TASMANIAN LEGISLATIVE COUNCIL INQUIRY INTO ACUTE HEALTH SERVICES

PERINATAL, INFANT CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

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This submission addresses the resourcing of Tasmania's major hospitals to deliver acute mental health services to pregnant women, infants, children and adolescents, across all regions of Tasmania.
The contributors to the submission, who can offer perspectives from all regions of the state, would welcome the opportunity to meet with the committee in a hearing.

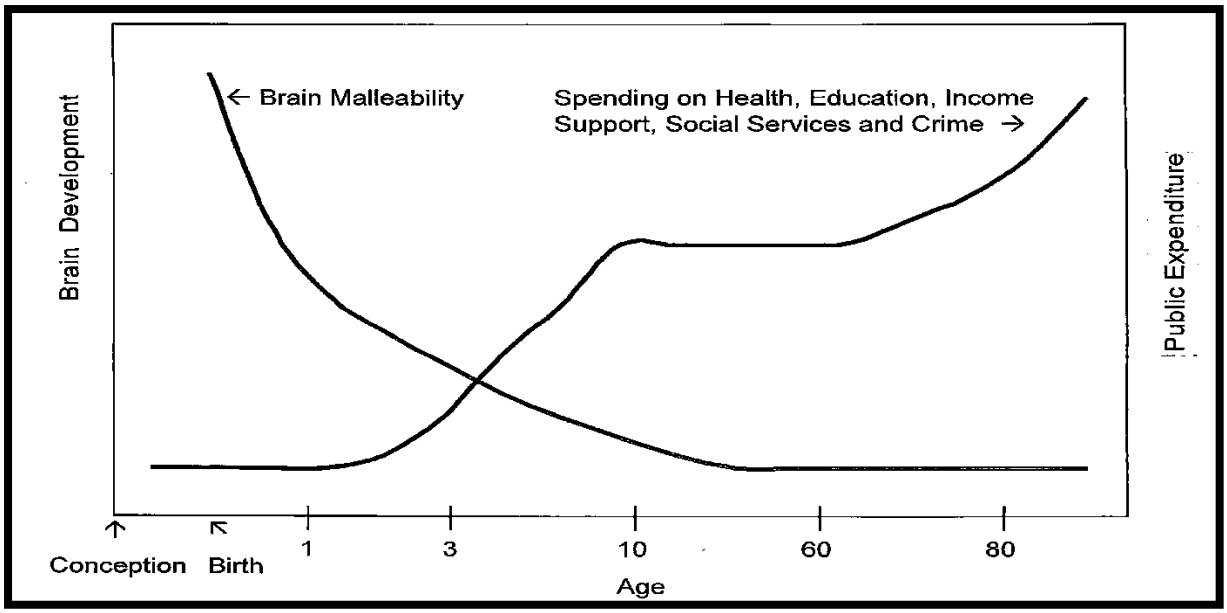
OVERVIEW

Child and Adolescent Mental Health Services (CAMHS), which in Tasmania includes Perinatal and Infant Mental Health Services (PIMHS), provide direct care for pregnant women, young people aged 0-18years and their families, who present with severe and complex mental health problems. CAMHS, including PIMHS, also provide consultation, support and education and training to primary and secondary services in the maternity, infant, child and adolescent sector. This support is provided to Child Safety Services, Education, Disability, Child Health and Parenting Services, Child and Family Centres, General Practitioners, Paediatricians, Maternity Services, private mental health providers, and community sector organisations.

CAMHS in Tasmania are the most poorly resourced CAMHS of all states of Australia, [1] and more poorly resourced per capita than Tasmanian Adult Mental Health Services.[2] This is despite the fact that mental illness occurs at similar rates throughout the lifespan.[3] There is a strong neuroscientific and economic evidence base that interventions early in the lifespan, especially during pregnancy and before the age of two years, are more clinically effective and cost effective than spending on established illness[4] [5]. Wellbeing outcomes and cost savings are demonstrable not only in the health

[1] Australian Government Department of Health (2013) National Mental Health Report
[2] ibid
[3] Harvard Centre for the Developing Child (2008) Working Paper 6
[4] Heckman et al 2007 The Productivity Argument for Investing in Young Children∗

sector but in education, employment, welfare, social security and justice. Rather than continuing to expend increasing amounts of money and resources on acute hospital care for established illness, adequate investment in mental health optimisation earlier in the lifespan could improve the health of the Tasmanian population and consequently demand on acute health services.
Bricker 2001



There are no dedicated inpatient beds for child and adolescent patients requiring hospitalisation for mental illness in Tasmania. Currently, these severely mentally ill young people (around 400 patients statewide per year) must be admitted to general paediatric units or adult psychiatric units at Royal Hobart Hospital (RHH), Launceston General Hospital (LGH) or North West regional Hospital (NWRH).

At LGH, NWRH and Mersey Hospital, there is no CAMHS hospital team. There is a small CAMHS hospital team at RHH that cares for inpatients; and attends the Emergency Department for crisis assessments (583 patients per year). At hospitals in the north (LGH), and north west (NWRH, Mersey) of Tasmania, CAMHS community teams must inreach to the Emergency Department to assess young people in crisis (over 300 patients per year) and to care for severely mentally ill young people in hospital (over 150 patients per year). This impacts severely on the capacity of CAMHS North and North West to provide necessary intensity of care and support to hospital patients; and also impacts on community care of young people who are outpatients whose appointments often are cancelled so acute care can be delivered.

There is no statewide PIMHS in Tasmania. A small PIMH service has been established at the RHH from existing CAMHS South resources. This service cares for women attending the antenatal clinic at RHH with severe and complex mental health problems (currently 13% of all women delivering at RHH, over 250 patients per year). **There is no PIMH service at LGH or NWRH.**

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5 Bricker 2001

There are no dedicated Mother and Baby Unit beds in Tasmanian public hospitals, whereas benchmarking and need reflect that two beds at RHH and two beds at LGH are required. There is limited public funded statewide access to one bed at the St Helen's MBU in Hobart. However, this is rarely suitable for women and infants from the north and northwest of the state due to separation from their families; and cannot accommodate the most severely ill women requiring involuntary treatment.

CAMHS Community Teams are significantly under resourced in all regions of Tasmania relative to national benchmarks[6]. Three external reviews have found CAMHS significantly more under resourced than Tasmanian Adult MHS.[7] Adequate resourcing of community services can significantly decrease demand on acute hospitals, decreasing both Emergency Department presentations and inpatient admissions. CAMHS across the state provide intensive community support for young people with eating disorders and personality disorders, significantly reducing acute hospital costs and occupancy for these patient groups[8]. Adequate resourcing of CAMHS community teams could further reduce demand on acute hospital services. Furthermore this provides better care and outcomes for young people who are able to recover in the context of their families and remain engaged in education and social relationships.

