COMPASS: COnnecting Mental-health Paediatric Specialists and community Services

Project report November 2021

Contents

Lead Organisation

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Project Team

Name	Role	Organisation
Prof Harriet Hiscock	Director, Specialist Paediatrician Group Leader Professorial Fellow	Health Services Research Unit, RCH Health Services, Murdoch Children's Research Institute Department of Paediatrics, University of Melbourne
Ms Sonia Khano	Evaluation Research Officer	Health Services, Murdoch Children's Research Institute
Mr Jagjit Dhaliwal	Executive Director	Service Development and Reform, North Western Melbourne Primary Health Network
Dr. Ric Haslam	Director	Mental Health, RCH
Dr Xingyang Hua	Health economist	Health Services Research Unit, RCH Health Economics Unit, University of Melbourne

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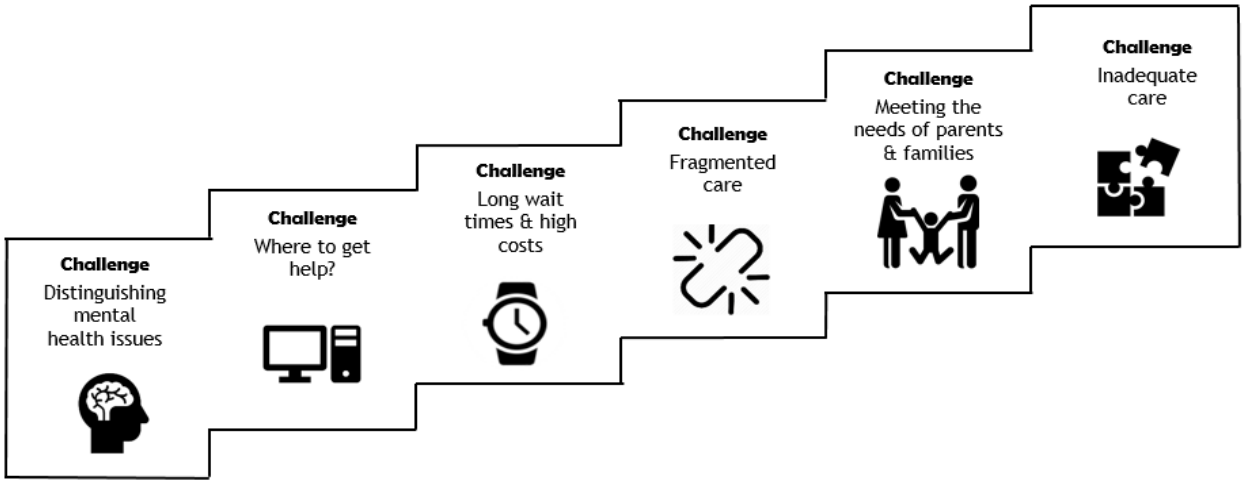
Executive Summary

The problem

Pre-2021, rates of mental health (MH) presentations by children and young people (0-18 years) to Victorian Emergency Departments (EDs) were accelerating, with increases 3-times higher than those of physical health presentations.[1] During the COVID-19 pandemic and associated restrictions, paediatric MH presentations to ED further increased, with a 35% increase in April to May 2020, compared with ED presentations for other conditions which largely declined.[2] Prior to the COVID-19 pandemic, the Health Services group at Murdoch Children's Research Institute interviewed 140 clinicians (general practitioners, paediatricians, psychologists, child & adolescent psychiatrists) and 28 families about the child MH system. We asked about challenges in the system and potential solutions. Multiple challenges emerged, as per below.



General practitioners (GPs), psychologists and paediatricians consistently voiced the need for improved access to child psychiatry expertise that would allow them to 'hold' patients for longer, thus reducing referrals to overburdened EDs and public child and adolescent MH services. Several international programs provide exemplars of how to do this, ranging from telementoring programs (e.g. Project ECHO[3]), and teleconsultations and shared care programs (e.g. Massachusetts Child Psychiatry Access Program[4]).

Potential solutions

In partnership with the North Western Melbourne Primary Health Network (NWMPHN) and The Royal Children's Hospital (RCH) Mental Health team, the Health Services Research Unit (HSRU) piloted an integrated care approach within the NWMPHN catchment to strengthen paediatric MH care and potentially reduce burden on specialist services and hospitals.

The COnnecting Mental-health PAediatric Specialists and community Services (COMPASS) approach comprises 4 components:

1. **An online community of practice (CoP):** 10 x one-hour sessions delivered over 5 months (March-July 2021) to community clinicians (GPs, psychologists, paediatricians, social workers, MH nurses and MH occupational therapists (OTs)). CoP sessions covered 5 topics: 1) Anxiety; 2) Aggression and challenging behaviours; 3) Depression, Self-harm, and Suicidality; 4) Eating disorders; and 5) Autism Spectrum Disorder/complex cases. Each session included educational information led by the child psychiatrist followed by case discussions and evidence-based resources shared between CoP members.
2. **Child psychiatry secondary consultation and liaison service**: A RCH child psychiatrist was made available by phone, email or in-clinic appointments to provide community clinicians (GPs and paediatricians) with medication advice, diagnostic, assessment, management, or referral options for their referred patients.
3. **Senior MH Clinician support to community-based Hub MH clinicians (HeadtoHelp)** A senior MH clinician from RCH was employed to help support community-based MH hub clinicians (HeadtoHelp – H2H). This support included primary and secondary consultations, facilitation of regular reflective practice, and education sessions and training in evidenced based practice and screening tools.
4. Referral pathway and information sharing between RCH Triage and H2H intake.

Objectives

1. improve the capacity of clinicians working in community settings to identify and manage child and adolescent MH presentations
2. reduce burden on EDs and specialist services

Key Findings

Below we summarise how we evaluated the first 3 components of COMPASS and key findings. Evaluation of the referral pathway and information sharing between RCH Triage and H2H intake is outside the scope of this report.

CoP: We used pre-post online surveys of clinician knowledge and confidence of paediatric MH and in-depth interviews to capture clinician experience of the CoP model.

- At 5 months post online CoP, clinicians reported that participation increased their professional knowledge and confidence in the assessment and management of child and adolescent MH difficulties. For example, from pre to post CoP sessions, clinicians reported a 20% increase in knowing how to refer children for MH services (70% to 90%), and a 40% increase in their confidence in managing children who present with self-harm (35% to 75%). Almost all clinicians (92%) would recommend this online CoP model to other clinicians
- Qualitative semi-structured interviews revealed a positive impact on multiple domains of clinical practice across all clinician groups. The CoP enabled professional connection, peer support, and lessened feelings of isolation. Clinician confidence improved with validation of clinical practice, reduced stigma and increase in knowledge and skills

Child psychiatry secondary consultation and liaison service: We analysed consultation logs completed by the child psychiatrist.

- RCH child psychiatry secondary consultation service averaged 22 consultations over a 2-week period from paediatricians and GPs. Consultations included primary and secondary consultations for medication advice and diagnostic reviews. All consultations (100%) resulted in the patient being referred back to the clinician, therefore avoiding referrals to RCH Child and Adolescent Mental Health Service (CAMHS).

Senior MH clinician support to community-based Hub MH clinicians (HeadtoHelp): We used pre-post online surveys of HeadtoHelp Hub clinician's knowledge and confidence of paediatric MH and a focus group to capture clinician experience of the support.

- RCH senior MH clinician support improved clinician awareness of services (100%), confidence in treating children and adolescents (91%), care provided (83%), knowledge of the needs of children and adolescents (100%) and knowledge of child and adolescent specific treatment approaches (75%).
- Further training in child and adolescent MH would be beneficial to HeadtoHelp Hub clinicians.

We also analysed changes in MH presentations to EDs for children 0-17 years across the NWMPHN hospitals campuses from 2019 to July 2021. We found no change in ED MH presentations for NWMPHN catchment hospitals vs other metropolitan hospitals. However, the

bulk of the state's MH presentations for children aged 0-17 years were to EDs in NWMPHN hospital campuses, highlighting the need to support community clinicians to help alleviate hospital demand.

We also analysed referrals to the RCH CAMHS between 2019-2021 and compared them with de-identified referral data for two other Victorian metropolitan CYMHSs (in 2021) for children aged 0-17 years. Referrals to RCH CAMHS declined in June/July 2021 in contrast to referrals to the other CYMHS which increased over this time.

COMPASS components and their evaluation

The following COMPASS components were piloted across the NWMPHN catchment.

