faced by CAMHS today in implementing an integrated service over the North and South and where young people in the 16-17 age group will be managed by the Youth Mental Health Service under Adult Mental Health Services.

Further discussion with the new executive of the integrated CAMHS, indicated that a change in terminology of the Model of Care could also be of value in the development of a clear guide to service and care delivery. The change process should work towards giving this a new name that better describes what the guide will accomplish. Examples could be Service and Care Guide, Service Model, Care Delivery Handbook, etc.

**Recommendation:**

14. Agree on a more descriptive name for the new Model of Care document that focuses on its function as a useful guide for staff and stakeholders
5.4.1.1. CAMHS role definition

The CAMHS open door policy has been alluded to throughout the report. As a first step CAMHS must clearly determine its role and this must be described in its Model of Care. The role needs to include for example:

- Treatment is patient-centred (putting the patient first)
- One CAMHS service
- Equity of access for patient regardless of postcode
- Everyone in the service owns the patient: e.g. a patient in the Emergency Department is the responsibility of all the CAMHS staff to assist in finding a bed or solution.
- A clear distinction of the role of a specialist CAMH Service and whether or not a tiered model of care applies is SA, and defining this operationally

**Recommendation:**

15. Establish a set of principles as a basis for clearly defining the role of CAMHS

5.4.1.2 Clarification of the role of the psychiatrist

The Model of Care must also clearly define the role of the psychiatrist. A position description is essential to clarify what are the core tasks of assessment, clinical review, primary versus secondary consultation with the treating team, secondary consultations external to the CAMHS, and the amount of psychotherapy or other specialist interest work they can undertake. Consideration also needs to be given to what is the role of the psychiatrist regarding clinical review, partnering with the team leader in decision-making, individual assessment and clinical governance.

There needs to be an expectation that the psychiatrist review of all cases at the multidisciplinary team meeting via the clinical team and that the psychiatrist or senior clinician signs off the review or discharge documentation of every patient. The psychiatrist also may be consulted as to whether there is a role for psychotropic medication for a given patient once an initial clinical bio-psychosocial assessment has been conducted. A breakdown of the separate clinical load, supervision load and administrative load (EFT or %) should be stated in the position description and priorities stated. The interface between private and public practice and the separate responsibilities must be clearly articulated. In addition, the feasibility of these expectations must be monitored in their implementation. Once the role has been clearly defined, the numbers of psychiatrists needed in CAMHS should be determined to fulfil the roles in all CAMHS services.

An excellent reference that explores the psychiatrist within the multidisciplinary team is *Attachment Five* of this report.

**Recommendations:**

16. Clarify the role of the psychiatrist in the various CAMHS services and develop a job description for each of these roles

17. Based on the role of the psychiatrist in each of the CAMHS services, review the requirement for increasing numbers of psychiatrists and work towards this requirement over time in accordance with the workforce strategy
5.4.1.3 Operation of the multidisciplinary process

The other aspect of service delivery that requires very clear definition is how the multidisciplinary Model of Care should work through the whole process of triage, assessment, management, review, escalation, discharge and/or transfer and enhanced access to a range of disciplines where indicated.

Whole of CAMHS guidelines, need to be established and practice monitored and evaluated and reviewed at operational level. The documented process should be supported by a definitive flow chart that can be easily understood by staff and by consumers and carers. The role of the psychiatrist must also be clearly defined in the process and in the flow chart.

An example of a definition of Multidisciplinary care from NSW Health is provided below:

Multidisciplinary care - when professionals from a range of disciplines work together to deliver comprehensive care that addresses as many of the patient's needs as possible. This can be delivered by a range of professionals functioning as a team under one organisational umbrella or by professionals from a range of organisations, including private practice, brought together as a unique team. As a patient's condition changes over time, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.8

The key to multidisciplinary care is that a range of health professionals is available and that the most appropriate people are selected to provide tailored services to individual clients. In addition, the whole team is available to discuss a specific client who requires review.

Another reference prefers to use the term “interdisciplinary” and this further clarifies how members of the team should work together:

The essence of interdisciplinary teamwork lies in the recognition, utilization and integration of the expertise and perspectives of different professionals, which derive from their professional discipline and which are focused on working towards a shared goal.9

Recommendations:

18. Clearly define the process of multidisciplinary care from end to end and the roles of all of the staff working in this process

19. Develop and implement a mechanism to monitor and report on how effectively this process supports care and service delivery

5.4.1.4 Assessment and management of clinical risk

Comprehensive clinical assessment including assessment of risk and clinical accountability in relation to the clinical risk needs further clarification and consistency of practice across each the clinical settings. The role of the clinician in assessing the patient, the documentation of the risk, the minimum frequency of review of the risk assessment, the escalation procedure, the role of the multidisciplinary team in understanding the formulation and the risk, and the role of the team leader and the consultant child psychiatrist in reviewing and managing the risk, all need to be documented.

There needs to be a mechanism for identifying high-risk patients, with the expectation of the development of a comprehensive management and treatment plan for these patients and specifically

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who should be involved in this (e.g. psychiatrist, team leader, clinician). The importance of establishing these processes cannot be minimised. The recent events have caused considerable angst amongst some staff and one submission makes a valid plea:

“Given the recent Coroner’s reports, an assessment done by a social worker in an emergency department or Paediatric Ward of a high risk client, would be insufficient in his view. This places the current social worker performing these assessments at considerable professional risk if an adverse event occurred, like a completed suicide. For the social worker there is now considerable stress and anxiety and it is an unsafe, vulnerable position to be in.”

Recommendation:
20. Develop and implement standardised processes for assessment, management and escalation of clinical risk and educate all staff in these processes

Standardisation also needs to apply to documentation in client records as this was another area of deficit identified in the coroner’s reports, in some of the submissions, in the visits to teams and by a number of staff at interview,

Recommendation:
21. Adopt standardised clinical documentation which includes risk assessment, mental state examination, bio psychosocial assessment etc.

5.4.1.5 Standardisation of care

Clinical pathways are useful tools to standardising patient care and these should be developed for different conditions examples being: depression, eating disorders and oppositional defiant disorder. Pathways will define minimum care, optimal care, and what clinicians would be expected to consider in treatment including assessment, involvement of the school, family involvement, feedback and safety plans. These clinical pathways can then provide a discussion point at clinical review.

Evidence-based guidelines (e.g. NICE, NHMRC, AACAP, beyond blue or RANZCP guidelines) have been written to outline the assessment and management of nearly all the psychiatric child and adolescent conditions. These are valuable references by which a given patient’s care can be compared and discussed, particularly in the event that the patient is not improving.

Recommendation:
22. Review the use of clinical pathways and evidence based guidelines and build these into the new Model of Care to support standardisation of practice

5.4.1.6 Defining CAMHS streams of care and service delivery

The changes that CAMHS faces are far reaching and there needs to be absolute clarity around how each of the different streams of service will work, how relationships with external services will be structured and how to manage the transition for the 16 to 17 year old cohort in the different streams. The CAMHS streams have not been altered in the organisation structure and presently relate to:

- Community- Country and Metropolitan
- Inpatient based services- Boylan Ward, Helen Mayo House
- EMHN Team which works in the WCHN emergency department
- ASEC and BIS
Aboriginal services

A review of the role of CAMHS may lead to a different mode of service delivery and the CAMHS Review Team does not believe that in the change process, CAMHS should be constrained by present structures. There are likely to be better ways to achieve the goals that CAMHS will set itself, so that service delivery is better integrated and provides enhanced support to both clients and staff. If this is the case, then some of the recommendations relating to country and metropolitan may no longer be relevant as the structure needs to reflect service lines.

All of the specialised services within the streams need to be described in the Model of Care and the ELMHS service manual provides a useful guide, to demonstrate what sort of information needs to be included.

However, the change strategy proposed is likely to see the Model of Care become more comprehensive and a more useful document both to clarify the role and objectives of CAMHS and to guide staff. This needs to be developed collaboratively with staff during the change process to ensure that there is staff buy in and to make this a living document.

Recommendation:

23. Once agreement has been reached on modes of service delivery, develop detailed descriptions of each of the services that make up CAMHS to include how each of the services will fulfil its service objectives and link to the other services

5.4.2 Role of Boylan Ward

As mentioned in 4.8.1.2, there are very few planned admissions to Boylan Ward and the overwhelming majority are crisis admissions. The use of planned admissions is entrenched in CAMHS services in other jurisdictions and fulfil a very positive role in patient care. Such admissions may be brief for respite and containment. The outpatient clinician will meet with the young person and their family to plan their goals and they are also orientated to the ward. At this time the young person is in a position to be able to consent to the admission and there is the advantage of the planned admission being at a time when the ward can facilitate an admission. The duration of the admission is negotiated in advance. Another advantage of planned admissions is that the control is given back to the young person and their family.

Discussion with ward staff indicated that there is good support for this, but that community teams are not always as supportive. The review of all of the services provided by CAMHS and the better integration of services as described in the recommendation above, provide the opportunity for improving internal stakeholder relationships and processes to deliver more efficient and effective care that is highly consumer focussed. This should extend to enhanced and standardised referral processes and very clear admission criteria.

Recommendation:

24. As part of the process of defining the roles of CAMHS services, ensure that the role and care processes of Boylan Ward are well defined to support the objective of consumer focused care and with clear linkages to services provided by community teams

5.4.3 Supporting country services

CAMHS teams in country areas, some of which are very remote, have suffered from lack of staffing, lack of psychiatrist input, lack of availability of significant other services and lack of support from metropolitan services. Staff in these teams have needed to develop their own solutions to service delivery and to develop their own networks. Some of the teams still use staff at Flinders Medical...
Centre for advice and support, others use Victorian hospitals. This is partly related to the lack of good systems, but is also related to the metropolitan/ country divide that is a hallmark of much of our Australian health system.

The change process and enhanced Model of Care provides a real opportunity to address this gap and create systems and processes to provide country CAMHS teams with appropriate support. This should include an accountability system with metropolitan services having responsibility for provision of adequate support.

It is not within the scope of this report to develop the system as this must occur through a collaborative process so that metropolitan services understand the needs of country areas and country areas also understand the limitations of the metropolitan services. However the Model of Care must clearly determine and describe these relationships and the processes needed to ensure that appropriate support is available in a timely manner. Different mechanisms of support need to be explored, such as better use of technology, memoranda of understanding, structured visits of specialised CAMHS staff and the ability for country staff to fully engage in clinical supervision, education and professional development activities.

As part of this development of support mechanisms it would be useful to review the time presently allocated to telepsychiatry and the processes for providing urgent psychiatric secondary and primary consultations.

**Recommendation:**

25. Review the support required by Country teams and develop and implement a strategy to provide the necessary support to staff and clients in country areas

5.4.4 Analysis of staffing mix and classification of positions

Staffing data was provided and this confirmed a preponderance of social workers in CAMHS community teams. The data provided indicated that there are 73FTE (81) social workers, 37 FTE (49) psychologists, 9 FTE (13) occupational therapists and 7 FTE (7) speech pathologists. There are 16 FTE psychiatrists (24), 74 FTE (89) registered nurses and 11 FTE (12) Aboriginal health workers. Administration staff number 43 FTE (57). There are small numbers of medical practitioners, enrolled nurses and psychotherapists. There are also three occupational therapists in discipline specific positions in specialised services. This data was current 12 months ago. (Figures in brackets are head counts in each group). The data also provided breakdowns of staffing classifications in each group and numbers of managers.

**NOTE:** It is conceded that this data may not be completely accurate and some of the data also includes managers, however **NOTE:** It is conceded that this data may not be completely accurate and some of the data also includes managers, however, it provides a close approximation of staffing mix in CAMHS.

It provides a close approximation of staffing mix in CAMHS.