TERMS OF REFERENCE:

(1) CURRENT AND PROJECTED STATE DEMAND FOR ACUTE HEALTH SERVICES

Activity Data

The severity and complexity of acute mental illness presentations in young people is increasing across Tasmania. There is a high level of demand for mental health clinicians and mental health beds for this age group. This increasing demand is reflected in activity data for inpatient admissions and Emergency Department presentations for under 18year olds with a mental illness:

Inpatient Admissions: <18yo with Mental Illness

	2016	**2015**	**2014**
RHH Paed	217	164	183
RHH Adult	7	11	9
RHH Total	**224**	**175**	**192**
LGH Paed	114	101	79
LGH Adult	9	7	8
LGH Total	**123**	**108**	**88**
NWRH Paed	29	25	22
NWRH Ault	6	6	10
NWRH Total	**35**	**31**	**32**
State Total	**382**	**314**	**312**

[6] Fjeldsoe 2010
[7] Fjeldsoe 2010, Bridging the Gap 2004, 2007, Growing Pains 2005
[8] Wagg & Williams 2017

Emergency Department Presentations: <18yo with Mental Illness:

Presentations	**2016**	**2015**	**2014**	Average Age (yrs)
RHH	**359**	221	228	14.4
LGH	**180**	167	124	14.0
NWRH	98	53	51	14.3
MCH	25	38	48	13.7
NW Total	**123**	91	99	
Total	**662**	**479**	**451**	14.1

Activity data reflects clinician impression of increasing severity and complexity of mental health presentations in young people. Increasing numbers of young people with mental illness are presenting to emergency departments and requiring inpatient admission across the state. ED presentation rates per <18yo population is similar in each region. In the North West region CAMHS has to cover emergency presentations at two hospitals which presents added challenges for this small team in providing timely and appropriate care.

Commonest acute presentations of young people are suicidality and self- harm, personality disorders, substance abuse, developmental disorders, family conflict and trauma. Less common but more severe presentations most often requiring inpatient care are psychosis, anorexia nervosa, mood disorders, anxiety disorders, neuropsychiatric disorders, somatoform disorders and psychological complications of medical illness.

The great majority of admissions of young people with mental illness are to Paediatric facilities with care provided by Paediatric staff with CAMHS support. A small number require containment in Adult psychiatric wards and cooperative CAMHS care with adult MHS staff. It is notable that inpatient admission rates for the <18yo population in the North West are half those of southern and northern regions. This supports the clinical experience of CAMHS NW that inadequate facilities and staff resources prevents access of young people to appropriate inpatient care. CAMHS NW is frequently providing intensive “hospital in the home” support to young people whose needs would be better met by inpatient care. While community care is preferred to hospitalisation where possible, lack of access to inpatient care when needed leads to adverse outcomes for patients. It also diverts community CAMHS resources to a small number of extremely high needs patients and diminishes CAMHS capacity to provide care to other mentally ill young people.

Overall CAMHS admission rates in Tasmania are 57% of the national average. This reflects that lack of appropriate specialist CAMHS inpatient facilities and staff has prevented young people receiving appropriate access to inpatient care. On average, mentally ill young people occupy 6 of the 24 beds on the Paediatric Unit RHH with a range of 2- 12.

Unfortunately current data collection systems do not capture occasions of service for CAMHS inpatient care. Introduction of ABC barcoding will address this.

The majority of young people presenting with mental health problems have medical comorbidities that require close cooperation with paediatric specialists. Anorexia Nervosa is a clear example of this where medical complications cause the highest mortality and morbidity of any mental illness. First episode psychosis also requires medical input. Somatoform disorders and chronic medical illness also clearly require input from both medical and mental health clinicians.

Young people presenting with psychosis often also require collaboration with adult mental health services in to ensure safe containment and appropriate care.

Perinatal and Infant Mental Health Service

New Assessments	2016	2015	2014
RHH	254	226	250

There is a high level of demand for antenatal assessment and care of pregnant women with mental health problems. The PIMH service at RHH is referred 13% of all women attending RHH for antenatal care. Those referred present with severe and complex mental health problems including borderline personality disorder, schizophrenia, bipolar disorder, substance dependence, developmental trauma and domestic violence.

The PIMH service is a mental health intervention not only supporting the health of the pregnant woman but is also a preventative and early intervention in the health and mental health of the infant. Pregnancy and the first two years of life is a critical period for brain development and is impacted upon by both neurobiological and environmental factors. Substance use, malnutrition and maternal stress hormones induced by mental illness are toxic to the developing brain of the foetus. Infants require appropriately responsive parental care, secure attachment, and this experience is crucial to normal brain development, especially the development of emotional regulation and social capacities critical in later mental health. Disorganised attachment in infancy is the strongest predictive factor of later teenage suicidality and mental illness[9].

The PIMH at RHH has been crucial in the identification of infant risk and works closely with maternity, neonatal, child safety, child health and parenting services to support parents and safeguard vulnerable infants. It is recognised that infants in the first year of life are at highest risk of child abuse and even death. While teenagers and adults at high risk can present themselves to the Emergency Department for acute care, infant risk requires relevant services to identify and address this need, but the severity of risk of these infants is no less an acute health problem. Development of PIMH services statewide is crucial in addressing infant risk and promoting optimal mental wellbeing for the Tasmanian population, which is founded early in life.

CAMHS Hospital Services

Where ever possible, young people with mental health problems and their families are supported in the community. However, for those young people with mental illness of the highest severity and complexity, there is a need for inpatient care. Currently there are no dedicated mental health beds for young people in Tasmania. In the redevelopment of RHH and LGH it is planned there will be

[9] Sroufe 2005

Adolescent Medical, Surgical and Mental Health Units, with six beds for mentally ill young people in each facility. Young people from the north west will be accommodated at LGH. Opening new adolescent units will require specialist multidisciplinary nursing, medical and allied health staff for which there is currently no budget. Mental health inpatient care of young people is a specialised field with no existing workforce currently in Tasmania.

Hospital CAMHS Teams

There is a need for CAMHS in each region to have an inpatient team to respond to children and adolescents with mental disorders: presenting to Emergency Departments (ED); admitted to inpatient care; having co-morbid medical and mental health difficulties; or attending outpatient clinics.

Currently CAMHS South has a four person Hospital Consultation Liaison team based in Royal Hobart Hospital which has considerably enhanced its capacity to meet this need. However, there continues to be unmet need, especially in psychological and family interventions for CAMHS inpatients; the psychological difficulties of medically ill young people; and provision of support to outpatient clinics. Documentation has been developed by this team including: criteria for CAMHS admission; pathways of care for CAMHS hospital patients; and guidelines for management of CAMHS inpatients.

CAMHS North and North West currently respond to ED presentations and inpatient care of under-18 year olds with mental health problems by in-reach services from the CAMHS community team. This in-reach impacts on CAMHS delivery of service to community clients whose appointments may need to be cancelled so that CAMHS clinicians, especially child psychiatrist, can attend to the inpatient crisis. Also, it can be challenging for CAMHS to provide the intensity and range of inpatient care required. There can be a reliance on adult mental health staff who lack specific CAMHS expertise and developmental understanding, to support admissions.

Hospital Consultation Liaison requires specialist expertise different to that required by those working in the community CAMHS, with greater emphasis on crisis assessment and management; acute care of anorexia nervosa, psychosis, somatoform and neuropsychiatric disorders; and therapeutic management in a ward context.

There is currently a significant unmet need for specialist mental health care for young people with medical conditions, especially chronic and severe illness, pain disorders, and physical symptoms without medical explanation. Appropriately staffed CAMHS HCL teams have specialist expertise to respond to this need.