1. Online Community of Practice (CoP) supported by a child psychiatrist

"A community of practice is a group of people who share a concern or a passion for something they do, and learn how to do it better as they interact regularly" (Etienne Wenger)

The online CoP model was led by two experienced child psychiatrists with the aim of supporting and upskilling community clinicians in their knowledge and confidence in child MH. Community clinicians seeing children and adolescents in the NWMPHN region and HeadtoHelp hubs were invited to take part.

We started by co-designing the CoP model in February 2021 with 39 community clinicians. The final model comprised one-hour evening (6.30-7.30pm) sessions held fortnightly via Zoom for 5 months from March to July 2021. 59 of the 75 (78.7%) clinicians who registered to take part in the CoP attended at least one session and 60% attended more than 5 of 10 sessions. Clinicians who did not attend any sessions reported the afterhours session time as a barrier.

A total of 10 sessions were implemented across five conditions: 1) anxiety; 2) aggressive and challenging behaviours; 3) depression, suicidal ideation and self-harm; 4) eating disorders; and 5) complex MH disorders such as autism spectrum disorder. Clinicians were encouraged to submit a case study for each session to thoroughly discuss the assessment, referral, and management of the case with the multidisciplinary group. Each session also included didactic information about the MH condition led by the child psychiatrist and shared resources recommended by participating clinicians including screening and assessment tools and evidence-based treatment resources.

Clinicians (84% female) included 19 GPs, 19 psychologists, 11 paediatricians, 4 MH nurses, 4 social workers, and 2 MH occupational therapists. Sixty percent had been practicing in their role for 6 years or more while seeing more than 11 paediatric patients per week. However, 85% of clinicians had no formal training in paediatric MH (excluding psychologists).

The evaluation

CoP clinicians were asked to complete an online survey before the CoP sessions commenced (pre) and after the last session (post). See Appendix 1 for the CoP Clinician Survey. Clinicians were asked to rate their responses to survey items on a 4-point scale, comprising *"not at all confident"*, *"not very confident"*, *"fairly confident"*, and *"completely confident".* We then grouped the responses into two categories: *"not confident"* (comprising *"not at all confident"* and *"not very confident"* responses) vs *"confident"* (comprising *"fairly confident"* and *"completely confident"* responses).

The following results present changes in clinician knowledge and confidence in paediatric MH services and specific conditions.

Clinician confidence in paediatric MH care

From pre to post-CoP, clinicians reported they were confident that they:

	Pre	Post
• Know how paediatric MH services are organised	68%	83%
• Know how to access paediatric MH services	75%	90%
• Can diagnose MH conditions	68%	78%
• Know how to refer for MH support	70%	90%

Personal factors that impact their decision to refer

Clinicians were asked to rate their level of importance ("unimportant to "important) of the following personal factors that affect their decision to refer a child for MH services.

From pre to post-CoP, clinicians reported a decrease in all personal factors, suggesting that being uncomfortable with a complex condition, lacking experience in managing a child's MH condition, not having enough knowledge about the condition and not feeling they were able to reassure parents were factors that were *less* likely to impact their decision to refer, post training.

• Not comfortable with a complex condition	81%	70%
• No experience in managing a child's MH condition	76%	73%
• Not enough knowledge about a child's MH condition	85%	80%
• Not confident to reassure parents	66%	53%

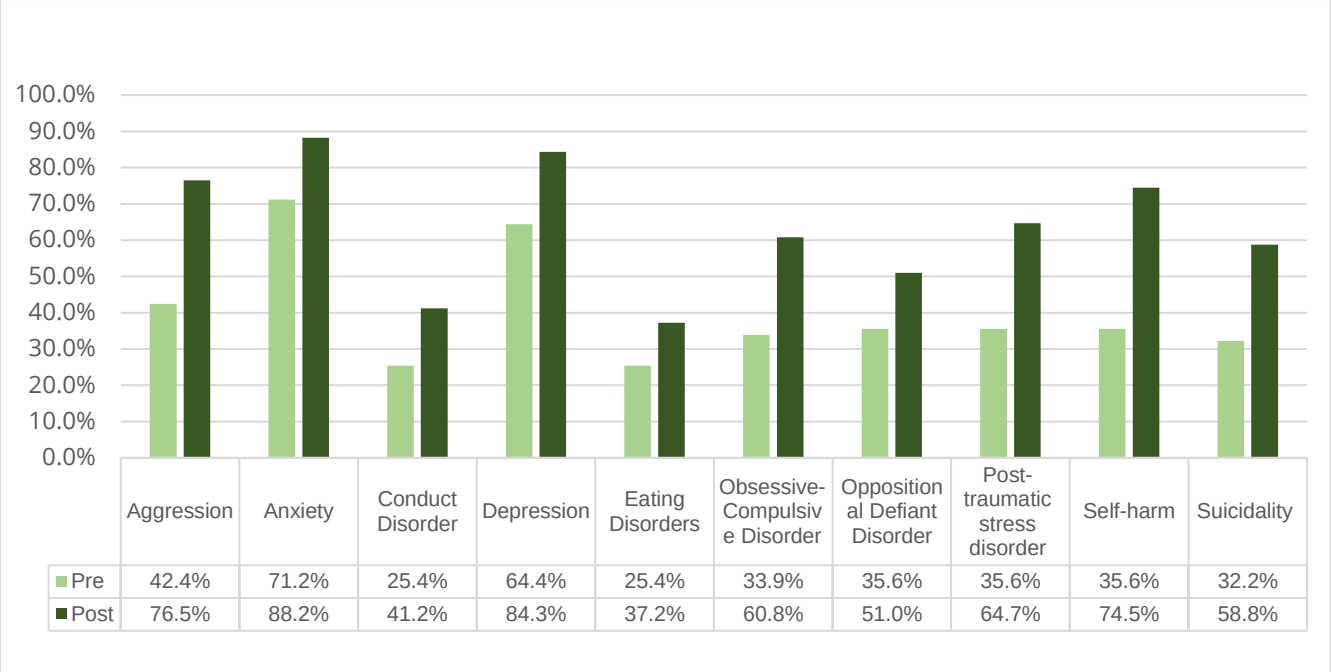
Clinician confidence in managing MH conditions for children and adolescents

Clinicians reported their level of confidence in non-pharmacological (non-medication specific) and pharmacological (medication specific) MH conditions for children and adolescents. The MH

conditions were covered in the CoP sessions (i.e. aggression, anxiety, depression, eating disorders, suicidality, and self-harm).

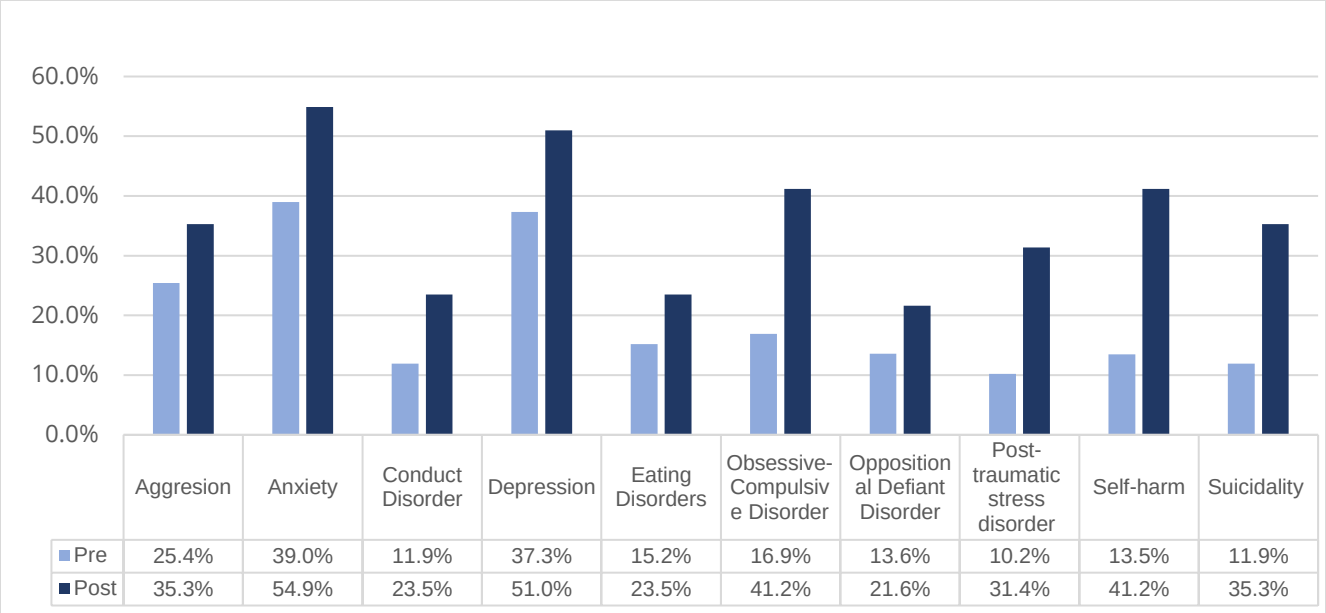
From pre to post, a greater proportion of clinicians indicated they were confident in managing all MH conditions, particularly; aggression, post-traumatic stress disorder (PTSD), self-harm, and obsessive-compulsive disorder (OCD). Figures 1 and 2 show pre- and post-CoP clinician reported confidence in non-pharmacological and pharmacological conditions for children. Similarly, clinicians reported an increase in confidence for adolescents (see Appendix 2 for CoP survey evaluation results).