5.4.4.1 Staffing mix

As Western Australia is more closely comparable to South Australia on a population basis than any of the other jurisdictions, a detailed benchmarking was carried out with WA and more general comparisons made with other jurisdictions.
The population profiles of South Australia and Western Australia are sufficiently similar to allow some rough comparisons (the population of 0-17 year olds in the area covered by Perth CAMHS was 408,196 in October 2011). CAMHS employed the equivalent of 288 clinical FTE.

Based on information (overheads) provided to the CAMHS Review Team in briefing documents at the beginning of the review process, staffing ratio per Child and Adolescent population are comparable, with WA having slightly less staff:

- SA had a ratio in 2011 of 1 Clinical FTE per 1206 C&A
- WA had a ratio in 2011 of 1 Clinical FTE per 1417 C&A

The following principle guides team composition in CAMHS in WA.

“Services are delivered by multidisciplinary teams with core team members from Child Psychiatry, Clinical Psychology, Nursing and Social Work. Currently other team members such as Occupational Therapists, Speech Pathologists, Aboriginal Health Workers, Paediatricians, Neuropsychologists, Research Psychologists, and Youth Workers are present depending on clinical and population need as well as historical precedents”.

It is noted that there are a number of anomalies in staffing mix and that these anomalies are also present compared with other jurisdictions:

- More social workers than clinical psychologists is unusual: the ratio is 1:1.5 in WA and 1:3 in NSW
- There are significant numbers of occupational therapists in generic positions
- There are no permanent positions for occupational therapists and speech pathologists on the ward
- Very low clinical psychology numbers
- When nursing positions are unfilled, they become generic positions and then never return to nursing when situation changes

It is clear that the reliance on generic position recruiting has led to a number of difficulties including poor and inappropriate multidisciplinary resourcing of teams, impacting ultimately on patient care, imbalance of professions relative to usual practice, difficulty organising supervision and confusion of scopes of practice. This is another example of the lack of a strategic approach and ongoing evaluation of appropriateness of service delivery, with opportunistic filling of positions rather than planning a means of appropriate staffing.

It should be noted however, that an imbalance in the mix of professionals does not reflect on the importance of the contribution of the different professions to the multidisciplinary team. The CAMHS review team would stress that social work is a key and valued profession in the team and that each of the professions provides specific skills and perspectives which contribute to patient care. However an imbalance, particularly in clinical psychologists (and psychiatrists), means that some clients will not easily have access to these professions in some community teams and so not have the benefit of full multidisciplinary care that can be tailored to their needs.

There is also difficulty in recruiting clinical psychologists to country CAMHS teams. This was alluded to in a number of interviews and submissions. As clearly stated in one submission, the underlying causes have been identified and some solutions have been put forward:

“There are also concerns about recruitment and retention issues for psychology positions in country areas severely limiting or completely denying access to specialised CAMHS clinical psychology services to clients in country areas. There are very few psychologists working in Country CAMHS
and recruitment has been difficult, especially to outer country regions e.g. due to additional barriers and costs in accessing professional development and appropriate supervision, additional responsibilities e.g. with pre-discharge assessments of clients with complex presentations at country hospitals.”

Different approaches to staffing need to be considered and these will flow out of the Model of Care and should be incorporated in a formal workforce plan including:

- Identification of profession specific positions for multidisciplinary teams, using accepted practice ratios.
- Using good HR practice by ensuring that any vacancy arising is reviewed and the profession specified depending on compliance with accepted clinical staffing practice.
- Where there are difficulties recruiting after advertising a variety of other strategies are considered such as collaborative relationships with private practice clinical psychologists, buying in support from external clinical psychologists and tele-psychiatry/psychology
- Adopting the practice used in Adult Mental Health Services of conjoint collaborative care of clients in the public and private sectors
- Adopting an active recruitment and retention program for clinical psychologists. This could be directed at making it easier for them to work part time in CAMHS while running a private practice as it is noted that most appointments are full time, unlike other mental health services
- Consideration of higher classifications for clinical psychologists taking on country positions

It is acknowledged that a change in staffing mix will take some time and that a number of different strategies will need to be undertaken to achieve longer term success.

**Recommendation:**

26. **Develop and implement a strategy to increase the numbers of experienced clinical psychologists in CAMHS and concurrently change the social worker/clinical psychology mix**

5.4.4.2 Classification of positions

Senior position classifications have been referred to in Section 5.2.3. The main issues that caused concern to staff and in the submissions relate to classification of clinical psychologists. Grade One clinical psychologists are not normally employed in mental health services and it is noted that these are not listed on the proposed new organisation chart and are not recommended by the CAMHS Review Team.

The other concerns expressed by staff was the ratio of Grade 2 to Grade 3 clinical psychologists. This is benchmarked at 3.5:1 in WA and so comparable to the 3.6:1 in SA. The issue seems to be that in South Australia, only two AHP 3 individuals have profession specific supervisory responsibilities, which is inadequate for adequate clinical supervision. Other AHP 3 clinical psychologists included in the 3.6:1 are employed in unit manager/co-ordinator roles. Figures from WA reflect numbers sitting in grade 3 clinical psychologist team member roles, and do not include unit managers/co-ordinators

When numbers sitting in these roles for SA CAMHS are removed, the ratio of AHP2 to AHP3 positions is 6.3:1. However the data provided indicated that 49% of CAMHS clinical psychologists are AHPRA approved supervisors, suggesting there are a number of people who could be progressed into these roles. This would provide sufficient ability for internal clinical supervision, as long as this accords with the South Australian allied health EBA
27. If in accordance with the SA EBA, ensure that AHPRA approved clinical psychology supervisors are able to assume a role in clinical supervision of junior staff

It is noted that AHPRA does not regulate all allied health professions and does not regulate supervisor status for all allied health professions in the same manner as clinical psychology. Where the supervisor approved status is not regulated by AHPRA, then the junior to senior staff ratio should be considered in the determination of service level staffing mix of AHP2/AHP3 profession specific positions.

The other area where benchmarking indicated some anomalies was in nursing. This related less to CAMHS and more to the classification structure for registered nurses in the SA health system which has fewer mid-level grades than other jurisdictions. This has resulted in CAMHS having many very junior positions and many senior positions. The relative lack of nursing staff in community multidisciplinary teams is noted and discussions and visits with CAMHS services in other jurisdictions should help inform the workforce plan and ensure an appropriate nursing complement and structure.

To improve accountability and engagement in relation to psychiatrists, a formal team of lead psychiatrists should be considered who hold the accountability for clinical service function and support the operational managers. This should be better defined during the change process as the best breakdown of roles needs to fit the Model of Care. Having regard to the history of psychiatrists in community teams, it may be worthwhile having a lead psychiatrist in this role to build the roles and accountabilities of psychiatrists in community teams and develop support mechanisms for provision of psychiatrist services to country teams.

28. Consider establishing a team of lead psychiatrists who will be accountable for the clinical service functions of the different CAMHS service areas

5.4.4.3 Roles of specialist disciplines

As alluded to in 5.4.2.1, it is unusual both to have occupational therapists and speech pathologists in generic positions and for these disciplines not to have temporary positions on the ward. Both of these disciplines had concerns that they were losing their discipline specific skills as a result. It is assumed that this has occurred with the difficulty in filling CAMHS professional positions and having an approach to make all positions generic so they could be filled by any discipline and a lack of a strategic approach to recruitment and retention.

Having regard to the guiding principle in WA in relation to core CAMHS positions, a review of how to ensure these disciplines provide the best value, what roles they should fill and how many are needed should be undertaken as part of the process of change. For this reason, although clinical leads have been put forward in these positions, these should initially be temporary as it may be more valid to have these two specific disciplines report to the senior allied health at WCHN as they may find a better professional fit there, being such small more specialised groups.

29. Review the roles of occupational therapists and speech pathologists in CAMHS in line with their roles in other Child and Adolescent Mental Health Services in Australia
5.4.5 Orientation, education and supervision processes for clinical staff

5.4.5.1 Clinical supervision processes

One of the major areas of concern, expressed by all of the clinical disciplines, other than psychiatrists related to inadequate clinical supervision. The degree of supervision accessed by clinical staff was highly variable and for most was either not enough to meet their needs or in some cases non-existent. The reason for this concern in clinical psychology has been discussed in 5.4.2.1.

Clinical supervision processes are an essential part of professional development and support and the Australian Social Work Association indicates that this should be 1 hour at least once a month for experienced social workers, but at least 1 hour every two weeks for newly qualified (less than 2 years) social workers or those entering a new field of health such as mental health. This is not presently being adhered to in CAMHS.

It is noted that clinical supervision is mentioned throughout the draft Model of Care for the integrated CAMHS, and there is a short paragraph that indicates:

“**The merging of the two organisations creates the opportunity for embedding a more formalised supervision structure and process that will bring CAMHS into line with current Enterprise Bargaining benchmarks for allied health professions. The professional leaders in CAMHS will be responsible for leading a collaborative development of professional supervision processes that ensures all clinicians engage regularly in clinical supervision.**”

However, there is no detail on this as is found in the ELMHS Model of Care or a framework as is found in the ACT Model of Care, so no clear guidelines as to what will be implemented or a means by which the effectiveness of this and observance with guidelines can be monitored.

The lack of a structured framework for clinical supervision and the ad hoc processes presently existing, place clinical staff at risk in their ability to provide competent practice and deal with the effects of difficulty cases and situations.

**Recommendation:**

30. As part of the development of the Model of Care develop a clinical supervision framework

5.4.5.2 Orientation processes

A number of comments were made about the lack of orientation by people who were new to the organisation. Many receive little or no orientation even though some clinicians coming into CAMHS for the first time may have little experience in mental health practice. Even for psychiatrists and clinical psychologists, orientation is required so that they are clear about their roles and accountabilities, how CAMHS actually works and who are the key people and what they do.

For those newly exposed to the mental health field, not only is the specialty a mystery and the understanding of consumer and carer needs, but the whole working of CAMHS is also unknown. This places the new staff member at risk and also consumers at risk. Orientation for new workers needs to be planned and substantial or confusion of roles and work practices may never be addressed. This seems to have been a long standing issue in community teams and the understanding of what multidisciplinary practice means is variable. This again was one of the issues picked up by the Coroner and needs to be addressed with an orientation framework in the Model of Care. Similar to the
supervision framework, such a document will allow evaluation of practice and improvement over time to ensure processes meet the needs of staff for contemporary and high quality practice.

**Recommendation:**

31. As part of the development of the Model of Care, develop and implement an orientation framework to assist new staff in their transition to CAMHS

5.4.5.3 ` Education and Professional Development

As alluded to in 4.4.2.1, there is reasonable education funding available to staff through the PSA award and often overseas speakers are brought in to speak to staff on site. However, this does not often provide the opportunity for staff to go outside their own jurisdictions not only to conferences but also to explore what other CAMHS are doing in other jurisdictions. In addition it is much more expensive and difficult for staff in country areas to access education outside their local area as travel costs are expensive and considerably more travel time is required than for metropolitan staff.

There is also only a 0.6 FTE nurse educator in Boylan Ward and she is able to provide considerably less of a service in this area than her better resourced fellow educators in other parts of the WCHN. A more comprehensive resource with expanded responsibilities should be considered with responsibility for coordinating a whole of CAMHS education strategy.

**Recommendation:**

32. Consider the appointment of a Training and Education Coordinator with responsibility for education and training for the whole of CAMHS

South Australia is a small state in relation to population and numbers of clinicians and its outlook can be insular. Education and professional development are ways to decrease this insularity, see new ways of doing things, expand horizons and keep up with contemporary care. Therefore it is essential that staff are encouraged and supported to regularly move out of their environment to see firsthand what others in the field are doing. The review team believes that simply exploring CAMHS services in other Australian jurisdictions would be of considerable value in developing a contemporary service and the costs of this would be minimal compared with the value gained by talking to other professional staff and having access to their ways of providing care and service delivery on site.