CAMHS Inpatient Facilities

Where young people require inpatient care, this should be provided in a developmentally appropriate setting, separate from adults. Best practice states the facility should provide family-centred care, space and activities to meet play, leisure and educational needs and have appropriately trained clinical staff in the psychological, developmental, communicative and cultural needs of children and adolescents.

There are no dedicated inpatient beds or specialist inpatient facilities in Tasmania for under-18 year olds with mental illness requiring acute hospital care. Further, no private hospital in Tasmania has staff or facilities appropriate for the accommodation and treatment of under-18 year olds.

Currently, options for accommodating these young people differ in each region.

In each region young people requiring acute mental health inpatient care are admitted preferentially to the Paediatric Unit. When a young person is too unwell to be accommodated in the Paediatric Unit they are cared for on the Adult Psychiatric Unit with one-on-one nursing by paediatric or adult psychiatric staff, supported by CAMHS consultation. Where possible these young people are separated from adult patients by being placed in the high dependency unit of the adult ward. Care is provided by a combination of CAMHS specialist clinicians, adult psychiatrists and psychiatric nurses and paediatric nursing staff. National and international guidelines (Hill, 2011; RCPsych 2013) recognise the high level of risk in accommodating young people with mental illness in adult psychiatric facilities. Young people require developmentally appropriate care, in safe and developmentally appropriate environments, with specialist multidisciplinary staff.

Royal Hobart Hospital

In the South a Hospital CAMHS team cares for these patients with the support of paediatric nursing, medical and allied health staff funded from WACS budget. There is considerable bed pressure in the Paediatric Unit. Young people with mental disorders impact on the unit in terms of bed time (prolonged admissions) and demands on staff (one-on-one nursing). There is no capacity to separate infant, child and teenage age groups on the paediatric unit. Staff must cater to a wide age range and variety of disorders from intubated infants to psychotic teenagers often accommodated in adjacent beds.

North/ North West

The North and North West do not have a HCL so the relevant CAMHS community team provides inreach services to these patients. This impacts on the care they can provide to their community clients. In the North at LGH and in the North-west young people are admitted to the paediatric ward and are cared for by paediatric nurses. If one-to-one nursing is required this may be provided by paediatric or psychiatric nurses paid for by MHS. If they are admitted to the adult psychiatric facility they receive one-to-one nursing. Often this care context is inappropriate so young people who would benefit from admission instead remain in the community where intensive “hospital in the home” support is attempted with serious impact on CAMHS community capacity. Further, the lack of on-site CAMHS clinicians limits the range and intensity of therapy that can be provided to these young people.

These arrangements do not meet best practice, as the facilities are not specifically adapted to young people with mental health issues and the paediatric staff do not have the requisite training to meet their needs. Further, due to lack of staff and inappropriate infrastructure, it has not been possible to develop a specialist groups or diversional programmes.

The above model of inpatient care for young people with mental health problems do not meet the requisite TRDF Level 5 service requirements. Inpatient services in each of the three regions are currently provided at a Level 4 or below.

On a population basis 12 CAMHS beds are required across the state. To be viable, a stand alone Adolescent Mental Health facility optimally has 10-12 beds. However, one facility for the state would result in many young people being hospitalised far from home.

A solution to this issue has been proposed in the planned redevelopments of RHH and LGH to develop Adolescent Units adjacent but separate from facilities for younger children. This planned development is supported in the white paper: "One State, One Health System, Better Outcomes - Tasmanian Role Delineation Framework(2014)" in which both adolescent units are designated to deliver Level 5 CAMHS inpatient services.

Adolescent Units would have two safe rooms with ensuite and indoor and outdoor living area that could be utilised flexibly by adolescents 13-17 years old with medical, surgical or psychiatric illness depending on demand. At any one time six CAMHS patients would be anticipated in each of LGH and RHH but demand can fluctuate widely. Admissions to the unit would be on the basis of the young person's developmental needs rather than chronological age. This would provide a more appropriate facility and developmental context for the care of young people with mental illness. Also, joint development of the flexible use unit with Paediatric medicine and surgery is more cost effective and mainstreams mental health care in line with the National Mental Health Plan. To ensure young people in North West Tasmania have access to the adolescent units, transfer criteria and transport protocols will need to be established (see Section

The lack of mental health facilities for young people in Tasmania has repeatedly been highlighted as the most glaring gap in mental health services in Tasmania (followed by the under resourcing of CAMHS community services). In 2011, Kevin Fjeldsoe in his report to MHS Tasmania:" The clear deficit in acute bed capacity is a service for adolescents. It is understood that planning is currently underway for a new unit to be collocated with the paediatric unit at the Royal Hobart Hospital. The development of an 8 bed adolescent mental health unit and associated 12 place day centre would be supported by the service planning data and contemporary modelling of inpatient services for adolescents."

National and international benchmarking support Mr Fjeldsoe. MH-CCP2 (2010) benchmarks (NSW) for CAMHS inpatient provision in Tasmania: 12 CAMHS acute inpatient beds: six in south at RHH; six at LGH for north and north-west populations.

Adolescent Unit Staff

Multidisciplinary staff of 10.4 would be required for each of these units to support mentally ill young people: Child and Adolescent Psychiatrist; Psychiatry Registrar; Psychologist; Social Worker; Occupational Therapist, Teacher and access to Dietician; Physiotherapist; and Speech Pathologist. CAMHS HCL teams would form a component of this staff.

Nursing ratios require 1:1, 1:2, and 1:3 during day shift depending on acuity, with CAMHS CNC during day and evening shift.

Viability of the unit would be supported by employing nursing and allied health staff with knowledge, skills and training to work across medical, surgical and psychiatric populations.

UK data (RCPsych 2013) suggest 10 beds and recommends multidisciplinary team provision as follows: Psychiatrist 1.0; Registrar 1.0; Clinical psychologist 0.5-0,75; SW 1.0; Family Therapist 0.5; OT 0.5; Dietitian 1.0; Physiotherapist 0.5; Speech pathologist 0.5; Teacher 1:4; Pharmacist 0.5.

This document recommends the CAMHS Mental Health Unit "needs a 10-12 bed unit to be financially viable. Alternatives are flexible use facilities combining adolescent medicine, surgery and mental health." Consequently a stand- alone CAMHS inpatient facility would not be viable in Tasmania unless it was to cater for need across the state, in which case young people would need to be cared for inappropriately far from family and community.

Prior to the opening of these new adolescent facilities it is proposed that CAMHS HCL teams be developed in each region to support existing care and to ensure the development of capacity to staff these units when they do open. In the North West this HCL CAMHS team will remain crucial in supporting those young people admitted locally and in ensuring safe transport of those transferred to inpatient units. Online training delivered via UTas is planned but not funded to support CAMHS specialist staff development across disciplines throughout the state.

Perinatal and Infant mental Health

Perinatal and Infant Mental Health Service.