Figure 1: Pre to post-CoP clinician reported confident in <u>non-pharmacological</u> management of MH conditions for children (N=59)



	Aggression	Anxiety	Conduct Disorder	Depression	Eating Disorders	Obsessive-Compulsive Disorder	Oppositional Defiant Disorder	Post-traumatic stress disorder	Self-harm	Suicidality
Pre	42.4%	71.2%	25.4%	64.4%	25.4%	33.9%	35.6%	35.6%	35.6%	32.2%
Post	76.5%	88.2%	41.2%	84.3%	37.2%	60.8%	51.0%	64.7%	74.5%	58.8%

Figure 2: Pre to post-CoP, clinician reported confident in pharmacological management of MH conditions for children (N=59)



	Aggresion	Anxiety	Conduct Disorder	Depression	Eating Disorders	Obsessive-Compulsive Disorder	Oppositional Defiant Disorder	Post-traumatic stress disorder	Self-harm	Suicidality
Pre	25.4%	39.0%	11.9%	37.3%	15.2%	16.9%	13.6%	10.2%	13.5%	11.9%
Post	35.3%	54.9%	23.5%	51.0%	23.5%	41.2%	21.6%	31.4%	41.2%	35.3%

Note. Approximately 40% of clinicians (n = 20) indicated pharmacological management of MH conditions was outside the scope of their role, and therefore did not complete this section of the survey.

Feedback of the model

Nearly all clinicians (90%) would recommend this online CoP to other clinicians, and 87% would informally support their colleagues with the key learnings.

Since participating in the CoP, clinicians reported that they:

- have used the CoP resources in their practice (45%)
- have made new connections with existing members (20%)
- are interested in deepening their skills to deliver paediatric MH training to others (70%)

Clinicians also stated that they would like to be supported in their new areas of learnings through booster sessions, an online practitioner network, and/or email/website of collated session resources.

Qualitative evaluation

A qualitative evaluation of the CoP was led by an independent researcher (paediatric advanced trainee). CoP clinicians who took part in at least 2 sessions were invited to participate in an in-

depth structured interview to capture clinician experience and feedback of the online CoP model.

Following the CoP session, 21 of 59 clinicians completed telephone semi-structured interviews between July and August 2021. All participants were asked a series of questions from an interview guide (see Appendix 3 for interview guide), with flexibility to explore emerging themes. Interviews were audio-recorded with consent, transcribed, cleaned and double coded, using qualitative research software (NVivo-15). We adopted an inductive approach using content analysis to code the data and generate broader sub-themes and themes.[5]

The sample included 21 participants from diverse professional backgrounds: 4 paediatricians, 5 GPs and 12 psychologists/ MH workers. Participants had accrued significant clinical experience, with approximately 40% having worked in healthcare for more than 15 years. CoP attendance rates were high, with more than 50% completing 8 (of a possible 10) or more sessions. Interviews ranged from 12 - 48 minutes (median 23 minutes).
The results of the analysis can be organized according to the following themes:

1. Program Structure, Content and Delivery
2. Group Dynamics and the Multidisciplinary Model
3. Participation, Networking and Professional Connections
4. Change in Clinical Practice
5. Clinician Wellbeing

Program Structure, Content and Delivery

Feedback from the participants supported the current structure of sessions, which includes a combination of didactic education content and case-based discussion. Several topics were reported to have been interesting, useful, and relevant to clinical practice, particularly education on the assessment and management of eating disorders. The high value of case-based discussion was a recurrent theme in the analysis, as these discussions provided opportunities to learn from other clinicians and obtain support for challenging clinical cases.

"It seemed quite supportive . . . open . . . certainly it felt like a safe place where people could present their cases and get advice from others . . ." (GP 19)

"I actually provided a case study for the eating disorders [presentation] . . . just because I was unsure what I was doing. . . Expert 1 was the paediatricians of the night and . . . really helped me out a heap" (Psychologist 14)

“The doctor that . . . worked in the anorexic unit ... I found the breadth of her knowledge particularly helpful . . . [her presentation] had a nice balance of information that . . . addressed a more counsellor/psychology approach, as well as the medical approach . . ." (Counsellor 9)

Participants also valued access to tertiary level MH expertise during the sessions, particularly with respect to assessment and formulation of complex presentations and potential management strategies. Resources provided through the CoP were universally well received, shared with colleagues and patients, and supported self-directed learning.

“. . . it was an absolute privilege to be able to pick Psychiatrist 1 brains for a number of case-based discussions” (Paediatrician 15)

". . . she added a lot of things from her experience that you wouldn't read in a text-book, or you wouldn't, you know from, a website, so different things to look out for" (Psychologist 1)

Some areas for improvement were identified, with respect to content and delivery of the model.

- The videoconferencing format was found to be both a facilitator and barrier to engagement in discussion. For many busy clinicians, the online format enabled attendance, and recordings were reviewed offline if a session was missed.
- However, the use of technology made it difficult for participants to contribute spontaneously to discussion and interpret non-verbal communication cues, which impacted the overall group dynamic. Many expressed a desire for face-to-face sessions, as a potential solution to this problem.

Group Dynamics and the Multidisciplinary Model

The multi-disciplinary aspect of the CoP was highly valued by participants, and provided significant insights into the knowledge base, skill set, patient caseload and challenges faced by other clinician groups.

"With a wide range of specialties . . . people are coming from different angles, including paediatricians, psychologists, GPs. That was really helpful to have people contributing from their area of expertise." (GP 19)

". . .the most important thing was the opportunity to hear from different, from people with a different professional background, and just the way they approach it . . ." (Head to Help Clinician 20)

Many participants described the model as a “missing piece” in community-based practice and gave them a sense that a more collaborative approach to care may be possible in the future.

"Overall, I did think it was a really useful community to be a part of. I do hope that it can continue. . . I find that it's relevant and I think that just having that connection with other people in this field is really good for me, particularly because I work on my own. . ." (Psychologist 12)

Participants described some aspects of the CoP that could be changed to support stronger group dynamics such as:

- Group structure, which should include an equal balance of clinicians from different professional backgrounds, and be smaller in size (CoP group size was ~15-20 participants) to encourage involvement in discussions.
- Need for clear rules for online engagement and facilitation which actively moderates the group discussion.

Participation, Networking and Professional Connections

In general, participants were engaged in the CoP. Case studies facilitated rich discussion, participants provided secondary consultation and shared resources. The sessions also inspired self-directed learning and for some participants, their involvement satisfied requirements for continuing professional development (CPD). Professional connections were made with local clinicians, and this was identified as a positive attribute of the CoP.

“. . . that prompted me to go off and do some researching too . . . which was quite interesting” (Counsellor 9)

“I think . . . where I was able to value add as well, being able to actually help . . . GPs and even psychiatrists [in] knowing about some different services” (MH social worker 3)

“. . . for me I was actually able to use this as paid study time” (GP 6)

“I've noticed a lot of the practitioners from around the Western suburbs, [that I] receive referrals from or refer to... so getting a bit of insight and connection face-to-face …is really, really good.” (Psychologist 1)

Participants identified some barriers to engagement and participation in group discussion:

- For GPs, some cases discussed were very complex, and key learnings were not generalisable to their own patient population.
- Some psychologists felt the didactic teaching had an over-emphasis on medical model of managing MH presentations, with a focus on pharmacological treatment.
- Whilst many participants made professional connections, they wanted more opportunities to network with others, possibly via face-to-face sessions.