It has been clear from the many discussions with staff, the review of clinical and administrative processes, the submissions and the review of the small amount of data that practices are out of date in many aspects of the service compared with other jurisdictions and the lack of exposure to other services as part of a planned education and professional development program is one of the underlying causes of this. An education framework should be set up as part of the Model of Care with a clear philosophy and objectives and a strategy to achieve these.

**Recommendation:**

33. As part of the development of a Model of Care, design and implement an education strategy to include in-service, onsite training, external training opportunities and regular visits to CAMHS services in other jurisdictions

Resources will need to be expended on professional development to overcome some of the effects of insularity and this should extend to investment in visiting other jurisdictions.
5.4.5.4 Research

There are some pockets of excellent clinical research underway in CAMH in SA. This should be showcased with a view to ascertaining if common priorities can be established with a focus on improving clinical care and related service delivery. Research skills in benchmarking, service data interrogation and related activities are available to inform CAMHS SA future development.

The research skills in Northern and Southern locations and their respective universities could form an excellent nucleus for strengthening strategic research opportunities and considering relevant partnerships.

These issues should be carefully considered by the executive leadership team as another mechanism whereby evidence based practice can be promoted and to engage staff in contemporary practice and its evaluation.

Recommendation:

34. Clarify and describe the role of research and evaluation in the development of the Model of Care

5.4.6 Whole of CAMHS accountability system

Throughout the review, it became clear that there was no evidence of a clear accountability system whereby there was ongoing reporting and holding to account against either clinical or financial performance indicators. Perhaps this had been present when CAMHS was in clearly defined Northern and Southern services, but this had not been put in place when CAMHS was integrated on paper in July 2013. The draft CAMHS Model of Care also had no reference to accountabilities or performance indicators of any type, nor was there reference to a framework that provided guidance on how the performance of the service as a whole would be managed or how clinical care would be monitored, evaluated and improved. Very little data was able to be accessed during the review.

Any health service needs to be accountable for the way it uses its resources and carries out its activities. In addition, staff members also need to be held to account for similar factors and performance indicators are integral to a robust governance framework, both clinical and corporate. Benchmarking against the ELMHS and ACT Models of Care clarifies the deficits in this area and if these are not addressed, CAMHS will continue to remain a service that is inconsistent, poorly governed and unable to continuously improve its services, as it will not be effectively measuring its performance.

Whilst it is not the role of this review to define all of the information needed for professional management of a service, the review team would expect at least the following to be available for discussion at operations and executive meetings:

- Overall CAMHS budget and budgets for all of the services
- Financial data against budget including breakdowns of inpatient services, community teams and ASEC
- Staffing numbers monthly and budgets against these
- Leave data including annual leave, study leave, sick leave and maternity leave
- Occupational health and safety data including accidents and workers compensation
- Staff workload data
- Capital expenditure
- Education, orientation and training data including mandatory training
• Performance against strategic plan
• Incident data and review of risk register

There would also be data to inform clinical practice. Useful data would include:

• Review the last 12 months data from serious clinical event entries into SLS.
• Number of new outpatient referrals broken down by age.
• The time from first referral to first appointment.
• The number of new referrals who sit on a waiting list.
• Those who have been referred to CAMHS but not seen and characterising their ages and conditions and if they are later referred back
• Time from discharge from hospital to first outpatient appointment
• Re-admission rates.
• Seclusion rates.
• Average length of ward stay.
• HoNOSCA and SDQ reviews consistent with business rules for the national minimum data set scores
• The duration of outpatient treatment (time and number of sessions)

The development of an accountability framework to support the Model of Care would be of value to staff and management and clarify what performance measures need to be collected and evaluated and where these should be discussed. This process has already commenced and needs to be embedded in CAMHS

**Recommendations:**

35. Further develop the CAMHS accountability framework and embed this in CAMHS operations
36. Develop the CAMHS’ capacity to utilise and interrogate existing data to improve quality of patient care and outcomes and better manage services

5.4.7 Transitioning clients to the Youth Mental Health Service and to Adult Mental Health

Adult mental health expressed its concerns about the process of transition for clients once they had reached 18 years of age. There will now be a transition at 16 rather than at 18 although it appears that some clients may be retained after 16 years of age. There were concerns from both CAMHS staff and external stakeholders that some young people are not mature at 16, may be mentally disabled and may suffer in an adult type service without all of the supports provided for CAMHS clients. Country teams were particularly concerned in this regard and felt they might be left looking after the 16-17 year age group with no real authority to do so.

From staff feedback, it appeared that there had not been a strategy developed for appropriate transfer of care to the new YMHS. At the time of the review, some CAMH staff believed the new service would not be implemented and the Adult Mental Health Service had also not taken the initiative to set up a process to define and document transition processes and develop strategies to deal with both issues of change and complex care clients whose transition could be very difficult. As Boylan Ward will continue to admit up to 18 years of age, the staff here will now have a close relationship with the Youth Mental Health Service as well as with CAMHS and this will add to complexity of communication and administration in this area.

Despite this view, it is noted that the YMHS Model of Care does describe transition processes and a structure to develop these, although implementation was not clear in any of the discussions held. It is
critical that the two services set up a transition strategy and document how this will work, to give guidance to all staff working with young people reaching the age for the YMHS. The risk to young people of not having robust, well understood, supportive processes is significant.

Also and importantly, since the last visit of the CAMHS Review Team, this has been overtaken by a readiness review which will address transition issues and there is now a consultative process to ensure all of these concerns will be addressed.

**Recommendation:***

37. Ensure that there are appropriate communication processes in place so that staff feel informed and confident about the transition of clients to the Youth Mental Health Service

5.5 Strengthening relationships with internal and external stakeholders

5.5.1 Linkages with external organisations

CAMHS clients are highly complex in that they are often engaged with a large variety of internal and external professionals and organisations in addition to being treated within CAMHS. This complexity, while providing a means of support, can also be a significant area of risk as all of the organisations and individuals involved are not conversant with what the others are doing. In addition, the lack of a formal relationship can lead to duplication of services and this makes suboptimal use of limited resources throughout the system.

One submission describes this succinctly:

“There is a duplication of services to adolescents with Headspace and state public mental health services for youth (CAMHS or Youth Mental Health Service) or from psychologists in private practice. This is inefficient and confusing for other agencies and for clients. Headspace often refers to state funded services because of the complexity and for long term therapy. Other agencies and therapists are now referring children and adolescents to CAMHS while they are still in therapy in the hope they will have less wait at CAMHS when therapy is no longer provided in the private sector or by Headspace. Many referred clients are then resentful that they have to go on another waiting list for therapy at CAMHS, begin a process with another therapist or the fact that they have to transfer from one service to another simply because of the different funding arrangements for state and federally funded services.”

As described in 4.6, the relationships that CAMHS has inconsistent relationships with internal and external organisations as a service, at team level and at individual staff level. There has been no whole of CAMHS or even a Northern or Southern CAMHS approach to build a robust strategy and structure to ensure that clients of the service receive as much as possible a seamless service with no duplication and confusion. The Coroner’s reports provided very clear examples of the lack of structured processes for communication with and feedback to general practitioners, school counsellors and private practitioners and these were confirmed during the review process with a large number of other individuals and organisations which work with CAMHS clients.

As indicated above, communication could work well if there was an MOU or if a specific individual was the basis of the relationship and if CAMHS staff were prepared to share information. However, often none of these conditions was present and communication ranged from negligible to ad hoc and depended on either CAMHS staff or staff from other bodies remembering to communicate.
As CAMHS is the link to all of these clients, it is CAMHS which needs to take the initiative to build a strategy and a structure that will minimise the risk to clients of lack of communication, duplication or miscommunication. Such a strategy is common in mental health services in other jurisdictions and can make a tangible difference to efficiency and effectiveness of operations, not just to the clients at the centre of a mesh of services.

The development of these formal relationships should include regular meetings at least every six weeks with services such as paediatricians, WCHN Emergency Department, Department of Education and Child Development and Families SA and at least two to three monthly with other services such as Police, Ambulance, Headspace and other relevant organisations. Initially these meetings will be aimed at developing processes which support collaboration and form the basis of good communication and minimisation of duplication. The way in which the two organisations should work together should be agreed and ratified.

These processes will need to be documented and then staff educated on the use of the processes. The adherence to processes will then need to be monitored and data collected to ensure that they are used and continue to meet the needs of both parties. The meetings will then be used to discuss service delivery and care issues which concern both of the parties so that collaborative problem solving can occur that will continuously improve delivery of care. The meetings will also be used to discuss specific clients to ensure that complex clients receive the most appropriate services based on their changing needs.

Whilst not recommending a second tier structure, the CAMHS Review team believed it was important to establish a position of Integration and Relationships Manager as part of the operational team reporting to the Director Operations. This position would be responsible for building structured, collaborative and consistent relationships with all external bodies that share CAMHS clients and recommending where memoranda of understanding should be developed. This position will set up structured, regular meetings, develop formal communication mechanisms, develop strategies to involve relevant CAMHS staff and monitor relationships and communication mechanisms to ensure that they meet the needs of both CAMHS and its stakeholders. The position will develop performance measures which will be reviewed by the operations committee and reported to the executive.

The rationale for recommending this position is that the time that will be needed for developing formal relationships from the ground up for the whole of CAMHS is considerable and will need to be dedicated at least for a 12 to 24 month period. It is possible that after this, the role can be subsumed either wholly or partly in the roles of other operations managers.

**Recommendation:**

38. Establish a position for an Integration and Relationship Manager to develop, monitor and report on the formal relationships with all internal and external CAMHS stakeholders.

### 5.5.2 Enhanced linkages with General Practitioners

The needs of general practitioners also should be considered to make the processes for referral easier and consistent. General practitioners at Central Adelaide and Hills Medicare Local have suggested a centralised metropolitan triage service for non-emergency cases where GPs and others could submit in writing (including email or fax) referrals of any young person. The relationship of the primary mental health care providers, such as Headspace and children’s services role in such an arrangement would require clarification. The triage service might make the decision about what the appropriate agency might be both internal and external to CAMHS. They also suggested that the
triage service could be funded jointly by CAMHS and the soon to be established Primary Health Network. Some primary health networks are prioritising support and funding of child and adolescent mental health service providers, including child psychiatrists.

GP’s are also interested in graded levels of collaboration and true shared care. There is a sub-population of GP’s with a potential interest in Child & Adolescent Mental Health who could undergo training to facilitate their seeing patients of moderate acuity with consultation and support from CAMHS. This would be an innovative initiative which could impact positively on the workload of both CAMHS as a whole and psychiatrists in particular, and deliver a more holistic care process for clients. Senior CAMHS psychiatrists have experience in providing GP consultation, advice and education in previously funded projects in GP support. They have substantial experience that could inform consideration of these issues.

It is noted that the Implementation of Guidelines for Public Mental Health Services sets out how to develop collaborative partnerships in Standard 5. This is a useful guide for the establishment of a consistent strategy.

**Recommendation:**

39. Establish a working group with the Medicare Local (or its successor body) to develop and implement a strategy for shared care with interested General Practitioners

5.6 Integrating consumers and carers into the new CAMHS structure

Evidence of long term involvement of consumers and carers in CAMHS services was provided and the attendance at consumer and carer forums was of great value to the review team. However it appears that the ways in which consumers and carers are used to improve service delivery have not been evaluated and with the new integrated CAMHS, there is a clear opportunity to evaluate these processes and determine if there are better mechanisms to integrate consumer and carer opinion and experience into care and service delivery.

With the advent of the National Safety and Quality Health Care Standards, many organisations have developed innovative ways to involve consumers and carers to the benefit of the individuals involved and the organisation. For example, involving consumers and carers in short term projects of particular interest to them could be more useful than committee work. Some benchmarking in this area could pay dividends and provide a suite of options for consumer and carer involvement.