A Perinatal and Infant Mental Health Service has been established at RHH as a hospital consultation liaison service to WACS. There is no PIMH consultation liaison team at LGH or North West Regional Hospital. National Perinatal Depression Initiative (NPDI) federal funding permitted development of PIMH clinical nurse co-ordinators in each region from 2010-2017, with each region receiving equivalent funds. The PIMH team at RHH was developed through reallocation of resources from CAMHS south and a federal Specialist Training Programme position. In the north and north-west PIMH clinical nurse co-ordinators occupy stand-alone positions due to terminate in 2017.

A statewide PIMH service could be developed as a hub and spoke model with further allocation of resources.

The RHH Perinatal Infant Mental Health (PIMH) team was established in August 2013 to provide consultation and liaison to the maternity and paediatric (neonatal) services at the Royal Hobart Hospital (RHH).

The service is provided for pregnant women identified as 'at risk' by their midwife or obstetrician in the antenatal period (i.e.: with elevated EPDS score, past or current history of mental illness, and/or a range of psychosocial stressors) and referred for assessment and treatment by the PIMH psychiatrist/registrar. Women are also referred in the antenatal period by their general practitioner.

Whilst it was originally intended that women would also be seen for follow-up for up to 12 months after their baby was born resources have not been sufficient for this to occur.

Also, due to limited resources most women referred for the first time in the post-natal period (usually by their general practitioner) are not primarily managed by the PIMH team, but rather through advice and support to their general practitioner

The PIMH team consists of: A Perinatal Mental Health Coordinator (PMHC) - 1.0 FTE Registered midwife, currently funded by Australian Government; Consultant Psychiatrist - 0.5 FTE, funded from CAMHS; Psychiatry Registrar - 1.0 FTE funded through the Australian Government, Specialist Training Program (STP); Clinical Psychologist funded by CAMHS South .

The team is supported by the CAMHS –South Community Team.

The PIMH team has links with: Women's and Children's services RHH; Primary Care providers i.e. GPs; Relationships Australia (ATAPS funded clinical psychology providers); Child Health and Parenting Services; Child safety Services; Alcohol and Drug Services through a Psychiatry Registrar Alcohol and Drug Consultation-Liaison position (also STP funded) with some fractional time allocated for perinatal services; and NGOs including Goodbeginnings, Gateway (PYPPS, IFS) , Early Support or Parents. The PIMH at times seek support of Adult Community Mental Health Team especially Crisis Assessment Team to assist with women who require more support after hours.

Antenatal Referrals are provided by antenatal clinics and treating General Practitioners for: a woman who has Edinburgh Perinatal Depression Score (EPDS) greater than or equal to 13; a woman who reports a past history of mental illness; a woman who has current mental health problems; or a woman who is currently prescribed lithium, sodium valproate, carbamazepine or an antipsychotic medication. Adult Mental Health Services for second opinion (plus /minus shared care arrangement).

The PIMH service sees approximately 25 new antenatal referrals per month. Over the past 3 years, the service has seen approximately 12% of women birthing at RHH. The service operates Monday to Friday during normal hospital working hours providing: consultation services for in-patient women on the maternity ward and for women who have a baby receiving care in the Neo-natal Intensive Care Unit (NICU); five (5) half day clinics each week; and up to four (4) hours emergency appointments per week for patients referred who need more urgent assessment. Mother-infant assessment and therapy is provided by CAMHS clinicians, but due to limited resources this is very limited. Short-term post-natal follow up is provided. A significant amount of the PMHC's time is spent liaising with various service providers to develop comprehensive management plans for support of women both in the antenatal and postnatal period. Team members attend Unborn Alert meetings co-ordinated by Child safety and provide feedback regarding patients who are being assessed by CP. The psychiatrist and registrar also provide written reports as requested by CP. The team work with adult mental health teams to co-manage women with pre-existing mental illness who are case managed and have become pregnant. After hours cover for women in maternity ward or who have babies in NICU is provided by the mental health on-call Psychiatry Registrar or Psychiatrist.

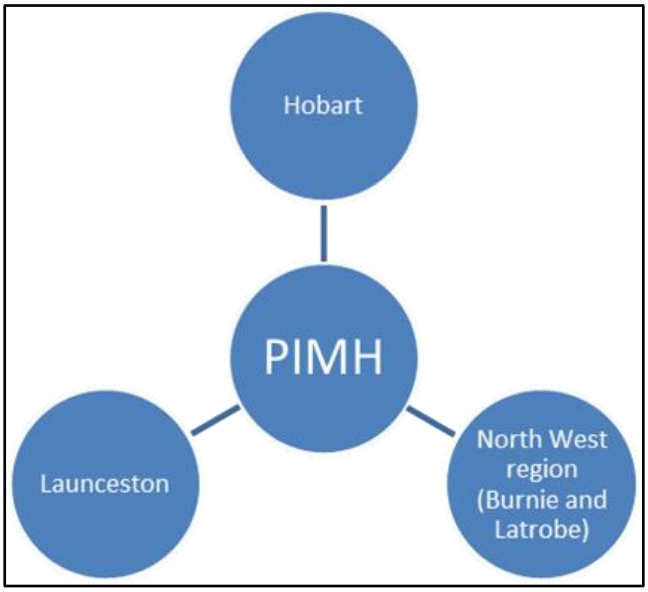
Women with a mental health problem who require inpatient treatment can be admitted to a public 'mother-baby unit' (MBU) bed at St Helens Private Hospital following approval from the Clinical Director of Mental Health. The RHH Re-development includes plans for MBU beds in the new in-patient Psychiatry Unit.

Currently the PIMH team's resources are not sufficient to allow for post-natal interventions for the women beyond the early weeks following a baby's birth. This would require additional Psychiatrist and Psychiatry Registrar FTE hours. The CAMHS-South Community Team provide some mother-

infant therapy in the post-natal period, and the PIMH service new Clinical Psychologist will also provide support.

The PIMH Team has undertaken training for a range of health providers, and also developed and co-ordinated a postgraduate unit in Perinatal and Infant Mental Health offered by the University of Tasmania.

Proposed PIMH 'Hub and Spoke' Model



This could be provided using a 'hub and spoke' model- with the 'hub' responsible for the provision of support and consultation to each of the 'spokes' which would include service development, clinical support and supervision, education and training.

Each 'spoke' would function as a consultation-liaison clinical service (including perinatal co-ordinator, psychiatrist/registrar and infant mental health clinician-FTE varying according to number of birth/year at site) involving women's and children's services at Royal Hobart Hospital, Launceston General Hospital and North West Region(Burnie and, Latrobe).Services should be based within CAMH service to facilitate ongoing input into clinical care for infants and their older siblings (who are often identified as vulnerable when a woman is pregnant), together with strong links to the Adult Mental Health Service. Of note, many referrals are young mothers who have a past history of involvement themselves with CAMHS.

The 'hub' based in the South would include a specialist perinatal psychiatrist, infant psychiatrist and perinatal and infant mental health co-ordinator, with sufficient FTE to ensure both service delivery in the South as well as support for the N and NW,. In addition, the 'hub' would be responsible for co-ordination of activities which have state-wide relevance e.g. team supervision, education etc .

The state-wide PIMH service would develop strong links with maternity, paediatrics, primary care, child and youth services and adult mental health services to provide effective early intervention during pregnancy and early in a child's life, especially for vulnerable families, which will reduce both

short and long-term morbidity and mortality and short and long term costs to the health system and to wider society.