Change in Clinical Practice

A common theme throughout the analysis was of remarkable changes in knowledge and clinical practice described by participants across all disciplines. Clinicians reported increased knowledge of resources, services, referral pathways and a more nuanced understanding of pharmacological management of child MH conditions. This knowledge also empowered them to advocate for their patients and communicate better with colleagues and families.

"I think it opened my eyes that I need to be really mindful around how important medication is and how I can encourage clients to, you know, make sure they attend the clinics. . . to prepare them sometimes if they've got an appointment so that they can ask questions about the potential side effects and, and what the medication is for. Because I think lots of people feel disempowered around that. And I think you've increased my own empowerment about empowering clients to do that." (Head to Help Clinician 20)

Clinicians also reported increased confidence in diagnostic skills and formulation of MH presentations in children, and utilised assessment and screening tools provided through the CoP. Paediatricians and GPs also provided numerous examples of change in their prescribing practices, in the child and adolescent population, and with positive results.

"I had a bit of a reticence to treat very young people for depression . . . certainly start with the psychology and then medication later . . . but I think following the depression series, I think, I probably have been a bit more proactive in treating younger people for depression. . . I'm a very cautious prescriber but. . . it has tipped me into that lower age group" (GP 11)

"For example, one of the cases that I talked to Psychiatrist 1 about one night, uh, she was telling me about a medication I've never heard of, which I did have the confidence to then use on the particular patient, and … it has been particularly helpful" (Paediatrician 15)

Access to child psychiatry expertise via secondary consultation was described as an invaluable aspect of the CoP. Paediatricians provided many key examples where advice obtained through this service expedited patient management, reduced referrals to tertiary services, supported professional development and empowered them to continue to hold patient care.

"[The CoP] has given us access to Psychiatrist 2 and Psychiatrist 1 to actually book in slots along cases . . . that's been absolutely vital. . . [for] difficult cases where I might let's say have to put in a referral . . . and an urgent assessment is, you know, a nine-month wait. . . I could pick up the phone, get a session with Psychiatrist 2 or Psychiatrist 1 within a week . . .instead of trying to support this young person when I'm feeling out of my comfort zone for weeks and months on end..." (Paediatrician 15)

"When you have that sort of secondary consultation model, it helps the person who's on the referring end to learn more and to skill themselves up . . . I'm actually referring less to psychiatrists... now... because I'm more confident in understanding these conditions... and what needs to be done" (Paediatrician 17)

"I think we overload the tertiary sector too much... there's a lot that we can do in the community, but we need to feel confident about it" (Paediatrician 17)

Clinician Wellbeing

Participants in the CoP overwhelmingly reported a positive impact on clinician wellbeing. Many described a reduction in stress levels, associated with better peer support, increase in knowledge and skills, as well as validation of their clinical practice.

"I think we, in General Practice, very much miss that, um, supervision ... and being part of a peer support group. So, I think this certainly positively impacts on, on your... own ability to cope with stresses from patients. And I think if you bring a case there that ... has been difficult to manage, it is good to have that support." (GP 9)

"[You're] burdened with all the stuff that you're trying to sort of figure out . . . You know, am I doing things, right? So having that community available, almost like a sounding board . . . and being able to hear that you're not alone in some of the conundrums that you face . . . because I think sometimes when you're doing work in private practice, I mean, even in a group practice, you can feel fairly isolated" (Paediatrician 17)

Improved clinical confidence was reported across all clinician groups, as well as reduced feelings of isolation. Many felt sharing cases with peers reduced the stigma of struggling to manage challenging patients. This was reported particularly amongst medical doctors, who do not routinely have group supervision as part of their practice.

"I think those sessions sometimes are really good because you hear a lot of other cases and other disciplines talking about how they're managing a case and how things are really, really tough. I mean, it's sort of sometimes a bit of a, almost like a relief, like, okay, we're all kind of... having the same struggles and, um, we're all kind of working together on them" (Psychologist 1)

"I think it's kind of just reassured me that I do have knowledge... around child mental health and I'm kind of on the right track . . . as a clinician, you really, kind of worry . . .with children, because it, it can present quite differently, so I feel like my confidence has increased in that regard..." (MH Social Worker 2)

CoP Clinician Recommendations

The table below summarises recommendations arising from the qualitative interviews on how the CoP sessions could be improved.

Theme	Issue Identified	Participant Derived Solutions
Program Structure, Content and Delivery	Online videoconferencing format	Options for face-to-face sessions
Group Dynamics and the Multi-disciplinary Model	Group Structure	Breakout sessions Ensure equal distribution of disciplines (medical and non-medical)
	Facilitation	Ensure rules or guidance for online engagement
Participation, Networking and Professional Connections	Overemphasis on the medical model	Include more content on psychological therapeutic models
	More networking opportunities	Breakout sessions Options for face-to-face sessions

2. Child Psychiatry Secondary Consultation and Liaison Service

One of the CoP RCH child psychiatrists provided further support to community-based clinicians within the NWMPHN catchment area through a secondary consultation and liaison service between April - December 2021. Funded by RCH MH, the experienced child psychiatrist provided weekday telephone, email and in-clinic secondary consultations to GPs and paediatricians on the management of MH problems in children and adolescents. The service was promoted via NWMPHN network communications including website, newsletters; and accessed through a MH intake phone number. The child psychiatry secondary consultation service provided advice regarding diagnostic, assessment, medication, risks, management, and referral options.

The evaluation

The nature of the consultations and resulting outcome were recorded by the child psychiatrist in a two-week snapshot (see Appendix 4). Over these two weeks, 22 clinicians (5 GPs and 17 paediatricians), accessed the secondary consultation service averaging ~45 contacts per month. Secondary consultations included a combination of phone, email and in-clinic appointments requesting medication and diagnostic advice. **All secondary consultations (100%) resulted in the patient being referred back to the clinicians therefore avoiding potential further referrals to CAMHS or emergency department presentations.**

The table below presents the summary of secondary consultations over the two-week period.

Clinician type	No. consults	Method	Reason for consult	Outcome
GP	5	Phone (5)	Medication advice (5)	All sent back to referrer
Paediatrician	17	Phone (4) Email (3) Clinic appointment (10)	Medication advice (7) Diagnostic review (10)	All sent back to referrer

These activities took around 14.5 hours (25 minutes per phone consultation, 60 min clinic appointment, 15 min per email consultation) of the child psychiatrist's time, which translates to $4074 ($281per hour for Year 9 Specialist). Taking into consideration the 22 avoided CAMHS referrals (at $414.75 per appointment), the total cost saving in the two-week snapshot is $5050.

3. Senior Mental Health Clinician support to community-based Hub MH clinicians (HeadtoHelp)

In response to the impact of the COVID-19 pandemic on MH, 15 HeadtoHelp (H2H) Hubs were funded by the Australian Government and established by Victorian PHNs (https://headtohelp.org.au/). There are three Hubs located within the NWMPHN region (Broadmeadows- DPV Health, Wyndham Vale- IPC Health, and Brunswick East - Clarity Healthcare). The hubs are supported by a central intake function that undertakes an initial assessment to connect people to the right type of support available in the region, people with more complex presentations are connected to their local HeadtoHelp hub. H2H is a unique service, and the first state-wide step towards integrating the MH system and coordinating care for people, when and where they need it most.

As the Hubs provide care for all age groups, a skilled workforce in paediatric MH care is needed. To address this, we integrated a senior MH clinician from the RCH to provide support to NWMPHN H2H Hub clinicians from February 2021. Although the functions of the H2H Hubs and H2H central intake are different, the MH clinician provided support to each group in a way that is relevant to their roles.

HeadtoHelp Hubs

The MH Senior Clinician: provided secondary consultation to Hub clinicians and primary consultation when required; facilitated reflective practice sessions on a regular basis; and delivered education sessions and training in evidenced-based practice and screening tools. In addition, the MH clinician delivered training on RCH and other child and youth services referral pathways within the NWMPHN catchment.