This report has suggested that one way forward would be to have a consumer/ carer consultant on the CAMHS executive. In addition, consumers and carers should be intimately involved in the change management strategy and the enhanced Model of Care and also in the Transition of Care Working Party for the new YMHS.

**Recommendation:**

40. Explore new ways of involving consumers and carers in CAMHS by discussions with consumers and carers and benchmarking mechanisms used in other health service organisations

The very positive comments made by consumers and carers in relation to ASEC may well reflect its high staff: patient ratio providing intensive clinical care and it is no doubt an expensive mode of service delivery. However, rather than replicate this service in other areas, the therapeutic approach

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10 Implementation of Guidelines for Public Mental Health Services and Private Hospitals 2010
used seems to indicate that there are some important changes of practice that could be considered by community teams who might be able to incorporate some of the ASEC modus operandi into their functioning. This is yet another opportunity for change of practice as is building relationships with private providers to share care, another suggestion from carers to enhance services and to decrease CAMHS workload.

**Recommendation:**

41. Implement expanded therapeutic models to support care and service delivery including an appropriate balance of individual, family, group and systemic therapies and working more closely with private providers

5.7 Implementation of sustainable change

The “on paper” integration of Northern and Southern CAMHS in July 2013, has been referred to on numerous occasions throughout this report and it certainly has been recognised as a failure both by staff in CAMHS and by the management of WCHN. There has recently been a flurry of activity to bring this to fruition, with new policies. Unsurprisingly in the climate that CAMHS finds itself post Coroner’s inquests, disagreements on executive structure and a feeling of being devalued, there is limited likelihood of success to bring about the badly needed cultural change without full leadership support and commitment and a clear focus for staff.

This report has put forward the many elements that need to be considered to develop an integrated CAMHS that is accountable, contemporary, consistent in practice and respected by all of the stakeholders it comes in contact with. This is about the service and the role of the service, not about the individuals working in it, all of whom are doing the best they can with limited resources, fragmented systems and poor support.

The Coroner identified a multitude of issues, all of which have been confirmed by the review team. However the solutions proposed by the Coroner will not address the underlying issues of systems failure in clinical and corporate governance. The system will not be repaired by overloading the small number of psychiatrists with unnecessary work, focusing blame on individuals, implementing new processes without understanding how they should fit into efficient and effective service function and without consultation and buy in of staff involved in the service.

Building a contemporary, consistent and accountable service is a long term project which requires a carefully planned and implemented change management strategy, sufficient resources and the support of government to see this through. Without this approach there is little likelihood that CAMHS will make significant improvement in the way it does business. It is noted that a change process was commenced in 2013, but this did not proceed past the first steps, most probably as it had not been resourced in a way to be sustainable.

The CAMHS Review Team is of the opinion that the recently appointed CEO of WCHN is committed to the leadership and support that is required to transform two services into an integrated, contemporary, consumer focused service. The change in reporting structure and the steps that have already been taken attest to this commitment as does the willingness of WCHN to undertake a planned, engaging and consultative approach over a period of time.

Section 5.2.4.1 indicated the need for a change facilitator to be on the executive as a key person over a two year period to work with both the executive of CAMHS and staff to facilitate a cultural change process that will culminate in a Model of Care that clarifies what the role of CAMHS will be in the new era, what it will strive towards, what values its staff subscribe to and how each component of CAMHS
will be part of this. The key is engagement and involvement of staff, consumers and carers in building a new CAMHS, by a process of collaboration and consultation, building on the positives in present service delivery and minimising inefficient and ineffective practices. A new name for the service developed using a collaborative process could be an important symbol of a new era.

**Recommendations:**

42. Appoint an experienced change facilitator to work with CAMHS management, staff, consumers and carers on developing an appropriate Model of Care, building a whole of CAMHS culture and focussing CAMHS on the future

43. As part of the focus on the future consider a name change for CAMHS to more clearly reflect its role

The person chosen to facilitate this change needs to be an expert in the field and a part of the CAMHS senior management team, not an external consultant, and needs to be selected by the executive team as someone they can work with over a two year period. This will of course mean that the executive team will need to be appointed first and so the time frame for commencing the process will be delayed somewhat. However it is critical that this is done in the right way. There have been many years of suboptimal systems and they need to be given the best opportunity of being developed to provide the most appropriate support.

It would be valuable for the change facilitator to be aware of the work of Bridges referred to in 5.1.1 as the first step will need to be “Managing Endings”. This will mean actually marking the endings, knowing what is continuing and what is not continuing, knowing what is over for everyone and what is over for only some people and treating the past with respect. This will assist staff to manage the grieving process and be able to move on with optimism.

Whilst awaiting these appointments there are however things that can be done with appropriate benchmarking and use of the recommendations in this review. Mention has been made of the two systems of data and these need to be assessed and a decision made as to which of these will provide the best means of providing the data referred to in 5.4.4. This will require the services of an appropriate business analyst to work with the Health Information Department to assess the systems and then implement the appropriate system across the service. In addition, the interim team can commence the process of building a data set so that this can be implemented as soon as there is a decision on the whole of CAMHS system.

**Recommendation:**

44. Review the data systems presently used in CAMHS and develop one robust data system to support clinical services and operations of the integrated service

Another action that can be undertaken is the development of the clinical governance framework to link in with the overall WHCN Clinical Governance Framework. This will need some expert assistance on a small scale to ensure it is in a format that will guide the executive and staff. However, again discussions and benchmarking with other like organisations will provide all of the information necessary for a useful document. The clinical governance committee can also be set up and the mortality committee enhanced to deal with mortality and morbidity and its membership expanded.

In preparation for the change management strategy, sending staff on visits to other jurisdictions will begin the process of cultural change and the quality and innovations committee can be set up to feed into the change process. It is suggested that a cross section of staff visit not just senior managers, to spread the learning and enthusiasm across the organisation.

**Recommendation:**
5.7 Resourcing the change

References have been made throughout this report that any major change process requires funding. This cannot be successfully achieved within present operational budgets and there will be a need for both once off budget allocations and some ongoing funding. It would be expected that the development of a contemporary and consistent system of service delivery will recoup some of these costs over time in increased service efficiency.

Funding will be required for:

- Some specific positions
  - Part time Psychiatrist Clinical Director if the Co-Director Model is adopted
  - Change facilitator- time limited two year contract
  - Part time consumer/ carer consultant
  - Integration and Relationships Manager
  - Business analyst- contracted 12 month position to determine the information system to be used and implement oversight including assisting with data set development
- Supervision and education
  - Implementation of an ongoing strategy
- Benchmarking visits
  - Need to become a regular feature of CAMHS operations
- Change strategy
  - Time limited over two years to ensure staff can be fully involved and backfilled where needed
- Staffing changes
  - Change of mix to employ and retain more clinical psychologists
  - Recruitment of additional psychiatrists if possible
  - Classification changes

This funding should be quarantined for CAMHS and not in the general revenue of WCHN.

5.8 CAMHS Review Team approach to Coroner’s recommendations

5.8.1 Coroner’s Recommendations

The following recommendations were made by the Coroner in his inquests into the deaths of Jason Hugo-Horsman and Michaela Mundy

Jason Hugo- Horsman

1) That CAMHS implement a genuine multidisciplinary team approach that possesses the following features:

   a) the triaging of clients in the first instance should not be made on the basis of a telephone referral alone, but should be made after the client has been seen by a CAMHS therapist;

   b) that the triage assessment, and in particular the decision as to the type of CAMHS therapist who will be responsible for the client’s care in the first instance, be made by the most senior therapist within the individual CAMHS facility;
c) that any practice or tendency for CAMHS therapists to operate as individual practitioners and not as part of a multidisciplinary structure should be curtailed with immediate effect such that a client experiences input into their care from all disciplines acting in concert, not merely from the one discipline acting alone or multiple disciplines acting separately from each other;

d) that CAMHS administrators have limited input into deciding the type of therapist that might appropriately be assigned to a client’s care during the currency of a client’s treatment, and that in any event any such decision should not be made by an administrator unless that person is a psychologist or a psychiatrist and is a person fully informed as to the client’s current and longitudinal history.

2) That within the operations of CAMHS that in the event of any suicidal ideation and/or self-harm being identified in respect of a client, it be deemed mandatory for that client to be referred immediately to a CAMHS psychiatrist who should thereafter have continued oversight of the case;

3) That all therapists within CAMHS who treat depressed young people be reminded that they must always be aware of the risk of suicide and to observe them closely for any signs of increased risk of suicide and that this approach is necessary regardless of the type of therapy provided and regardless of whether or not a formal diagnosis of a recognised mental illness has occurred;

4) That within CAMHS all risk assessments and management plans for clients be referred to, unless compiled by a psychiatrist, to a therapist of the level of psychiatrist for the psychiatrist’s input and evaluation;

5) That any practice or requirement that involves the need for a period of three months to transpire or for a set number of sessions to have occurred before a client can be considered for further intervention by more senior therapist, or be considered for medication. Any such referral should be based on clinical grounds as they exist in respect of the particular client. In any event, delay should be eliminated where the client’s clinical situation warrants an expedited approach to therapy;

6) That CAMHS consider the evidence of Professor Goldney and the materials that he produced to the Inquest in respect of a revised approach to the prescription of antidepressant medication to adolescents and that CAMHS revise its practices regarding prescription if it is considered necessary or appropriate in the light of that material. In particular, I recommend that the Director of CAMHS together with the Chief Psychiatrist give careful consideration to the recommendations set out in the Isacsson paper of 23 January 2014 referred to herein;

7) That CAMHS reinforce with its therapists the desirability for consultation with a client’s general practitioner or other private medical practitioner regardless of any perception as to whose obligation it may be to initiate such consultation. Such consultation should include, but not be limited to, discussion concerning the type of CAMHS therapist who is involved in the client’s care and its appropriateness, the type of therapy currently being administered or to be administered, the appropriateness of the client’s care plan and the appropriateness of the client’s risk assessment as well as discussion concerning the appropriateness of medication in respect of the particular client;
8) That insofar as it is necessary, that the Minister for Mental Health and Substance Abuse provide the necessary resources to CAMHS to enable more frequent and more meaningful consultation between CAMHS therapists, such as social workers and psychologists, with CAMHS psychiatrists. If this requires the employment of a greater number of psychiatrists within the service then I recommend accordingly.

Michaela Mundy

1. That the current approach of CAMHS in which it fails to take proper advantage of the multi-disciplinary team approach be reformed so that therapists are no longer operating as individual practitioners;

2. That the number of psychiatrists employed within CAMHS be increased so that the current disincentive to refer a patient such as Michaela is removed;

3. That all services provided by CAMHS be provided under the same level of consultant supervision as a surgical service in a public hospital. To be absolutely clear, I refer to supervision by a consultant psychiatrist.