To develop PIMH Service 'spokes' in each region, clinical hours for a Perinatal Psychiatristwould be required to support and provide clinical direction for the regional Perinatal Mental Health Co-ordinators. Clinical hours would also be required for a perinatal psychiatry registrar and for specialist mother-infant work.

Clinical support could be provided via outreach from Hobart and via telemedicine capabilities. This would require expansion of the existing Psychiatrist and Registrar FTE in the South.

The PIMH-South has identified a number of gaps which need to be addressed in the current South service, and which would need to be considered for the State-wide service. These include:
[1] capacity for longer-term post-natal follow-up (to baby aged 12 months)
[2] capacity for greater primary consultations in post-natal period for women not seen antenatally
[3] capacity to provide assessment of fathers when required- and facilitation of follow-up when needed by other appropriate services
[4]Capacity for provision of psychological therapy focusing on mother-infant interaction a for women with severe mental illness
[5] capacity for provision of psychological therapy (e.g. dialectic behaviour therapy) for women with severe personality disorders
[6] capacity for undertaking formal parenting assessments for Child safety

MBU beds will be needed at North and North West (Burnie and Latrobe) spokes as well as in the RHH, along with access to both Alcohol and Drug Services (ADS) and a Social Worker who is linked with maternity services.

It has not yet been determined if services for perinatal loss should be part of PIMH or if best dealt with by Grief Counsellors. In other sites, it is usual for Grief Counselling to be the first step and then if loss is complicated or grief is very severe then refer to PIMH services.

Mother and Baby Units

There are no dedicated public mother-baby inpatient beds in Tasmania. Limited access to in-patient care for women with severe mental health problems and her infant in the post-natal period is provided through a private hospital in Hobart. Extended perinatal stay in maternity beds for mother with mild to moderate mental disorders can be suitable, supported by the perinatal and infant mental health team. Pregnant women who require inpatient care are admitted to acute adult inpatient units which do not have any special facilities for their support.

Psychiatric mother–baby units (MBU) admit women with severe mental health problems or disorders. They require two different types of expertise: the first in treating women with psychiatric disorders; and the second in child care and development. Caregivers in these clinical settings face especially complex situations. The units should also facilitate interaction between parents and infant and enable the father to participate in the child's care and interact with him.

Whilst an inpatient mother-baby unit would ideally be developed on a statewide basis it is likely to be unacceptable in most instances due to the isolation of mother and baby from their families and communities consequent upon a single state wide location.

(2) FACTORS IMPACTING ON THE CAPACITY OF EACH HOSPITAL TO MEET THE CURRENT AND PROJECTED DEMAND IN THE PROVISION OF ACUTE HEALTH SERVICES

Tasmanian demographics, with highest levels of poverty, social exclusion[10], transgenerational trauma and disadvantage of all Australian states outside of indigenous populations, is correlated with higher rates of mental illness across the lifespan[11].
Tasmanian activity data and national trends reflect that the numbers of young people presenting to acute health services with severe and complex mental health problems is increasing year by year. Data indicates that current demand on acute health services by mentally ill young people is high; and fewer are admitted than national averages indicating that staffing and facility issues are impacting on the delivery of appropriate care.
Similarly, where a PIMHS has been established at RHH, a very high proportion of antenatal presentations (13%) are being identified as at high risk of mental health problems and referred to the PIMHS. This is unsurprising given Tasmania's demographic profile. Tasmanian rates of teenage pregnancy are higher than the national average[12]; as are rates of child protection notification, particularly antenatally and in the first year of life[13].

The most significant factors impacting on the capacity of each hospital to meet demand for acute mental health services for young people is the lack of a hospital-based CAMHS team at LGH and NWRH; and the lack of Perinatal and Infant Mental Health teams at LGH and NWRH. These service gaps and the impact on service delivery have been described above. As part of the "One State, One Health System, Better Outcomes state government health service review, CAMHS Clinical Advisory Group statewide developed a business case for development of these services. The business case was submitted in February 2017 but not feedback has been received to date[14].

Other factors include:

- The structure and governance of CAMHS across the state, especially the need for integrated statewide services

There is a need for structural and resourcing arrangements that facilitate collaboration and joint service delivery between CAMHS and other services in the infant, child, adolescent and family sector. The support of a tertiary CAMHS service to primary and secondary services in the sector could increasingly provide care in the community, reduce need for emergency department

[10] National Centre for Social and Economic Modelling (2013); Tasmanian Government DHHS(2013) Kids Come First Update
[11] ibid
[12] Australian Institute of Health and Welfare (2014) – Fertility statistics
[13] Tasmanian Government Department of Health and Human Services (2013) Kids Come First Update
[14] CAMHS CAG Business Case 2017

presentation and hospitalisation, save health dollars and improve health outcomes. It could also reduce costs in education, welfare and justice systems.
CAMHS model of care is different to that of adult mental health services. Structurally CAMHS needs to be a separate service stream within mental health services (or within Child and Adolescent Health Services[15]) with its own strategic planning, organisational and clinical governance arrangements[16]. Alignment of CAMHS with Women's, Child and Adolescent Health was proposed in the recent "One State, One Health System, Better Outcomes". The rationale was that CAMHS was best located within WACS clinical stream as it has overlap of patient group, facility utilisation, service delivery and clinical governance with WACS. CAMHS also has important relationships with MHS but these involve patient transition rather than shared care and shared clinical responsibility. CAMHS and WACS share patient groups, facilities, model of care, legislative framework, stakeholders; and co-operate to deliver services including eating disorders, inpatient care and outpatient clinics. However, a decision was made to maintain CAMHS within the Mental Health Services clinical stream. It is proposed that in the Mental Health Services stream, CAMHS operates statewide with a 0.2 CAMHS Specialty Director but this is not implemented to date.

CAMHS needs a strong relationship between regional services across the state to become truly statewide; and this is necessary to develop the critical mass to develop and deliver sustainable and subspecialty services in an equitable manner to all young Tasmanians wherever they live. Historically CAMHS in Tasmania has existed as three small regional community teams in the south, north and north-west of the state. These CAMHS teams sat within a generic regional mental health organisational and clinical governance structure with Adult Mental Health Services (MHS) and Older Person's MHS. There has been no CAMHS Clinical Director role or organisational manager to oversee governance, operational control and resource allocation of CAMHS. The small critical mass of CAMHS statewide and of each regional team has prevented the development of necessary specialist services and posed serious difficulties in developing and sustaining a specialist CAMHS workforce. State wide integration, governance, operation and resource allocation will allow capacity to support specialist services and staff through hub and spoke models, rotating clinics and shared training and supervision including use of telemedicine capacity.

- Workforce development and sustainability

The challenge for CAMHS is to deliver timely and accessible services, as locally as possible, of sufficient intensity and duration to address the complex difficulties experienced by young people with mental disorders.
The principal asset of CAMHS is a multidisciplinary workforce of clinicians with specialist training and expertise in child and adolescent mental health. The majority of this workforce is deployed in the

[15] Government of Western Australia Department of Health (2012) *Child and Adolescent Health Report;* UK Department of Health (2006) *The Joint Planning and Commissioning Framework for Children, Young People and Maternity Services*.
[16] UK Department of Health (2006) *The Joint Planning and Commissioning Framework for Children, Young People and Maternity Services*; Victorian Government Department of Health (1996) *Victoria's Mental Health Framework: The Framework for Service Delivery: Child and Adolescent Services*; The National Assembly for Wales (2001) *Child and Adolescent Mental Health Services: Everybody's Business Strategy Document*.

community, supporting young people and families to promote recovery from mental illness and optimal development in the context of their lives.
Effective treatment requires specialist therapeutic expertise, delivered to child and family, or alternate care givers, over a number of months, and bringing together multiple service systems seamlessly and coherently.