HeadtoHelp central intake

The same MH clinician also provided secondary consultation to intake clinicians, delivered training on RCH and other child and youth services referral pathways, and developed additional questions to use alongside the Initial Assessment and Referral Decision Support Tool (IAR-DST), a multi-domain assessment tool used in HeadtoHelp to guide referral decisions for a person seeking MH support.[6]

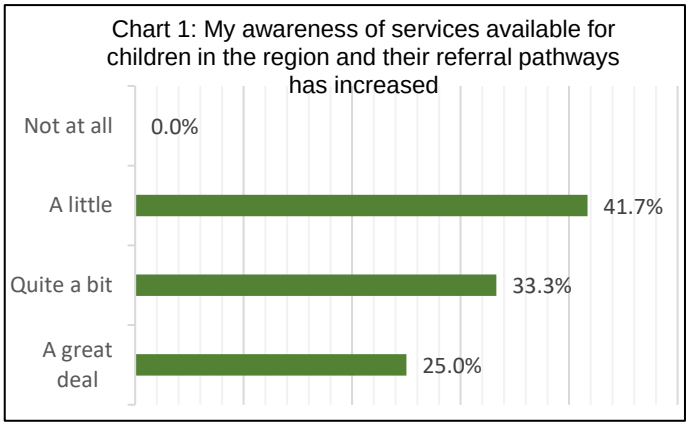
The evaluation

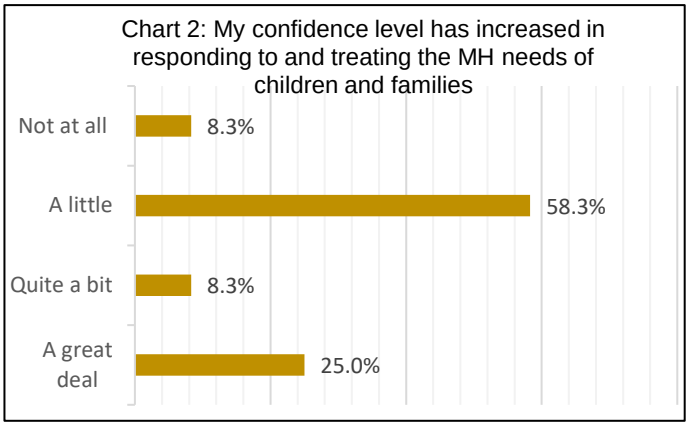
Clinician surveys

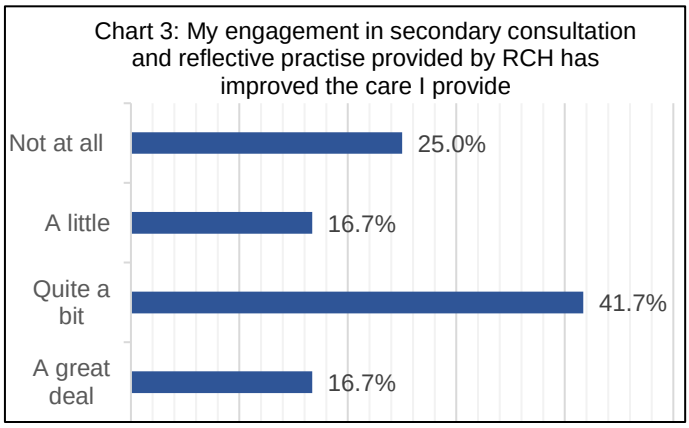
A total of 12 participants completed the H2H clinician survey (see Appendix 5); 8 H2H Hub clinicians and 4 intake clinicians. The group was experienced, with 75% indicating they have been in their current profession for 6+ years and 50% for more than 10 years. The experience of the Hub clinicians varied more than that of central intake with 37% being in their profession for less than 5 years whereas 100% of intake clinicians have been in their current profession for 6+ years. Figure 3 indicates that both intake and hub clinicians responded positively to the support provided by the Senior MH clinician. Clinicians responded that the provided support has:

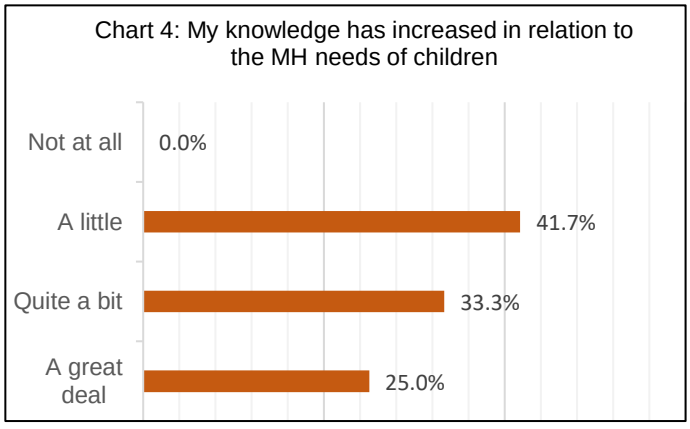
- increased awareness of services (Chart 1,100%)
- increased confidence in treating children and adolescents (Chart 2, 92%)
- improved the care they have provided (Chart 3, 75%)
- increased knowledge of the needs of children and adolescents (Chart 4, 100%)
- increased clinical knowledge of child and adolescent specific treatment approaches (Chart 5, 75%)

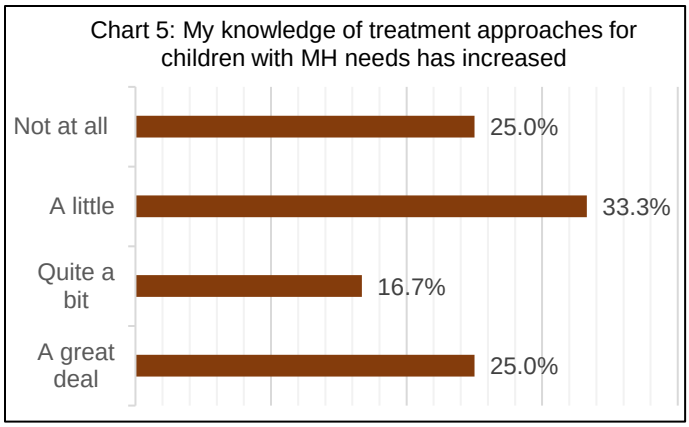
Figure 3. H2H clinician confidence survey results (N=12)











Focus group

In August 2021, a focus group was held with a variety of clinicians from the three H2H hub clinical teams and central intake to further explore clinician feedback of this initiative. The focus group was held online via Microsoft Teams and was facilitated by a RCH Mental Health team member, independent from H2H.

The aim of the focus group was to measure how the Senior MH Clinician support was implemented and received by the H2H clinicians and sustainability beyond the funded timeframe. The facilitator reflected the participants being open and honest in their responses.

The focus group questions included:

- What aspects of this collaboration with the senior MH clinician have you been engaged in? Of the aspects that you've engaged in, what's been helpful?
- What have been the barriers to engaging in other aspects?
- Are there aspects that you find less helpful?
- Thinking forward to when the senior MH clinician role no longer exists, what support or training do you need to enable to work most effectively with children and families?
- Is there anything else you wish to share?

The focus group encapsulated the following themes:

Benefits

- Lots of resources (access to literature, referral pathways)
- an increase in confidence due to the support provided

"*Working with the senior MH clinician has enabled clinicians to have more confidence in working with children"(H2H clinician 1)*

- Reflective space has been useful

"*Reflective space has allowed for debriefs which also enabled clinicians to grow as a team*" (H2H clinician 2)

- Primary consultation

"*fantastic learning experience for clinicians*" *(H2H clinician 3)*

Challenges

- Some teams do not have the fundamentals of child and adolescent MH

  "*Felt ethically challenged (taking child referrals)*" *(H2H clinician 4)*

- Secondary consultation isn't as helpful without more work in building strong training foundations in child and adolescent MH
- In relation to some referrals from RCH Mental Health to HeadtoHelp, this process didn't always feel like a collaborative approach
- Struggle to balance clinical and professional development needs
- Senior MH clinician fixed days working days do not always align with clinician's availability
- Significant concern that when working with complex children's presentations this may be working outside their scope of practice

Suggestions from Head to Help Clinicians

- Training and education to upskill on the fundamentals, so they know how to use the Senior MH Clinician's skills and expertise. Training to be more specifically 'hub' focused (e.g. anxiety).
- Developmental disorders, organic neuropathology leading to certain behaviours or psychiatric symptomology or a combination of both is one area that needs to be covered by further education
- The need for some psychiatrist support for cases
- The team needs to build capacity, within their own system, so the work of the team isn't dependent on what senior MH clinician has to offer

Case Study

14y.o female. Referred to RCH Mental Health and paediatrician at RCH. Presenting problems of self-harm, suicidal thinking, impulsivity, conflict with parents, aggression at home and sleep

disturbance. Currently prescribed SSRI for anxiety. H2H clinician initiated a consultation request and wanted support around how to engage the young person with the current acuity of symptoms and distress

Three secondary consultations were accessed with the senior MH clinician focusing on formulation, diagnosis, and treatment. This included administering symptom-rating measures (MFQ, SNAP and SPENCE) and support around scoring, interpretation, and feedback to family and young person. Interpretation of formal assessments such as Cognitive and Speech and Language assessment and how these might inform treatment. Case formulation also included how to involve and support systems around the young person including: school, treating paediatrician, RCH Intake team and parents. Treatment options included parent work, individual therapy and systems work explored and planned with clinician including resources.