5.8.2 Comments on recommendations

The team believes that:

- Ms Mundy No. 1 is covered in Mr Hugo-Horsman
- Ms Mundy No. 2 is the same as Mr Hugo-Horsman No. 4
- Ms Mundy No. 3 is incorporated in Mr Hugo Horsman No. 8

The following recommendations were made by the Coroner in the two inquests. The Review Team provides a response to each of these as below:

1. That CAMHS implement a genuine multidisciplinary team approach that possesses the following features:

   a. the triaging of clients in the first instance should not be made on the basis of a telephone referral alone, but should be made after the client has been seen by a CAMHS therapist; An appropriate process needs to be established for triage as there will be clients who will not require the services of CAMHS but need to be referred to another service in the first instance. Once CAMHS has very clearly established its role and robust processes, this will be able to be successfully implemented and will require regular evaluation as part of CAMHS measurement of appropriateness of care.

   b. that the triage assessment, and in particular the decision as to the type of CAMHS therapist who will be responsible for the client’s care in the first instance, be made by the most senior therapist within the individual CAMHS facility; Triage must be carried out by a highly experienced clinician who is trained and skilled in triage assessment. They may not be the person who decides who the client then sees as this decision can be made by the team when allocating new referrals unless the referral is urgent and needs to be seen within 24-72 hours for example.

   c. that any practice or tendency for CAMHS therapists to operate as individual practitioners and not as part of a multidisciplinary structure should be curtailed with immediate effect such that a client experiences input into their care from all disciplines acting in concert, not merely from the one discipline acting alone or multiple disciplines acting separately from each other;
team is in complete agreement with this and the multidisciplinary process must be fully
documented in the Model of Care.

d. that CAMHS administrators have limited input into deciding the type of therapist that might
appropriately be assigned to a client’s care during the currency of a client’s treatment, and that
in any event any such decision should not be made by an administrator unless that person is a
psychologist or a psychiatrist and is a person fully informed as to the client’s current and
longitudinal history. A team leader who is highly skilled clinically could also be a nurse or social
worker and so this this should not be limited to psychologists or psychiatrists – it will depend on
the person’s skills and job role. The key is the person’s credentials in relation to triage: i.e.
qualifications, training and experience.

2. That within the operations of CAMHS that in the event of any suicidal ideation and/or self-harm
being identified in respect of a client, it be deemed mandatory for that client to be referred
immediately to a CAMHS psychiatrist who should thereafter have continued oversight of the
case; The CAMHS Review Team does not believe that this is either feasible or warranted.
Psychiatrists would become rapidly overwhelmed. One of the commonest issues in community
practice is suicidal ideation and self-harm and all clinicians need to be competent in assessment,
identification, management and monitoring this. Appropriate escalation processes need to be in
place for patients at higher levels of risk as part of a robust multidisciplinary process involving
senior and experienced clinicians. The role of the psychiatrist is to provide advice and face to face
consultation where required. This means the psychiatrist will act in the role of a consultant to the
referring clinician or key worker.

3. That all therapists within CAMHS who treat depressed young people be reminded that they
must always be aware of the risk of suicide and to observe them closely for any signs of
increased risk of suicide and that this approach is necessary regardless of the type of therapy
provided and regardless of whether or not a formal diagnosis of a recognised mental illness has
occurred; The team is in complete agreement with this and the process must be fully
documented in the Model of Care. All CAMHS therapists must be highly skilled as outlined in 3.

4. That within CAMHS all risk assessments and management plans for clients be referred to,
unless compiled by a psychiatrist, to a therapist of the level of psychiatrist for the psychiatrist’s
input and evaluation; This is not regarded as feasible. An alternative to every suicidal patient
being seen by the child psychiatrist is that:
• Each outpatient team has a register/list of high risk patients who are discussed each week by
the child psychiatrist and team leader at the clinical review.
• Those patients who are at higher levels of suicidal (or homicidal) risk are identified by the
clinician or outpatient team and those are the ones that are reviewed by the psychiatrist or
senior clinician with the clinician and care planning determined. Those at the highest level of
risk are reviewed by the psychiatrist as a consultative assessment
• Those patients who are at higher risk of suicide are reviewed regularly by the clinician (at
least fortnightly and probably weekly) as agreed to by the child psychiatrist and team.
• A plan for non-attendance follow-up is factored into the management plan.
• A comprehensive safety plan and management plan is written by the clinician, discussed at
the clinical review and signed off by the senior clinician. Every patient should have this
regardless of risk.
• Development of a high risk panel (like a Quality and Safety Clinical Review Panel but before the incident). This panel would have referrals of complex and difficult patients by the child psychiatrist.

5. **That any practice or requirement that involves the need for a period of three months to transpire or for a set number of sessions to have occurred before a client can be considered for further intervention by more senior therapist, or be considered for medication. Any such referral should be based on clinical grounds as they exist in respect of the particular client. In any event, delay should be eliminated where the client’s clinical situation warrants an expedited approach to therapy;** the process for review will need to be clearly documented in the Model of Care as part of the multidisciplinary approach.

6. **That CAMHS consider the evidence of Professor Goldney and the materials that he produced to the Inquest in respect of a revised approach to the prescription of antidepressant medication to adolescents and that CAMHS revise its practices regarding prescription if it is considered necessary or appropriate in the light of that material. In particular, I recommend that the Director of CAMHS together with the Chief Psychiatrist give careful consideration to the recommendations set out in the Isacsson paper of 23 January 2014 referred to herein;** This has been considered by the CAMHS Review Team and a number of points need to be made:

• Medical staff are extensively trained to use their clinical judgement based on the education in their field of expertise, experience, continuing professional development, evidence based practice, an understanding what is clinically effective and keeping up with changing practice

• Medicine is not a formulaic science and while some areas of medicine lend themselves to a more structured approach i.e. procedures, a case by case approach is taken for many conditions as patients differ in their responses to treatment, co-morbidities, approach to undergoing treatment and other factors

• Not all doctors agree about the best ways to treat patients and commonly there are options to be explored with colleagues and with patients themselves. In addition, research does not always provide a clear cut way forward where the pathology is complex.

• In relation to treatment of young people with antidepressants there is considerable research evidence both for and against. The use of antidepressants in this cohort is never a first line therapy and because in young people depression is almost always found in conjunction with other co-morbidities, its treatment in this group can be highly complex

• Treatment of young people with depression must be on a case by case basis, using clinical judgement and consulting with colleagues where necessary so that the most appropriate treatment is prescribed for the individual. This may involve the use of antidepressants if the psychiatrist believes these are indicated. In either case, good documentation is required to clearly identify the rationale for prescribing (or not prescribing) antidepressants

• It is very important that psychiatrists keep themselves abreast of the latest literature and clinical guidelines. These include beyondblue guidelines, RANZCP/RACGP position statement, and NICE guidelines from the UK.

7. **That CAMHS reinforce with its therapists the desirability for consultation with a client’s general practitioner or other private medical practitioner regardless of any perception as to whose**
obligation it may be to initiate such consultation. Such consultation should include, but not be limited to, discussion concerning the type of CAMHS therapist who is involved in the client’s care and its appropriateness, the type of therapy currently being administered or to be administered, the appropriateness of the client’s care plan and the appropriateness of the client’s risk assessment as well as discussion concerning the appropriateness of medication in respect of the particular client; The team is in complete agreement with this and the process must be fully documented in the Model of Care. Building good relationships with GPs will increase rates of referral for at risk children and young people. Further involvement of GPs was noted in 5.5.2.

8. That insofar as it is necessary, that the Minister for Mental Health and Substance Abuse provide the necessary resources to CAMHS to enable more frequent and more meaningful consultation between CAMHS therapists, such as social workers and psychologists, with CAMHS psychiatrists. If this requires the employment of a greater number of psychiatrists within the service then I recommend accordingly. As indicated in the report, CAMHS will require more resources in order to adopt a contemporary Model of Care and some of these resources will need to be directed to recruiting more psychiatrists if they are available. The number of psychiatrists depends on what is the service Model of Care and benchmarking against what is happening in the other states.

9. That all services provided by CAMHS should be provided under the same level of consultant supervision as a surgical service in a public hospital. To be absolutely clear, I refer to supervision by a consultant psychiatrist. The comparison of a mental health service with a surgical unit reflects a lack of understanding how child psychiatric services are delivered and managed in South Australia and the rest of Australia. Surgeons will see a patient, decide if they need an operation, operate on the patient, see them once or twice postoperatively and then discharge them. Mental health patients are seen for many months as their conditions when severe run chronic courses and a relationship is formed between the psychiatrist and his or her patient to manage ongoing care.

‘Note: Attachment five provides a good analysis of the role of the psychiatrist in the multidisciplinary or interdisciplinary team.

Recommendation:

46. Utilise the comments that the CAMHS Review Team has made in response to the recommendations in the Coroner’s reports in the development of the Model of Care and in the development of the specific processes that should be part of the Model of Care
6. Conclusions

When scoping this review, the concern of staff was about the impact of the Coroner’s reports and that the focus would be on the recommendations from these reports and the blame apportioned to the individuals concerned. In addition, staff previously from Southern CAMHS were concerned that the review would merely confirm that the processes in the Northern CAMHS were better and that these should prevail.

Despite the concerns of the staff about the Coroner’s reports, such reports always need to be taken seriously and any recommendations considered with a view to making appropriate change. As with any complex report, not all recommendations can or should be implemented as they may not be feasible, may not suit the overall context of care delivery or may not have been aware of all of the issues that contributed to the situations described. The CAMHS Review Team did carefully consider all of the recommendations of the Coroner and agreed that many of these should be incorporated and clearly documented in the Model of Care as well as being subject to ongoing monitoring. For those that are not practical in their entirety the CAMHS Review Team has indicated the rationale for this and what changes can be made to satisfy the intent of the recommendation while providing appropriate clinical care.

The CAMHS Review Team always believed that the review should focus on systems of care and service delivery with the key objectives being what the community needed and deserved in 2014 and beyond and what was regarded as contemporary in the delivery of care to children and adolescents with mental health issues. The review was very much about “what should be” rather than about “what there is” or “what there was”. The aim was a future focus but based on an understanding of both the present and the past as these are always the foundation for change.

It was clear from the outset that this review was important to many people including CAMHS staff, internal and external stakeholders who shared clients with CAMHS or relied on CAMHS for outcomes, WCHN management, government, professional associations and of course the consumers and carers of CAMHS themselves. This importance was demonstrated by the numbers of individuals who came to interviews and forums at short notice and/ or provided submissions to articulate their perspectives. This in itself is of significant importance as it means that there are many individuals ready to embrace change if it delivers enhanced care and service delivery and cements the reputation of CAMHS as a professional, contemporary, consumer focused service.

The themes that were most prominent during the review related to governance both clinical and corporate and clinical leadership. Almost all other themes were related to these three areas, all of which were lacking due to a breakdown of systems, a poor accountability framework and a lack of a long term strategy to define both the role of CAMHS and the roles of the people working within it based on both community needs and on relationships with other organisations that have a vested interest in CAMHS clients.

The lack of clarity of role has meant that professionals working in CAMHS community teams in particular have tried to be “all things to all people” and have been unable to prioritise what should be their work and what should be the work of other organisations and individuals within the system. This has caused the system to become overloaded and unable in many of the teams to provide the true multidisciplinary care that a Child and Adolescent Mental Health Service should demonstrate at its core. The review team is very clear that these concerns cannot be blamed on individuals who work conscientiously and provide the best service that they are capable of without the support of strong, reliable and consistent corporate and clinical governance systems.
As with any complex system, there is no easy fix. Added to this is the further complexity of bringing together two cultures and losing services that relate to young people over 15 years of age. The building of an integrated mental health service for children and adolescents will take time, the right people to lead the process and adequate funding to achieve the outcomes.

The review team sees this as an opportunity for South Australia to adopt the right strategy and to implement this in the right way. The newly appointed CEO is a key part of this strategy and she has indicated her commitment to leading this change and also tangibly demonstrated that support. This will set the scene for a service that will not only match those in other jurisdictions, but will build staff capability to lead the field in innovative practice. The corollary is the risk of not taking the initiative now. This means that this service will continue to languish, staff morale will continue to decline and the community will never achieve the standard of care it deserves.
Attachment One: Terms of Reference
Review of South Australian Child and Adolescent Mental Health Services
May 2014

Introduction
Child and Adolescent Mental Health Services (CAMHS) in South Australia are under the governance of the Women’s and Children’s Health Network. There is a single inpatient unit, regionally based community teams located across South Australia and day patient teams providing services to children and young people in South Australia. In addition the state-wide mother and baby inpatient psychiatric unit also is under CAMHS governance. The CAMHS teams have merged from 2 services into one organisation twelve months ago and while there is much commonality there are also distinct differences in structures and processes across the now combined service.