-There is a need to recruit and support child psychiatrists and child psychiatry registrars across the state especially in the north and north- west. Child and Adolescent Psychiatrists are a scarce commodity worldwide. Child Psychiatry roles in Tasmania are challenging as there is a very small cohort of Child Psychiatrists in the state, with only 2.6 in the south; 1.0 in the north with uncertainty about the future of this; and 1.0 in the north west. While there are good relationships between child psychiatrists across the state, the relative isolation of the work situation requires competent experienced staff to fill roles. Furthermore, in Tasmania, child psychiatrists must deal with a wide range of severity and complexity, as there is no opportunity to refer to major centres as exists in other regional areas and major cities. The functioning of the entire CAMHS team is reliant on clinical governance provided by Child and Adolescent Psychiatrists, and it is not possible to safely provide CAMHS care without this team member. Furthermore, training of future child and adolescent psychiatrists is reliant upon employment of appropriately qualified Child and Adolescent Psychiatrist to provide supervision to Psychiatry trainees. This has become a critical issue in registrar placements in the north and north west of the state, impacting not only on service delivery but also on future workforce development. **Thus there are key dependency issues related to Child and Adolescent Psychiatrists within CAMHS.**

-There is a need for CAMHS teams state wide to have CAMHS staff resourcing to develop and sustain multidisciplinary teams in both hospital and community contexts. Issues pertaining to CAMHS hospital teams and staffing for adolescent units have been identified above. CAMHS community teams have been identified as under resourced, compared to national CAMHS data where CAMHS Tasmania was the most poorly resourced of any state.[17] Also, three external reviews identified inequity in the distribution of the mental health budget in Tasmania with per capita spending on Adult MHS being over four times that for CAMHS whereas in other states the per capita spending for CAMHS is around half that for Adult MHS[18]. Fjeldsoe (2010) stated: " Of significance is the relatively poor investment in services for children and young people. A case for additional resources particularly in the south (17 positions) is demonstrated." Increased funding for CAMHS South in 2015 has resulted in significant reduction in wait times for access to Community CAMHS and enhanced PIMH capacity however, shortfalls remain. Despite these challenges, CAMHS has developed integrated hospital/community services that significantly reduced rates of hospital admission and length of stay for patients groups including eating disorders and high risk teenagers.

- Facility Issues

-The planned development of Adolescent Units including appropriate facilities for the care of mentally ill young people at RHH and LGH is welcomed. In the interim, significant challenges persist in caring for this group of patients that places significant stress on Emergency Departments and Paediatric and Adult Psychiatric Units, particularly with frequent bed block in both these wards at RHH. Some young people have spent entire admission within the Emergency Department at RHH. All

[17] National Mental Health report 2013
[18] ibid

young people I have cared for, needing containment in Adult Psychiatric facilities, report this as a traumatic experience. This is despite the very best and sincere efforts of all clinicians involved to provide optimal care. The facility is not designed to meet developmental needs, and exposes young people to severely mentally ill adults. Also, young people accommodated at RHH cannot currently be kept separated from adult patients. Three recent admissions all reported experiences resulting in fears of assault and distress.

-There is currently no plan in the redevelopment of RHH or LGH to develop youth-specific areas within Adult Psychiatric wards. This is not consistent with best practice and Australian Hospital standards. Benchmarks suggest a need for four beds at RHH and four beds at LGH. Furthermore, even with the development of Adolescent Units, some under 18 year olds with severe mental health problems and need for a high level of containment are likely to require accommodation on adult facilities.

-There is currently in the redevelopment of RHH or LGH a plan to include the provision of Mother and Baby Unit beds associated with Adult Psychiatric units. There is a need for two MBU beds at RHH and at LGH.

- Existing strengths are the commitment and competence of current CAMHS teams statewide; and the good collaboration and working relationships of CAMHS with other health, child safety, education and CSO services in the child and family sector.

(3) THE ADEQUACY AND EFFICACY OF CURRENT STATE AND COMMONWEALTH FUNDING ARRANGEMENTS

In the perinatal, infant, child and adolescent sector, acute health services including CAMHS, PIMHS, maternity, neonatal, paediatric and child health and parenting services are state funded; as is Child Safety Services. These services care for young people with the most severe and complex mental and physical illnesses and risk issues. Federal funding is directed to primary and secondary service level interventions most often delivered by non-government organisations (NGOs). Some NGOs, such as headspace youth health service, and Relationships Australia deliver secondary level clinical interventions. Most NGOs, including Gateway family support services; i-Connect; National Disability Support Service (NDIS), Good Beginnings and New Pin working with families with young children, are social support services.

CAMHS and PIMHS in general work in a collaborative fashion with both state and federally funded services. However, there are inadequacies and inefficiencies in the current state and commonwealth funding arrangements that impact on delivery of care, some of which are specific to the Tasmanian context. These difficulties include:

- Short term commonwealth contracts for NGOs. Most often commonwealth funding is for three year projects. Start-up delays are common, often related to difficulties in staff recruitment. CAMHS and PIMHS frequently have the experience of forming working relationships with NGOs delivering a particular service, only to have that service lose funding just at the point young people are beginning to access the service. This is clearly a failure of service delivery to vulnerable families and young people; and frustrating and inefficient use of time for CAMHS staff who have expended considerable effort in building relationships and accessing appropriate supports for clients.

- Failure of NGOs to work with state services in developing their service pathways and models of care. Also such collaboration is not specified in commonwealth contracts with NGOs.

  - For NGOs to efficiently and effectively deliver the support the Commonwealth is funding, collaboration with state health and other services is crucial. This is particularly the case in Tasmania, which is resource poor; and has a small, socially disadvantaged, dispersed population. In a large metropolitan centre such as Sydney or Melbourne, a "silo" service may meet the needs of a specific group. In Tasmania, all services involved in a young person's care must plan and deliver together the care of young people and families in order to ensure optimal outcomes.

  - In the perinatal, infant, child and adolescent sector, specific models of care are needed that recognise the developmental, capacity and family dynamic issues intrinsic to this field of care. Young people under 18 years of age are generally deemed to lack capacity to make decisions regarding their own care. Also, mental illness or disability may impact on a young person's capacity to define their own support goals. It is not an uncommon experience that NGOs state they cannot work with a young person as that individual has not been able to articulate their own specific goals. Thus inclusion of parents and other involved adults in care planning with young people is crucial.

  -Furthermore, where a parent is struggling with their own mental health or other difficulty, this may impact on their capacity to safely parent their child. Models of care must recognise in this context a need to separately evaluate and respond to the needs and best interests of the child and of the parent as separate issues. NGO workers without specific knowledge, training and experience in this sector may struggle with these multiple roles. For example, it is not an uncommon experience that NGOs will see parenting support as support for the parent; rather than recognising the need to support the parents capacity to care for their child, which may include feedback and support around ways the parenting approach may need to change.