Outcome: RCH intake was able to close the referral and not allocate the patient to MH program as the young person was engaging with H2H and symptoms were improving. Young person and family reported good engagement with H2Hclinician and reduction in self-harm, anxiety, and conflict at home. A school meeting occurred, and the school started developing a support plan for the young person around self-harm. The care team around the young person are working more collaboratively. There is a plan in place for the RCH Senior MH Clinician to continue supporting H2Hclinician through secondary consultations.

4. Hospital and specialist services

As part of the evaluation of the COMPASS, we examined changes in metropolitan ED presentations for MH problems in 0-17year olds and changes in referrals to CAMHS for the same age group, before and during COMPASS.

Emergency department presentations for mental health

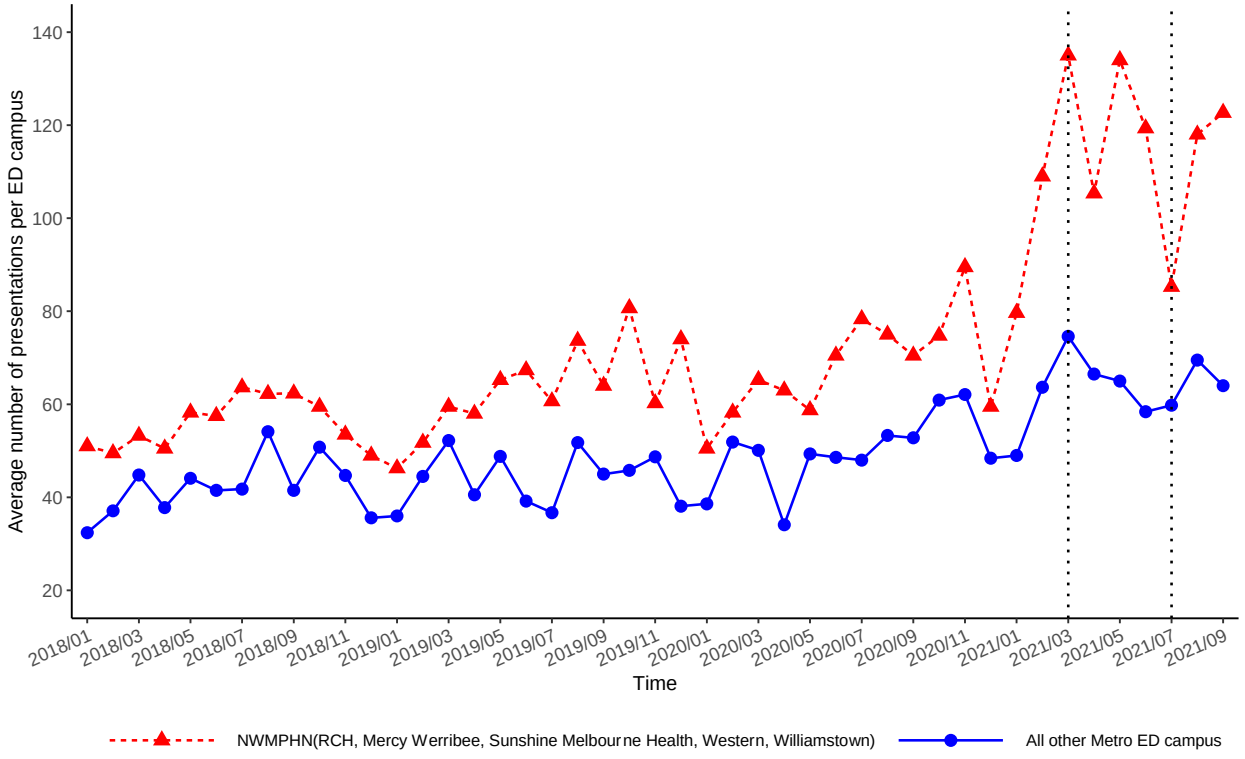
Figure 4 below presents rates of ED presentations for MH in children and adolescents aged 0-17 years to hospital campuses in NWMPHN catchment and other metropolitan ED campuses. The blue line represents presentations to EDs in the NWMPHN catchment area, i.e. The Royal Children Hospital, Werribee Mercy Hospital Sunshine Hospital, Western Hospital, and Williamstown Hospital. The red line represents all other metropolitan EDs. The dotted vertical lines represent when the CoP model was running (March - July 2021).

Key findings:

- overall, MH presentations for 0-17-year-olds to metropolitan EDs are rising
- most ED MH presentations for 0-17-year-olds are to NWMPHN catchment area hospitals
- changes in ED presentations during the COMPASS model are similar for NWMPHN catchment area hospitals and other hospitals.

These findings indicate a high economic burden of ED MH presentations for 0-17-year-olds in the NWMPHN catchment area hospitals. On average there are around 80-140 visits per month in the first half of 2021. The average cost of one such ED presentation is estimated to be $1316.

Figure 4: MH presentations 0-17 years between NWMPHN and other metropolitan EDs.



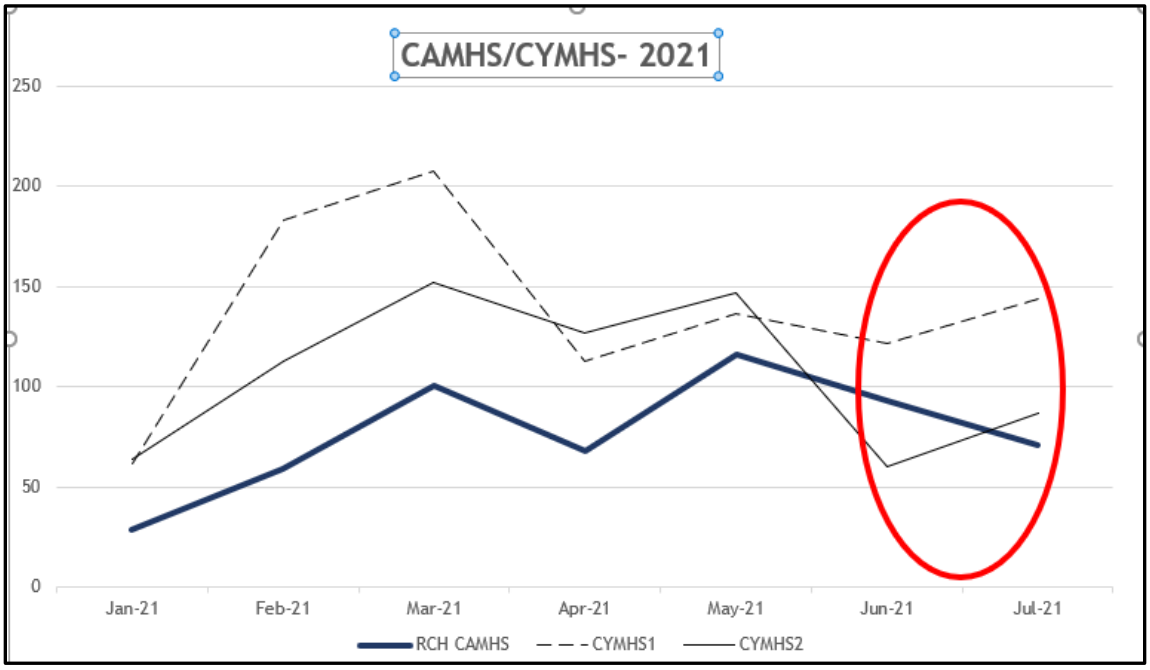
Child and adolescent mental health service (CAMHS)

We also examined change in referrals for 0–17-year-olds to RCH CAMHS and compared these with data from two other metropolitan CYMHS (see Figure 5 below).

Key findings:

- across all 3 CAMHS/CYMHS, referrals appear to peak in February-March 2021 and then decline
- at the RCH CAMHS, this decline in referrals continues across June-July 2021 (when the CoP stopped) but appears to increase in the 2 other CYMHS.

Figure 5: CAMHS/CYMHS referrals for 0–17-year-olds for RCH and two other metropolitan services



Cost Analysis

The table below shows the costs of running COMPASS on a monthly and annual basis. Costs are for 1 CoP stream (i.e. 2 sessions per month). Note for the pilot, we ran two streams of the CoP concurrently to cater for clinician demand.