Changes in Service Delivery
South Australia is moving towards the establishment of a new mental health system of care for young people aged 16 to 24 years under the governance of the Adult Mental Health Services in each Local Health Network. It is proposed that Child and Adolescent Mental Health Services age range will be from zero-15 years. However inpatient services at Boylan Ward will remain for young people to age 18 years.

Scope of Review
Review CAMHS inpatient and community based services and make recommendations on:
- Clinical Governance, leadership, supervision and accountability.
- Models of care including:
  - Care pathways and transfer of care within the service.
  - Integration with non-CAMHS providers of mental health services, other government agencies, non-government organisations and General practice.
- Multi-disciplinary staffing model.
- Facilitating transition to Youth services.
- Consumer focus and engagement across the continuum of care and within governance structures.
- Clinical risk management policy, procedures and processes.
- Documentation standards.

Review outcome
The review team will report and make recommendations in line with the Terms of Reference.

Review Team
It is proposed that the review team should consist of child and adolescent psychiatrist, social worker, clinical psychologist, mental health nurse and a consumer. All persons should be external to the state of South Australia and be held in very high regard within their respective constituents

Governance
A steering Committee independent of WHCN will be established to oversee the review process and will be chaired by Dr Stephen Christley.
## Attachment Two: People Interviewed

<table>
<thead>
<tr>
<th>People seen</th>
<th>Position / organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naomi Dwyer</td>
<td>Chief Executive Officer, WCHN</td>
</tr>
<tr>
<td>Liz Prowse</td>
<td>A/Director, CAMHS</td>
</tr>
<tr>
<td>Phil Robinson</td>
<td>Executive Director Corporate Services</td>
</tr>
<tr>
<td>Pauline McEntee</td>
<td>Director Primary and Population Health</td>
</tr>
<tr>
<td>Dr Prue McEvoy</td>
<td>A/Clinical Director, CAMHS</td>
</tr>
<tr>
<td>Dr Stephen Christley</td>
<td>Chair CAMHS Review Steering Committee</td>
</tr>
<tr>
<td>Dr Peter Tyllis</td>
<td>Chief Psychiatrist – SA Health</td>
</tr>
<tr>
<td>Dr Jon Jureidini, Kathy Crossing, Clive Skene, Lyn Jones, Brian Frost, Sandy Terry</td>
<td>CAMHS Executive members</td>
</tr>
<tr>
<td>Sandy Terry</td>
<td>CAMHS Quality Consultant</td>
</tr>
<tr>
<td>Social Workers</td>
<td>Group from a number of teams and regions</td>
</tr>
<tr>
<td>Clinical psychologists</td>
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</tr>
<tr>
<td>Child and Adolescent Psychiatrists</td>
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<td>Occupational Therapists</td>
<td>Group from a number of teams and regions</td>
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<td>Nursing staff</td>
<td>Group from a number of teams and regions</td>
</tr>
<tr>
<td>Speech Pathologists</td>
<td>Group from a number of teams and regions</td>
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<td></td>
<td>Adult Mental Health Psychiatrists</td>
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<tr>
<td></td>
<td>Headspace staff</td>
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<td></td>
<td>Second Story/ Youth Health Service</td>
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<tr>
<td>Dy Smith-McCue, Dr Hsu En-Lee, Christine Walsh, Vivien Ridgway, Nadine Foster, Anne Swed Williams, Sue Ellershaw, Lee Marling, Kathy Robinson, Stephen Johns, Kate Rooney, Robyn Duckworth, Michael Loder, Cathy Walmsley</td>
<td>CAMHS Managers</td>
</tr>
<tr>
<td>Various Staff</td>
<td>CAMHS Country North</td>
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# People interviewed (cont)

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<tr>
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<tr>
<td>Various Staff</td>
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<tr>
<td>Various Staff</td>
<td>APY Lands</td>
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<td>Aboriginal Mental Health Consultants</td>
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<td>Child Protection Service (WCHN CPS)</td>
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<td></td>
<td>Yarrow Place Youth team</td>
</tr>
<tr>
<td>Dr Malcolm Higgins</td>
<td>Paediatric ED and Emergency Mental Health</td>
</tr>
<tr>
<td>Monique Anninos, EMH Team</td>
<td>Child development Unit and Paediatricians</td>
</tr>
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<td>SASMOA, Public Service Association, ANMF</td>
<td>Unions</td>
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<td>Department of Education and Child Development</td>
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<tr>
<td>Various staff</td>
<td>Elizabeth</td>
</tr>
<tr>
<td>Various staff</td>
<td>Onkaparinga</td>
</tr>
<tr>
<td>Various staff</td>
<td>Mt Barker</td>
</tr>
<tr>
<td>Various staff</td>
<td>Adolescent Services Enfield Campus</td>
</tr>
<tr>
<td>Various staff</td>
<td>Port Adelaide</td>
</tr>
<tr>
<td>Various staff</td>
<td>Marion</td>
</tr>
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<td>Paradise</td>
</tr>
<tr>
<td></td>
<td>Consumer group</td>
</tr>
<tr>
<td></td>
<td>Carer Group</td>
</tr>
<tr>
<td>Linda Dandy</td>
<td>Director of HIM and Decision Support</td>
</tr>
<tr>
<td>Professor Robert Goldney</td>
<td>Adult Psychiatrist</td>
</tr>
<tr>
<td>Dr Rachel</td>
<td>Carer</td>
</tr>
<tr>
<td>Dr John Brayley</td>
<td>Public Advocate</td>
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<tr>
<td>Sandy Edwards</td>
<td>Health Complaints Commission</td>
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## People Interviewed (cont)

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<tr>
<td>Dr Quentin Black and Adrian Nipress</td>
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<tr>
<td>John Maratos</td>
<td>Department of Education and Child Development</td>
</tr>
<tr>
<td></td>
<td>Families SA</td>
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<tr>
<td>Various Staff</td>
<td>Behavioural Intervention Service at ASEC</td>
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<tr>
<td>Various staff</td>
<td>Helen Mayo House</td>
</tr>
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<td>Various staff</td>
<td>Boylan Ward</td>
</tr>
<tr>
<td>Various staff</td>
<td>Consultation Liaison Service</td>
</tr>
<tr>
<td>Catherine Quinn, Kathryn Beattie, Kate Rooney, Sue Martin</td>
<td>Allied Health Chiefs</td>
</tr>
<tr>
<td>Trish Strachan</td>
<td>Previous Director Primary and Population Health Current Executive Director, Office for Children and Young People</td>
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## Attachment Three: Submissions received

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<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>1 Suscha</td>
<td>Carer</td>
</tr>
<tr>
<td>2 Helen Mayo House</td>
<td>Staff</td>
</tr>
<tr>
<td>3 Anne Sved Williams</td>
<td>Helen Mayo House Medical Unit Head</td>
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<tr>
<td>4 Allied Health Chiefs</td>
<td>Allied Health</td>
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<tr>
<td>5 Jacqueline Wiseman</td>
<td>Nurse CPC</td>
</tr>
<tr>
<td>6 Gary Dugan</td>
<td>Nurse CPC</td>
</tr>
<tr>
<td>7 Tony Colhoun</td>
<td>Nurse CPC</td>
</tr>
<tr>
<td>8 Catherine Quin</td>
<td>Chief Clinician, Speech Pathology CAMHS Western</td>
</tr>
<tr>
<td>9 Port Adelaide, Elizabeth and Paradise teams</td>
<td>Social Workers</td>
</tr>
<tr>
<td>10 Kate Costello</td>
<td>Acting Chief Social Worker Eastern CAMHS</td>
</tr>
<tr>
<td>11 Paul Dignam</td>
<td>Psychiatrist CAMHS Northern Region</td>
</tr>
<tr>
<td>12 Kathy Robinson</td>
<td>Manager CAMHS Western Region</td>
</tr>
<tr>
<td>13 Professor Robert D Goldney (3parts)</td>
<td>Emeritus Professor of Psychiatry, University of Adelaide</td>
</tr>
<tr>
<td>14 Libby Druce</td>
<td></td>
</tr>
<tr>
<td>15 Enfield site team</td>
<td>Adolescent Services Enfield Campus</td>
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<tr>
<td>16 Tanya Leysley</td>
<td>Social Work, Onkaparinga</td>
</tr>
<tr>
<td>17 Dr Don Tustin</td>
<td>Director, Adelaide Psychological Services</td>
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<tr>
<td>18 Tamara</td>
<td>Consumer</td>
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<tr>
<td>19 Di Skene,</td>
<td>Nursing and Midwifery Director, (CAMHS)</td>
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<td>20 Jon Jureidini in discussion with</td>
<td>General Practitioners</td>
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<td>Central Adelaide and Hills Medicare Local</td>
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<td>21 Occupational therapists</td>
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<td>22 Julie Ide</td>
<td>Nurse CPC, Onkaparinga</td>
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### Submissions received (cont)

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<thead>
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<th>Name</th>
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<tbody>
<tr>
<td>23 Dr Quentin Couper Black</td>
<td>General Secretary Psychologists Association (SA Branch)</td>
</tr>
<tr>
<td>24 Dr Stephen Allison</td>
<td>Psychiatrist Unley</td>
</tr>
<tr>
<td>25 Emergency Mental Health Team</td>
<td>Nursing</td>
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<tr>
<td>26 Prof Michael Sawyer</td>
<td>Research Paper Indigenous and non Indigenous Clients</td>
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<tr>
<td>27 Prof Michael Sawyer</td>
<td>Head Research and Evaluation Unit</td>
</tr>
<tr>
<td>28 Karen Bradbury</td>
<td>Social Work</td>
</tr>
<tr>
<td>29 Dr Brian Coppin</td>
<td>Clinical Director Dept. Paediatrics and Child Health Flinders Medical Centre</td>
</tr>
<tr>
<td>30 Robyn Duckworth</td>
<td>Regional Manager Hills Murraylands CAMHS</td>
</tr>
<tr>
<td>31 Sue Martin</td>
<td>Chief Clinician Clinical Psychology CAMHS</td>
</tr>
<tr>
<td>32 Donna R</td>
<td>Carer</td>
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<tr>
<td>33 SASMOA</td>
<td>Union</td>
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<tr>
<td>34 Dr. Leigh Roeger</td>
<td>Manager, Research Southern Child and Adolescent Mental Health Service Flinders Medical Centre</td>
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<tr>
<td>35 Australian Association of Social Workers: SA Branch</td>
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<td>36 Australian College of Mental Health Nurses</td>
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<tr>
<td>37 Shelley Rogers</td>
<td>Chair, Australian Psychological Society- SA Section</td>
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<td>38 Australian Medical Association: SA</td>
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<tr>
<td>39 Robert Goudie</td>
<td>Social Work Therapist, CAMHS Hospital Liaison Service, Flinders Medical Centre</td>
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<tr>
<td>38 Dr Michael Batterham</td>
<td>Senior Consultant Psychiatrist CAMHS FMC Team</td>
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<tr>
<td>39 M McCarthy</td>
<td>Manager, WCH Social Work Service</td>
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<td>40 Project Implementation Committee</td>
<td>Statewide Eating Disorders Service</td>
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<tr>
<td>Dr Michelle Atchison</td>
<td>Chair, Royal Australian and New Zealand College of Psychiatrists – SA Branch</td>
</tr>
<tr>
<td>Jenny Moody</td>
<td>Speech Pathology Australia</td>
</tr>
<tr>
<td>Dr Peter Parry</td>
<td>Senior lecturer, University of Queensland visiting senior lecturer, Flinders</td>
</tr>
<tr>
<td>Bailey, Michelle</td>
<td>Southern Fleurieu Team</td>
</tr>
<tr>
<td>Martin Gare</td>
<td>Acting Chief Social Worker</td>
</tr>
<tr>
<td>Shane Mohor</td>
<td>Aboriginal Health Council SA</td>
</tr>
</tbody>
</table>
Attachment Four: Documents Reviewed