- Lack of work force with specialist expertise in perinatal, infant, child and adolescent care in Tasmania. Working with infants, children adolescents and families is a specific field of expertise requiring specific developmental understandings; and skill sets in working with complex systems. CAMHS and PIMHS have difficulty recruiting appropriately trained staff to their services and frequently have to train those they recruit as there are very limited opportunities for such experience in Tasmania. This differs from large metropolitan regions where an existing highly skilled workforce is available to be recruited to NGO sector. Consequently NGOs frequently employ staff without the knowledge base, training or experience to deliver the care required. This is a difficulty with the commonwealth always directing funding to non-government sectors rather than permitting state services to bid for funds. This is particularly a disadvantage to service delivery to young people and families in Tasmania.

- The intensity of intervention provided by NGOs is not sufficient to the need of the young person or family. This relates to the amount of funding allocated to deliver a particular service being in adequate for the level of need. An example of this is funding of Gateway services which were required to offer family support to highly vulnerable young people and families. However, the funding model did not permit the level of expertise of staff or the intensity of intervention to meet the needs of this group.

(4) THE LEVEL OF ENGAGEMENT WITH THE PRIVATE SECTOR IN THE DELIVERY OF ACUTE HEALTH SERVICES

There is a very limited capacity in CAMHS and PIMHS to work with the private sector as no private hospital admits young people with mental illness below the age of 18 in Tasmania; and there is an extremely limited number of private practitioners with the specialist qualifications and required to provide care to this group of patients.

PIMHS does collaborate with the Mother and Baby Unit at St Helen's Hospital in Hobart, where there is one publicly funded bed for maternal mental illness requiring admission. However, this unit cannot cater for the most severely unwell new mother's as it cannot accommodate those with Borderline Personality Disorder, nor those requiring involuntary care for major mental illness such as schizophrenia, bipolar disorder or severe depression. PIMHS also attempts to collaborate with private psychiatrists and psychologists who might offer outpatient support to vulnerable pregnant women or new mothers. However, timely access to care is crucial and often private practitioners have waiting lists; also the majority of PIMH clients cannot afford to pay for care.

CAMHS does collaborate with private child psychiatrists, private psychologists, private paediatricians and general practitioners delivering care to young people with mental illness. However, there is extremely limited access to private child and adolescent psychiatry anywhere in the state. Where a young person receiving care for a private practitioner presents to hospital for acute care, CAMHS conducts their own assessment and liaises with private practitioners, either referring back to private care with diagnostic and management advice, or taking over care if necessary. A large number of young people presenting at Emergency Departments in distress are referred by general practitioners and private psychologists. In some instances it is evident these private practitioners lack risk assessment and safety planning knowledge and skills. Further training of this private workforce in this area of care may alleviate pressure on Emergency Departments.

(5) THE IMPACT, EXTENT OF AND FACTORS CONTRIBUTING TO ADVERSE PATIENT OUTCOMES IN THE DELIVERY OF ACUTE HEALTH SERVICES

- Significant adverse outcomes for infants and young people related to acute health service provision have been identified in two separate coroner inquests.

The inquest into the suicides of six teenagers in the south of the state in 2015 identified "a serious gap in Tasmanian mental health services for adolescents"; and the need for early intervention services to assist traumatised children. The coroner recommended "a comprehensive early intervention service for children aged up to three years, to identify children at high risk of suffering mental health issues in the future, " noting the recognised trajectory from early childhood neglect and abuse, to childhood emotional and conduct problems, to teenage mental illness and suicidality. **In 2017 the inquest into the death of an infant from the north west of the state due to paternal abuse noted that no intervention to ensure the safety of the child had occurred despite multiple**

notifications to child safety services of risk, including one even before the child was born. The coroner noted of Child Safety Services: "entrenched systemic and cultural deficiencies in the context of inadequate resourcing. The evidence strongly indicates …inexperience and turnover of workers, inadequate staff numbers and lack of training were constant issues preventing effective responses to the notifications." There is no Perinatal and Infant Mental Health Service in the north or north-west of the state. At RHH, where a PIMH operates, this service plays an essential role in identification of infants at risk; in antenatally and postnatally developing plans in collaboration with other services including Child Safety Services, to intervene therapeutically and to mitigate this risk; and in educating and supporting other services involved with the vulnerable infant and family.

- More generally adverse outcomes relate to morbidity rather than mortality with inadequate treatment or delayed treatment related to insufficient CAMHS staff resources and/or inappropriate or inadequate inpatient facilities.

- Factors contributing to these adverse patient outcomes include:

1) **Lack of hospital CAMHS teams at LGH and in CAMHS north- west**.

Impacts on ability of CAMHS at LGH, NWRH, MCH to respond to acute presentation in the Emergency Department; adequately provide intensity of care required for young people admitted as inpatients; and delays in access of community patients to CAMHS care due to appointments being cancelled to meet crisis demands.

This need could be met by the establishment of CAMHS hospital teams at LGH and with CAMHS NW. Identified need is described in the CAMHS CAG Business Case:

CAMHS HOSPITAL CONSULTATION LIAISON TEAMS

In light of the long term plans and actions to develop adolescent medical, surgical and mental health units at both RHH and LGH identified in Re-think Mental Health, hospital redevelopment plans at RHH and LGH, and in the Tasmanian Role Definition Framework, the CAG recommends that establishment of a CAMHSHCL Teams over the next 3-4 years to continue to meet current and increasing service demands. This team would be experienced and trained in CAMHS prior to the opening of the adolescent unit. Further capacity would be needed leading up to planned opening of LGH Adolescent Unit in 2020. CAMHS HCL teams would then form a component of Adolescent Unit staffing.

LAUNCESTON GENERAL HOSPITAL

Costs	Salary Costs	Totals
Clinical Nurse Consultant Grade 6 1 FTE (2017-1)		
CAMHS Medical Registrar 1 FTE (2017-18)		
Allied Health Professional Level 3 1 FTE (2017-18)		
Psychiatrist 0.5 FTE (2017-18)		
Registered Nurse Grade 3 – 4 1 FTE (2018-19)		
Allied Health Professional Level 1-2 1 FTE (2018-19)		
Total		**$**

NORTH WEST REGIONAL HOSPITAL

While future plans are for the transport of <18yo with mental illness requiring prolonged inpatient care from the north west region to LGH there is an existing requirement in the north west for HCL CAMHS team to meet current demand for ED and inpatient assessment and management. The need for this resource will be ongoing as only some <18yos requiring inpatient care will be transferred to LGH. Those being transferred will require specialist care during transfer. Those who are admitted locally will continue to need HCL care.

Costs	Salary Costs	Totals
Clinical Nurse Consultant, Grade 6 for acute emergency, inpatient care, education and consultancy services (2017-18)		
Registered Medical Officer for mental health inpatient and out-patient care. This role would be supported by the acute and community based care (2017-18)		
Allied Health Professional – Level 3-4 (2017-18)		
Total		**$**

ROYAL HOBART HOSPITAL

While first priority is to establish inpatient team in the North, and HCL team in North West, there is a need for expansion of RHH Inpatient team to ensure equity as CAMHS South has catchment population comparable to North and NW CAMHS together.