Item	Description of Item	Monthly Cost	Annual Cost
Online community of practice and secondary consultation service			
Child psychiatrist	Year 9 Specialist Child Psychiatrist *2 sessions per week to cover: 2 x fortnightly 1.5hour online CoP sessions (including prep time) and weekday consultation service*	$8,539	$102,468
GP Facilitator of CoP sessions	General practitioner *2 x fortnightly 1hour online CoP sessions and prep time (3 hours per month)*	$522	$6,264
Admin support for secondary consultations	Provided back end admin support of secondary consultations	$893	$10,716
PHN admin support of CoP sessions	One day per week PHN admin support to support back end CoP sessions	$1,533	18,396
Senior MH clinician support - HeadtoHelp			
Senior MH clinician	1 x 0.3FTE Senior MH nurse clinician (45.6 hours per month)	$4119	$49,428
Integrated MH Care Pilot Evaluation Officer *admin support and research evaluation of model*			
MCRI Research evaluation officer	1 x 0.4 FTE research officer	$4,686	$56,232
Total cost of COMPASS components (12-month period)		**$20,292**	**$243,504**

Summary and Recommendations

The COMPASS model appears to have increased frontline clinician confidence and competence in managing common child and adolescent MH problems, improved their ability to “hold’ children whilst awaiting specialised services, reduced fragmentation of services, and reduced clinician burnout. Secondary consultations were used by GPs and paediatricians, primarily for advice around medication and diagnosis, with all consultations resulting in referrals back to the GP or paediatrician. H2H Hub clinicians reported improved confidence in managing child and adolescent MH difficulties including referral options and knowledge of child and adolescent specific treatment approaches. The COMPASS model appears to be associated with a reduction in referrals to the RCH CAMHS although review of ongoing referral patterns would be useful.

Ways to improve COMPASS were identified by participating clinicians and include:

- availability of in-hours sessions for the CoP to allow greater participation
- in-person (as opposed to online) CoP sessions
- CoP booster sessions
- discipline-specific breakout rooms during CoP sessions to empower all clinicians to have a voice (NB. this has been successfully trialled in the November booster session)
- training and education to upskill H2HHub clinicians in the fundamentals of child and adolescent MH. This training and education should focus on developmental disorders and organic neuropathology leading to certain behaviours or psychiatric symptomology
- greater availability of the senior MH clinician so that more H2HHub clinicians can take advantage of this valued resource.

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Appendices

Appendix 1: Community of Practice clinician survey

Appendix 2: Community of Practice evaluation results

Appendix 3: Community of Practice qualitative interview guide

Appendix 4: Child psychiatry secondary consultation data log

Appendix 5: HeadtoHelp and RCH collaboration survey

APPENDIX 1

Appendix 1. Community of practice clinician survey

Clinician Survey - Pre and Post

About This Survey

This survey is about your experiences in providing child mental health care and management for paediatric (<18 years) patients.

The survey will take about 10 minutes to complete.

Section 1: Demographics

1.1 For research purposes, please provide your name? _____

1.2 What is the name of your organisation? _____

1.3 What is your gender?

- ☐ Male
- ☐ Female

☐ Other, please specify: _____

1.2 Are you a:

- ☐ General Practitioner
- ☐ Paediatrician
- ☐ Psychologist
- ☐ Other

Please specify other: _____

1.2b How long have you been practising in this role?

- ☐ Less than 6 years
- ☐ 6 – 15 years
- ☐ More than 15 years

1.3. How many half-day clinical sessions do you work per week?

- ☐ Less than 6 clinical sessions per week
- ☐ 6 – 10 clinical sessions per week

☐ More than 10 clinical sessions per week

1.4. What is the average number of paediatric (0 – 17 years) patients you see per week?

☐ Less than 11 paediatric patients

☐ 11 – 20 paediatric patients

☐ More than 20 paediatric patients

1.5. Have you ever had formal training in paediatric mental health?

☐ Yes *(please specify below)*

☐ No

1.5b Yes (please specify): _____

Section 2: Paediatric Mental Health care and services

The following statements relate to your perspectives on, and experiences of, paediatric mental health care and services. Please read each item, and tick the box that best describes how much you agree with each statement.

For children: ***I am confident…***	Not at all confident	Not very confident	Fairly confident	Completely confident	Not my role
2.5 I know how mental health services are organised	☐	☐	☐	☐	☐
2.6 I know how to access mental health services	☐	☐	☐	☐	☐
2.7 I can diagnose mental health conditions	☐	☐	☐	☐	☐
2.8 I know how to refer for mental health support	☐	☐	☐	☐	☐
2.9 in prescribing first-line psychotropic medication (e.g for anxiety)	☐	☐	☐	☐	☐
2.10 in prescribing second and third line psychotropic medication	☐	☐	☐	☐	☐

For adolescents: ***I am confident…***	Not at all confident	Not very confident	Fairly confident	Completely confident	Not my role
2.11 I know how mental health services are organised	☐	☐	☐	☐	☐
2.12 I know how to access mental health services	☐	☐	☐	☐	☐
2.13 I can diagnose mental health conditions	☐	☐	☐	☐	☐
2.14 I know how to refer for mental health support	☐	☐	☐	☐	☐
2.15 in prescribing first line psychotropic medication (e.g for anxiety)	☐	☐	☐	☐	☐
2.16 in prescribing second and third line psychotropic medication	☐	☐	☐	☐	☐

2.2 How important are each of the following **personal factors** in your decision to refer a child/adolescent to mental health services

	Very Unimportant	Somewhat Unimportant	Somewhat Important	Very Important
a. I do not have enough knowledge about a specific child's mental health condition	☐	☐	☐	☐
b. I have no experience in treating or providing ongoing mental health management of a specific child's condition	☐	☐	☐	☐
c. I do not feel comfortable caring for a child with a complex mental health condition	☐	☐	☐	☐
d. I do not feel confident in reassuring parents that they do not need to seek a second opinion	☐	☐	☐	☐

Section 3: Paediatric Mental Health Management

The following questions relate to your confidence in managing non-pharmacological and pharmacological child mental health problems for infants, children and adolescents. Please select box that best describes your confidence as a clinician.

3.1 How confident are you in the **non-pharmacological** management of:

For children, how confident are you in the **non-pharmacological** management of:

	Not at all confident	Not very confident	Fairly confident	Completely confident	Not my role
ADHD					
Aggression/challenging behaviours					
Anxiety symptoms/ Generalized Anxiety Disorder/social anxiety					
Conduct disorder					
Depression					
Eating disorders-anorexia/bulimia					
Learning difficulties/Intellectual disability					
Obsessive-Compulsive Disorder (OCD)					
Oppositional Defiance Disorder					
Post-traumatic stress disorder (PTSD)					
Suicidality					
Self-harm					

For adolescents, how confident are you in the **non-pharmacological** management of:

	Not at all confident	Not very confident	Fairly confident	Completely confident	Not my role
ADHD					
Aggression/challenging behaviours					
Anxiety symptoms/ Generalized Anxiety Disorder/social anxiety					
Conduct disorder					
Depression					
Eating disorders-anorexia/bulimia					

Learning difficulties/Intellectual disability					
Obsessive-Compulsive Disorder (OCD)					
Oppositional Defiance Disorder					
Post-traumatic stress disorder (PTSD)					
Suicidality					
Self-harm					

For children, how confident are you in the **pharmacological** management of:					
	Not at all confident	Not very confident	Fairly confident	Completely confident	Not my role
ADHD					
Aggression/challenging behaviours					
Anxiety symptoms/ Generalized Anxiety Disorder/social anxiety					
Conduct disorder					
Depression					
Eating disorders- anorexia/bulimia					
Learning difficulties/Intellectual disability					
Obsessive-Compulsive Disorder (OCD)					
Oppositional Defiance Disorder					
Post-traumatic stress disorder (PTSD)					
Suicidality					
Self-harm					
For adolescents, how confident are you in the **pharmacological** management of:					
	Not at all confident	Not very confident	Fairly confident	Completely confident	Not my role
ADHD					

Aggression/challenging behaviours					
Anxiety symptoms/ Generalized Anxiety Disorder/social anxiety					
Conduct disorder					
Depression					
Eating disorders- anorexia/bulimia					
Learning difficulties/Intellectual disability					
Obsessive-Compulsive Disorder (OCD)					
Oppositional Defiance Disorder					
Post-traumatic stress disorder (PTSD)					
Suicidality					
Self-harm					

Section 4: Clinician Interviews

At the end of this pilot, we are interested in learning more about your experiences as a clinician during this community of practice model. An advanced paediatric trainee will be leading this extra part of the pilot with the aim to conduct clinician interviews by telephone in July. Please tick the box below if you would like to be contacted to learn more about taking part in this interview.