- Present organisation structure of CAMHS
- Proposed organisation structure of CAMHS
- Overview of CAMHS services March 2014
- Model of Care 2013 (proposed)
- Staffing levels: nursing and allied health
- Risk register
- Coroner’s reports: Michaela Mundy and Jason Hugo-Horsman
- Committee minutes
- Consumer feedback information
- Adverse events data
- Comparative Service Delivery Models from ACT and Monash Health
  - Early in Life Mental Health Service Manual
  - Acute Mental Health Inpatient Unit for CAMHS: WA Mental Health Services working draft
  - Child and Adolescent Model of Care ACT: May 2013
- A selection of CAMHS policies
- Comparative staffing data from CAMHS WA: Community CAMHS WA Mental Health Services
- Comparative Data on Child Psychiatrists in Australia: RANZCP Workforce Survey Report June 2014
- Various research literature as referred to in footnotes
- Clinical Business Rules 2013: metropolitan Adelaide Adult Integrated Community Mental Health Teams
- Youth Mental Health Services SA Model of Care
- HCSCC Charter of Health and Community Services Rights
Attachment Five: Interdisciplinary Teamwork and Leadership: Issues for Psychiatrists

_Australasian Psychiatry_ 2005 13: 234
Alan Rosen and Tom Callaly
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Australasian Psychiatry 2005 13: 234
DOI: 10.1080/1440-1665.2005.02195.x

The online version of this article can be found at:
http://apy.sagepub.com/content/13/3/234

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>> Version of Record - Sep 1, 2005

What is This?
Interdisciplinary teamwork and leadership: issues for psychiatrists

Alan Rosen and Tom Callaly

Objective: To review the constructs and applications of interdisciplinary teams in mental health services, with a particular view to ascertaining the most effective types of teams and their leadership.

Method: Some of the most challenging questions from a psychiatrist’s viewpoint regarding the functions of interdisciplinary teams in the mental health service are addressed.

Results: The effectiveness of the interdisciplinary team in mental health services is supported by an extensive literature that is much more qualitative and descriptive than quantitative and empirically rigorous, except as part of packages of variables subjected to randomized controlled trials.

Conclusion: Effective interdisciplinary teamwork in mental health services involves both retaining differentiated disciplinary roles and developing shared core tasks. It requires sound leadership, effective team management, clinical supervision and explicit mechanisms for resolving role conflicts and ensuring safe practices. No one profession should hold a monopoly on leadership.

Key words: interdisciplinary, leadership, management, multidisciplinary, psychiatrists’ role, teamwork.

Life used to be so simple. Doctors used to be able to assume leadership of the clinical unit almost by divine right, other professional disciplines knew their place as ‘handmaidens’, hospitals were the centre of the known health-care universe and administration was done centrally and unobtrusively with budgetary stability assumed as ‘last year’s budget plus 5% for inflation’. Generic community health teams, with their flattened hierarchy, developed in the 1970s in Australia to provide mainly preventive services, and were often dismissed by entrenched hospital clinicians as ‘small groups of people, sitting in circles, smoking, drinking coffee and plotting revolution’.

This phase was superseded by the concurrent shift away from reliance on stand-alone psychiatric institutions in favour of general-hospital-based in-patient units, and the development of distinct community mental health teams, organized around specific functions, often evidence-based, focused mainly on the needs of individuals with severe mental illnesses and their families living in the community (e.g. 24 h home-visiting crisis and assertive community treatment teams). In the 1990s, encouraged by National Mental Health reforms in both Australia and New Zealand, clinical and management integration was promoted between general-hospital and community-based mental health services. Following a period of service innovation and growth, responsibility for shrinking budgets was devolved to service managers and team leaders, whose teams magically transformed into cost-centres, often forcing them to make unpalatable choices and cut staff.

Many psychiatrists have been ill-prepared in their training for working within the interdisciplinary team. Although psychiatrists have belatedly recognized that ‘the other members of the team are not the handmaidens of the doctors...
and have to be treated on an equal professional footing; they can still find that their sense of responsibility to consumers and the discovery of their limited leadership and management authority may cause conflict and frustration both for themselves and for other team members.3

In order to promote readability in a necessarily brief overview of a large topic, the most challenging questions commonly asked by perturbed or otherwise sceptical psychiatrists regarding interdisciplinary teamwork and leadership will be addressed.

Q1. Do we really need teams in mental health services? Do they really work, or do we just idealize ‘teamwork’ to paper over the cracks between the warring approaches of different professional disciplines involved?

A team can be thought of as a small group of people who came together for a common purpose,2 or as a method for organizing the contributions of people in different roles required to complete a task.1 An interdisciplinary team in a modern mental health service brings specialist assessments and individualized care together in an integrated manner and is the underlying mechanism for case allocation, clinical decision-making, teaching, training and supervision and the application of the necessary skills mix for the best outcomes for service users.4 However, while the interdisciplinary team can be demonstrated to be an efficient, effective and satisfying type of work organization, it can also be a disaster, torn with conflict and leading to disrespect with the pretence of cooperation.2,5 Service users, their families and health workers can all benefit and grow from good teamwork or all suffer and be diminished by poor teamwork. Good teamwork depends on clear structure and accountability, good leadership, delegation of tasks, role delineation and mechanisms to resolve role conflicts.3,5,6 Sound interdisciplinary teamwork has the ability to bring different expert points of view and bodies of knowledge to bear on the person’s problems. Alternatively, a veneer of gestural teamwork may be employed in a futile effort to superficially ‘paper over the cracks’ of interprofessional differences. These include: interprofessional misperceptions, misunderstanding, ignorance and stereotyping of each other’s roles, for example, psychiatrists who do not value or comprehend the skills of an occupational therapist1 or a social worker5 interprofessional rivalries – based on a disturbing tendency regarding the unique aspects of one’s own profession as superior to the unique aspects of other professions (this is unfortunate because most of these different approaches are complementary and potentially synergistic); and power, status and salary differentials that can lead to simmering resentments about differing rewards for seemingly similar activities.2 Rather than focusing on within-team rivalries and ideological differences over treatment philosophies, these should be put aside in favour of the principle ‘the service-user comes first’, and focusing on the combined tasks of the team to meet the needs of that individual and their family.3,5,8,10

Q2. What is meant by the multidisciplinary team? Doesn’t every clinical unit claim to be one? Isn’t it an inflationary currency?

Many clinical units that claim to operate as ‘multidisciplinary’ teams are in fact loose-knit ‘network’ type teams,3 which provide easy exchange of information and referral between service providers who may otherwise work separately, in relative isolation from each other. They may or may not meet, except in passing, and usually do not review or assist in each other’s work. Such ‘multidisciplinary’ or ‘network’ teams may occur in primary health-care centres, in large community health centres with little formal structure, or in any medical specialty. Where this structure exists in mental health services, typically in old-style sedentary adult or child and adolescent mental health outpatient-style units, it is difficult to provide more complex evidence-based psychiatric service components such as extended hours mobile crisis intervention or assertive community treatment intensive case management subsystems. These require cohesive interdisciplinary teams.

The essence of interdisciplinary teamwork lies in the recognition, utilization and integration of the expertise and perspectives of different professionals, which derive from their professional discipline and which are focused on working towards a shared goal.11 Interdisciplinary teams may involve service providers from several professional disciplines (e.g. medical, nursing, allied health) working simultaneously with the same service user and their family with a division of labour or components of intervention coordinated by one designated case manager. These team members meet regularly and participate in the review of the quality, flow and amount of each other’s work.

Q3. Which professions are part of the interdisciplinary mental health team anyway, and which are expected to work from outside the team?

Delineating and clarifying membership often marks a transition from an informal loose-knit group to a more formal and organized team. Five professional disciplines are usually involved with interdisciplinary mental health teams: psychiatry, psychiatric nursing, psychology, occupational therapy and social work. Onyett et al. reported, using a standardized measure with 57 community mental health teams across the UK, that the staff who have the highest job satisfaction and lowest burn-out are those who have identification both with the team and their profession, and who are both clear about the role of their team and their own role within it.12 Other professionals who often work in close liaison with mental health service teams include general practitioners, primary health-care workers, health educators, indigenous and transcultural workers (e.g. bilingual
counsellors), consumer peer support workers, family carer support workers and educators, and rehabilitation and vocational counsellors etc. These professionals may or may not be able to participate full time in the interdisciplinary mental health team for practical purposes, but may become essential members of the ad hoc interdisciplinary team set up around particular service users and their families. Other partners outside the team whose inputs are more effective with good coordination and reciprocal communication include: public housing officers, employment and welfare benefit officers, domestic assistance and home nursing carers etc. Managers who do not see themselves as team members often have considerable influence over the team’s functioning.15 Boundaries between management and teams are often blurred, so both parties should work progressively on clarifying this relationship.

Q4. Why are there interdisciplinary teams in psychiatry and not in medicine, surgery, paediatrics etc.? Is this just another way for the government to save money by not employing the number of psychiatrists needed, and by using cheaper alternative staffing?

Psychiatry is arguably ahead of many medical disciplines in its recognition that most severe disorders have a multifactorial biopsychosociocultural aetiology, requiring corresponding multimodal intervention responses. It is unrealistic to expect that each individual psychiatrist, even if comprehensively trained to appreciate all these needs, has either the time or the training to provide all of these interventions effectively. It may be gradually dawning on other medical and surgical disciplines that all clinical disorders have such multifactorial predisposing, precipitating and perpetuating factors, and that they would resolve more quickly and completely if they also employed such a multimodal interdisciplinary approach.

Employing interdisciplinary teams may not be a cheap option, but has been demonstrated to be the more cost-effective strategy, rather than mainly relying on traditional outpatient and inpatient psychiatric services. The use of assertive mobile interdisciplinary teams can result in increased attendances and contact with care, decreased use of hospital-based care, more housing stability and better functional outcomes,16 in any case, the supply of trainee and consultant psychiatrists is too limited to fill many more positions in public mental health services and teams, even if sufficient funding was available.

Q5. Is there an evidence base for the effectiveness of an interdisciplinary team approach?

Although there is extensive literature, most of it is qualitative and descriptive, and empirically somewhat limited. Interdisciplinary teamwork is often a characteristic of psychosocial interventions that have been subjected to randomized controlled trials and shown to be cost-effective (e.g. assertive community treatment,17 crisis behaviour and family intervention15), but its effect as a centrally operative variable remains largely unknown, except as part of a package of variables. Nevertheless, ‘multidisciplinary team-based care has been demonstrated in Cochrane reviews to provide cost reductions per patient and care that is at least as good when compared with inpatient (based) services’.18 The evidence regarding interdisciplinary teamwork has been reviewed by Trauer et al.;2 advantages include continuity of care,11 the capacity to take a broad and comprehensive view of the patients’ problems,19 the availability of a range of skills17 and synergistic working between providers via mutual support and reciprocal education.18 This can prevent professional isolation and lead to cross-fertilization of approaches and skills.20 The team may also be more than the sum of its parts. ‘A well-functioning team with a strong sense of shared responsibility can produce significantly more and better work than its individual members working as solo practitioners’.20 Mohrman et al. found that working in teams enabled organizations to rapidly develop and deliver high-quality products and services cost-effectively, allowed the organization to learn and retain learning more effectively, promoted innovation through the cross-fertilization of ideas, achieved better integration of information and saved time by having tasks undertaken concurrently.21 Opie concluded that advantages of the interdisciplinary team include the development of quality care for users through the achievement of coordinated and collaborative inputs from different disciplines: improved, better informed and holistic care planning; higher productivity; the development of joint initiatives; increased job satisfaction and greater professional stimulation and consequently more effective use of resources.22

Q6. Increasingly, multidisciplinary teams are made up of different disciplines playing the same case-management role. Are they not getting an opportunity to practise their particular professional skills, and will they lose them? On the other hand, if they all play separate professional roles, can they be called a ‘team’?