Costs	Salary Costs	Totals
Allied Health Professional Level 3 1 FTE (2017-18)		
Registered Nurse Level 3-4 1 FTE (2017-18)		
Total		**$**

2) **Lack of appropriate facilities and trained staff for inpatient care, especially where a young person must be accommodated on an adult psychiatric ward.**

There is currently no budget for staffing Adolescent Units planned in the redevelopment of RHH and LGH. Both have developed business cases for multidisciplinary staffing of these facilities:

RHH

RECURRENT COST ANALYSIS FOR ADOLESCENT UNIT (MEDICAL, SURGICAL AND MENTAL HEALTH STAFFING)

Adolescent Unit - 16 beds recurrent costs				
NURSING NHPPD 11.90	**Classification**	**FTE**	**Recurrent**	
Registered Nurse	G3-4n	9.37	1,186,175	
Registered Nurse	G3-4h	9.99	1,355,335	
Registered Nurse	G3-4e	9.99	1,029,448	
Enrolled Nurse	G2 Y4	5.89	563,312	
Clinical Nurse Consultant	G6 Y4	1.23	117,636	
				4,031,927
SENIOR MEDICAL	**Classification**	**FTE**	**Recurrent**	
General Paediatric Staff Specialist	SMP1-11	1.00	429,839	
Child & Adolescent Psych Staff Specialist	SMP1-11	1.00	429,839	
Paediatric Registrar	MP5-11	1.00	237,168	
Psychiatric Registrar	MP5-11	1.00	237,168	
				1,332,556
ALLIED HEALTH	**Classification**	**FTE**	**Recurrent**	
Physiotherapy	AHP 3 Y5	1.00	126,598	
Occupational Therapy	AHP 3 Y5	1.00	126,598	
Social Work	AHP 3 Y5	1.00	126,598	
Dietician	AHP 3 Y5	1.00	126,598	
Psychology	AHP 3 Y5	1.60	202,566	
Speech Pathologist	AHP 3 Y5	0.20	25,320	
Pharmacy	AHP 3 Y5	0.50	63,299	
				797,564
Support Services			**Recurrent**	
Hospital Aide	HS03-3	1.00	89,810	
Therapy Assistant	HS05-4	1.00	100,462	
Ward Clerk Day	HS03 3	1.00	64,810	
Ward Clerk After Hours	HS03-3	1.16	88,419	
Sitters /AIN / Security Guards	HS04-3	1.00	93,419	
Medical Consumables / Pharmacy			440,000	
Overheads including Telephony & PC's			215,000	
				1,091,919
Total Salaries (excluding Support Services)				**6,162,047**
Total Support Services				**1,091,919**
Total Cost				**7,253,966**

LGH

CAMHS STAFFING ONLY

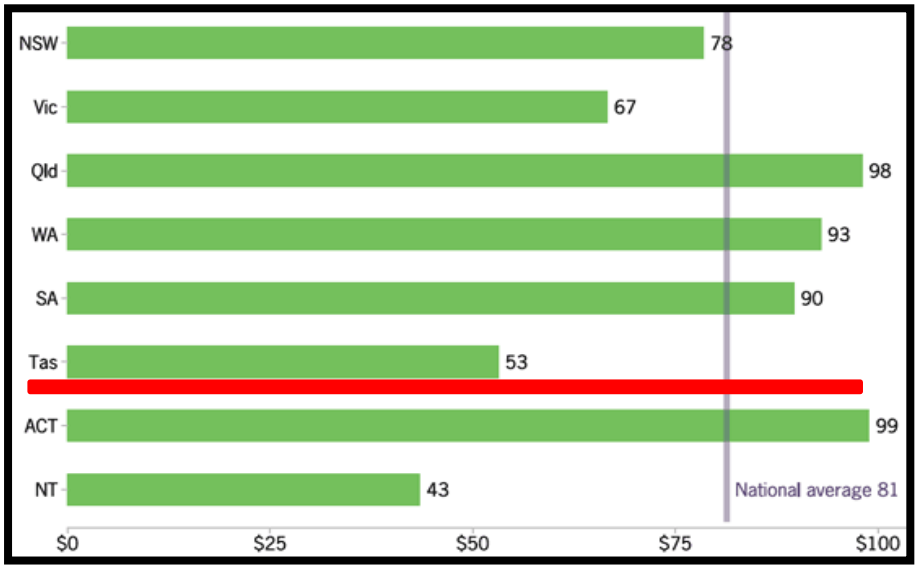
To meet above requirements following human resources will be required to operate a the child and adolescent mental health inpatient unit independent of the general ward:

- 11.8 FTE Registered Mental Health Nurses. This is sufficient to run 2 staff per shift (morning, evening, night) as well as provide 0.23 FTE for leave and training per FTE worked as per Nursing Hour Per Patient Day model. 1.00 FTE will be a Grade 6 and remaining 10.8 Grade 3-4.
- 1 x FTE Registrar
- 0.5 FTE Staff Specialist
- 1 x FTE Social Worker (HP03)
- 0.5 x FTE Occupational Therapist (HP03)
- 0.5 FTE Psychologist (HP03)
- 1 x FTE Ward clerk (BAND 2)
- Speech pathology and dietetic services to be provided by existing resources

3) Lack of community team resources to offer frequency and intensity of support, and earlier intervention to prevent presentation to acute health services.

CAMHS Community teams are currently staffed at 50-60% of national benchmarks and considerably under resourced compared to CAMHS in other Australian states. Addressing CAMHS community resources could prevent presentations of young people to acute health services; improve access to care; decrease morbidity in this population and improve long term mental health outcomes for the Tasmanian population.

Per capita expenditure by states and territories on child and adolescent mental health services ($), 2010-11: National Mental Health Report 2013



4) Lack of Perinatal and Infant Mental Health Services at LGH and NWRH; and lack of sufficient resources in PIMH south and state wide to deliver effective early identification and intervention to prevent immediate infant risk; and trajectory to lifelong mental illness.

CAMHS CAG Business Case identified resources needed to address this deficit:

PERINATAL AND INFANT MENTAL HEALTH TEAMS

Hub and spoke model

ROYAL HOBART HOSPITAL

Costs	Salary Costs	Totals
Perinatal Psychiatrist 1.0 (0.5 additional clinical for RHH; 0.5 statewide clinical leadership and support)		
Psychiatry Registrar 1.0		
Psychologist 1.0		
CNC 0.2 UTas PIMH coordination		
Total		

LAUNCESTON GENERAL HOSPITAL

Costs	Salary Costs	Totals
Perinatal Psychiatrist 0.5		
Psychiatry Registrar 1.0		
Clinical Nurse Co ordinator 1.0		
Psychologist 1.0		
Total		

NORTH-WEST REGIONAL HOSPITAL

Costs	Salary Costs	Totals
Perinatal Psychiatrist 0.5		
Psychiatry Registrar 1.0		
Clinical Nurse Co ordinator 1.0		
Psychologist 1.0		
Total		

Dr Fiona Wagg, August 2017