Interdisciplinary teamwork, while systematizing core multidisciplinary skills, should also ensure that the distinct contribution of each professional discipline is valued highly within the team, and that strong professional support links are maintained. Australasian guidelines do not support the development of a ‘generic’ mental health case-manager role, either by merging professions or on a non-professional basis.23,24 Cooperative effort between professionals of diverse tertiary training and backgrounds brings many more up-to-date skills to bear on shared challenges, enhances peer support and strengthens hybrid vigour, while also maximizing professional ethical standards and the quality of care.19

All staff should be encouraged to maintain links with their professional discipline for ethical and professional advice and at least a significant proportion of their postgraduate learning and professional supervision.
Table 1: The 12 practice standards

<table>
<thead>
<tr>
<th>National Practice Standards for the Mental Health Workforce (2003)</th>
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<tr>
<td>1. Rights, Responsibility, Safety and Privacy</td>
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<tr>
<td>2. Consumer and Carer Participation</td>
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<tr>
<td>3. Awareness of Diversity</td>
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<tr>
<td>4. Mental Health Problems and Mental Disorders</td>
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<tr>
<td>5. Promotion and Prevention</td>
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<tr>
<td>6. Early Detection and Intervention</td>
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<tr>
<td>7. Assessment, Treatment, Relapse Prevention and Support</td>
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<tr>
<td>8. Integration and Partnership</td>
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<tr>
<td>9. Service Planning, Development and Management</td>
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<tr>
<td>10. Documentation and Information Systems</td>
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<tr>
<td>11. Evaluation and Research</td>
</tr>
<tr>
<td>12. Ethical Practice and Professional Responsibilities</td>
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Although each profession within the interdisciplinary team should have relatively protected time to contribute specialized work derived from their own professional discipline’s skill set (e.g., clinical psychologist undertaking cognitive behaviour therapy (CBT)), each professional should also contribute core clinical skills common to all when rostered to do so (e.g., acute intake assessments, continuity of case management). The Australian National Practice Standards for the Mental Health Workforce defined the core knowledge, skills and attitudes that all mental health professionals should have when working in a mental health service (Table 1). The workforce standards do not attempt to limit the knowledge and skills base or competencies expected to be attained and maintained for each professional discipline.

The team needs to allow a degree of autonomy for each professional, while providing a space within which the various professionals may collaborate with safety and even creatively, together with service users and carers. The level of collaboration required to support the complexity of these interventions demands sophisticated management of boundaries and authority.

So is role overlap a problem? No – inevitably a great deal of overlap or ‘core’ case-management function will form the bulk of work with some service users, but there needs to be space for each of the professions to contribute their specific expertise.

Q7. The terms ‘team leader’, ‘team manager’ and ‘clinical leader’ are confusing. Are there real differences or are they just used interchangeably by bureaucrats to confound us clinicians and impose senior management ‘plants’ on our teams? Shouldn’t a real team elect its own leader?

In traditional psychiatric hospitals, line managers often led unidisciplinary professional departments, but this is now less common. Initially, interdisciplinary team leaders were often voted for from within the team, leaving these posts with little real authority. The term ‘team manager’ connotes more formal management responsibility as well as leadership, and may therefore be more likely to be an officially advertised and appointed post. In its simplest and most common form, the team manager position is held responsible for specified management functions, with delegated authority to ensure that the team applies operational policy, but does not oversee the clinical decision-making of other team members.

In this model, the team manager may work in tandem with a clinical leader, who undertakes or ensures all clinical supervision, or the professional line manager may retain responsibility for clinical supervision. In its more complex and richer form, the team manager assumes all administrative functions and oversees all clinical work allocation, assessment, operational practice review and case termination. In this model, the team manager or supervisor may be assisted by other senior professionals allocated responsibility for clinical supervision of more junior members, or peer supervision dyads or groups may be arranged.

The distinction between management and leadership is critical. A number of individuals on a team can simultaneously demonstrate clinical leadership, including the psychiatrist.

Q8. Who is really accountable for care? It is all very well to say that each team member carries clinical responsibility for their own decisions and the case plans they devise, but if something goes wrong isn’t it me who ends up in court, while they run for cover?

An unquestioned assumption underlies the traditional response to this issue: ‘Obviously, in legal terms the consultant is responsible for (all) patient care.’ Guidance from the UK National Health Service (NHS) National Steering Group in conjunction with the Royal College of Psychiatrists states that consultant psychiatrists ‘have the ultimate responsibility to diagnose illness and prescribe treatment. This authority may be delegated to other professionals, but the responsibility cannot be abrogated’. This type of authoritative statement becomes a two-edged sword and can result in assumed centrality of psychiatrist responsibility and blame when anything goes wrong during intervention. Boyce and Tobin argued the need for psychiatrist supervision of all other health professionals and insisted on direct psychiatrist overview of and accountability for every case. Such insistence would waste scarce and much-needed medical expertise, delay effective treatment as waiting lists to see ‘the doctor’ get longer, allow people in need of services to drop out, and leave medical staff with no time for home visits or participation in service-system building or service management.

The opposing view emphasizes the difference between responsibility and leadership in stating that because of
the circumscribed nature of professional responsibility, no professional can be held accountable for another professional’s actions except in part by negligent delegation or inappropriate referral. This resolves the unhelpful conflation of medical responsibility and ultimate clinical responsibility. Medical responsibility is best regarded as a particular instance of professional responsibility whereby practitioners are accountable for those tasks for which they are recognized as competent as a result of their medical training. Ultimate clinical responsibility is often claimed by the senior medical member of the team when he/she asserts that he/she is accountable for the work of the team as a whole should disaster occur or that although personally blameless she/he may be held accountable after the style of a military commander. But this assertion is almost certainly unjustified. The Nodder Report concluded that there is no basis in law for the commonly expressed idea that a consultant may be held responsible for negligence on the part of others simply because he or she is the responsible medical officer. In Australasia, unlike the Northern American documented experience, non-medical members of the mental health team, including case managers, are much more likely to be clinical professionals who take professional responsibility for their work. They are held clearly accountable for their own work by their professional bodies (e.g. Royal Australian and New Zealand College of Psychiatrists (RANZCP) position statement 47) and by state government regulation (e.g. New South Wales Department of Health). A recent National Health Service Department of Health Guidance Report advises that doctors in psychiatry are not responsible for the quality of care provided by another team member, and there is no requirement to have a consultant’s name on the file of any service user who is not actually seen by that consultant.

Q9. Aren’t team managers in an impossible position? The team expects them just to look after the team, and defend their habitual practices, while the bureaucracy considers them to be management, and expects their loyalty in terms of implementing senior management decisions.

Team managers sit on the team boundaries, facing outsides when representing the team to management and other agencies, and facing inwards when supporting the team. Living on the boundary can be difficult and lonely. An effective team manager needs to be both internally in touch with the team and externally aware of the demands on the team as a whole. They often find themselves the receptacle of the group’s hostile projections, particularly in a context where structures are constantly evolving and fail, and there is no longer a robust institution to provide containment of these projections. They can neither entirely join the group nor distance themselves from it.

Turquet stated that teams need a manager who can ‘bear being used…otherwise the negative projections go elsewhere…’ to an external enemy, or the projections go rocketing around the organization precipitating personalized conflicts among peers, or become reinternalized ‘so that workers can no longer find meaning or pleasure in their work’. So team managers have an important role in containing difficult team emotions, and an equally important role in articulating and standing up consistently for the team and service values and vision based on the experienced needs and safety of its clientele, their families and its staff. Balancing these roles can be very challenging. It is up to senior managers to listen to and heed this advice and to ensure that their decisions are well informed by it. Otherwise, bureaucratic pressures (e.g. to save money) can easily eclipse clinical priorities and rapidly denature well-functioning teams.

Q10. With so much bureaucratic interference, how can there be real leadership (or stronger operational management) at team level?

‘Transaction leadership’ entails influencing others to engage in the work behaviours necessary to reach organizational goals. Transformational leadership goes beyond management and involves challenging the status quo to create new visions and scenarios, initiating new approaches and stimulating the creative and emotional drive in individuals to innovate and deliver excellence. Corrigan et al. demonstrated the superiority of transformational over transactional and laissez-faire leadership styles in 54 mental health service teams. Studies demonstrate that training to improve leadership and team functioning is feasible. Q11. Obviously, I (the psychiatrist) must be the team leader. After all, I have the most comprehensive training. But it seems that some of my team don’t really accept this – so what can I do?

This assertion confuses the responsibilities of management with leadership. At the same time, other disciplines all recommend increased leadership roles for their own professionals. Boyce and Tobin argue strongly that the psychiatrist’s roles as service leader, manager and supervisor of every case and every clinician of other disciplines, are pivotal and base this on the assumption that the psychiatrist has had the longest, widest, deepest and most practical apprenticeship-based training, and therefore is usually in the best position to provide ‘comprehensive biopsychological management plans’, to offer ‘higher-order’ diagnostic and treatment skills and to give ‘higher-order’ consultant opinions on management of complex cases. Other professions would equally claim to provide ‘comprehensive’ assessments and interventions, with a detailed focus on their particular areas of expertise. If every profession claims it provides a comprehensive or holistic approach, it becomes meaningless to state or imply that any one profession has a...
monopoly on comprehensive training, assessment or intervention. The term ‘comprehensive’ is often employed like the term ‘holistic’, as an exhortation from within the membership of a particular profession or staff of a type of service to go wider\textsuperscript{43,49}, to fully contextualise the problem in focus.

It follows that it is difficult to construct a comparative hierarchy on the basis of who is more comprehensive in their training or skills. Psychiatrists, among other senior professionals, should be given or encouraged to seek specific training if they wish to undertake the roles of clinical supervision, clinical leadership or service management. The new psychiatry training curriculum now offers such opportunities in both mandatory and elective advanced training modules in leadership and management.\textsuperscript{43} A study by Tan concluded that teaching interpersonal and team leadership skills to psychiatry medical staff was likely to improve their multidisciplinary team functioning.\textsuperscript{49}

CONCLUSION

Interdisciplinary teams have become the principal vehicle for the delivery of integrated, comprehensive services in modern mental health systems.\textsuperscript{45} Although there is considerable evidence of a qualitative and indirect quantitative nature for their effectiveness, much needs to be done to fully evaluate this model. Effective interdisciplinary teamwork in mental health services involves both retaining differentiated disciplinary roles and developing shared core tasks, and requires sound leadership both in terms of team management and clinical supervision. No one profession should hold a monopoly on leadership and management. The RANZCP Position Statement, ‘Psychiatrists as Team Members’,\textsuperscript{26} makes a laudable start in introducing psychiatrists to these complex issues for which we have tended to be ill-prepared. Although the Statement only obliquely concedes that ‘Management of a multidisciplinary team is not necessarily the domain of the psychiatrist’, it should be amended to say squarely that ‘Management should be performed by the person in the team best qualified, experienced, and most committed to performing the management role independent of the type of clinical professional background.’ Psychiatrists should be encouraged to learn to understand and participate in management and particularly in leadership roles, and future training for psychiatrists must help equip them for these roles.

ACKNOWLEDGEMENTS

To Sylvia Hands and Melanie Robson for help with the manuscript, Vivienne Miller, Tony Cowlin, Sue Capel, Pauline Hamner, Tom Trauer, John Houtl, Ray Diamond and Ela Devor for assistance with the content.

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