This does NOT mean that you must take part – only that you want to hear more! Interviews will be conducted at a mutually agreed time.

☐ Yes, I wish to be contacted regarding the clinician interviews in July.

Section 4: Your experience of this Community of Practice model

Thinking about the Community of Practice sessions you have attended over the last 5 months, please complete the following questions that best describe your experience.

4.1 What was the <u>best</u> thing about the Community of Practice model?

4.2 What was the worst thing about the Community of Practice model?

4.3 What could make the Community of Practice model better?

4.4 Would you recommend this Community of Practice to other clinicians?
1 Yes / 0 No

4.5 This Community of Practice model ran for a total of 5 months (10 sessions). **What do you think is an ideal number of sessions for a Community of Practice in child and adolescent mental health?** Please record below and explain why.

4.6 Have you used any of the Community of Practice resources in your practice?
Yes/No

If yes, which resources have you used

4.7 As a result of the Community of Practice, have you formed any new connections with the participating clinicians?

YES/NO

4.8 What could we do to support you to maintain your new areas of learning?
Checkbox selection: tick all that apply

Run booster sessions
Establish an online practitioner network
Collate existing session resources on a website
Other, please explain_____

4.9 Do you feel confident in informally supporting colleagues with what you have learnt?
Yes/No
If No, what might make you feel confident to be a go to person in your service or local network? Please explain

_____

4.10 Would you be interested in deepening your skill level (e.g. to participate in a train the trainer course) to more formally support colleagues?

Yes/No/Maybe

4.11 If the Community of Practice model were to continue, how would you like this to happen? What ideas do you have to make it sustainable?

4.12 Do you agree to have your contact details (name, profession, email and phone number) shared with the community of practice members?

1	Yes- phone and email
2	Yes- email only
3	No

4.13 Further comments

Please provide any further comments about the Child Mental Health Community of Practice model

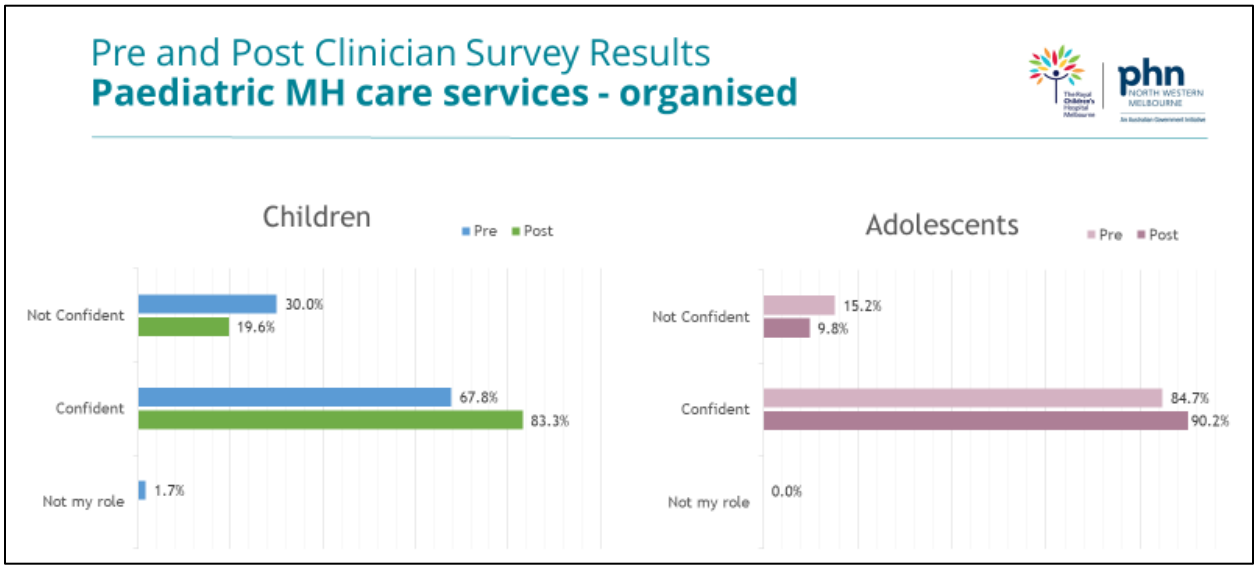
Thank you for taking the time to complete the Child Mental Health Community of Practice final survey!

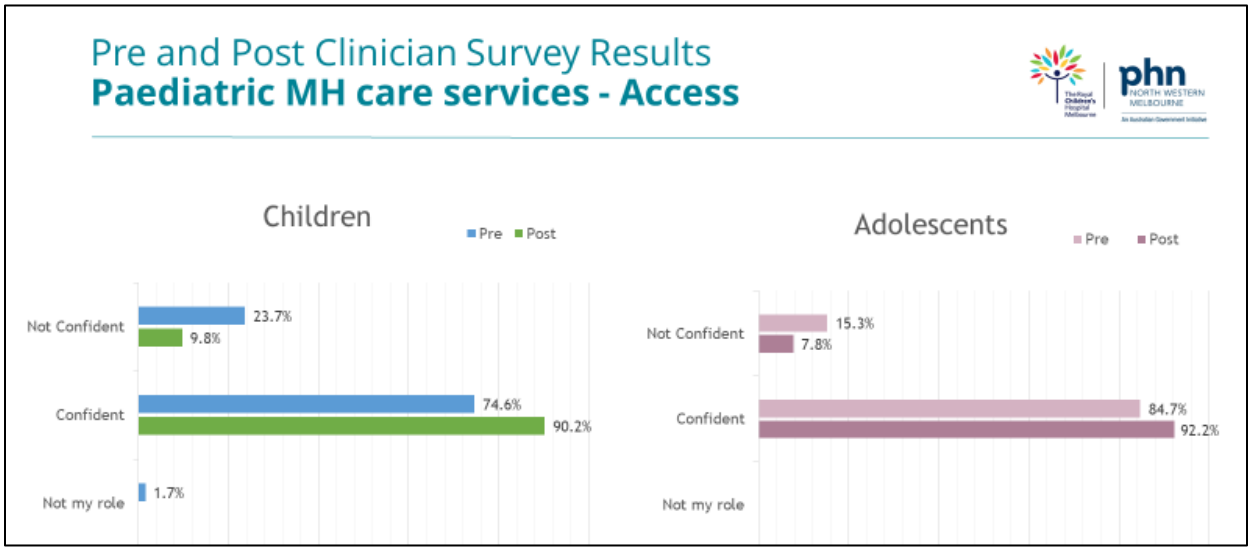
Your participation and feedback is greatly appreciated.

If you have any questions, please contact Prof. Harriet Hiscock - harriet.hiscock@rch.org.au

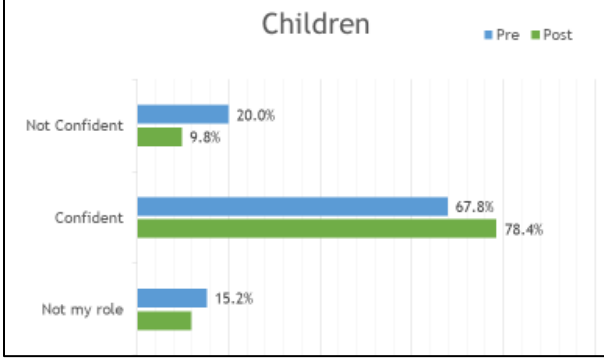
APPENDIX 2

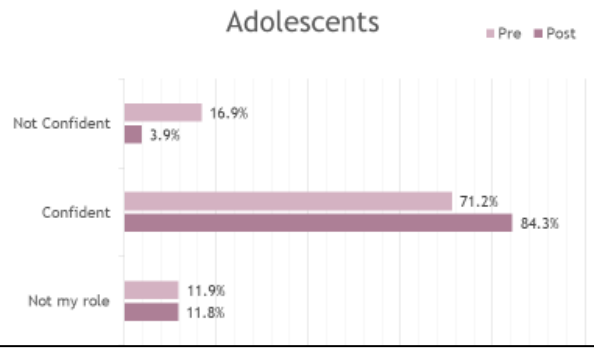
Appendix 2. Community of practice survey evaluation results



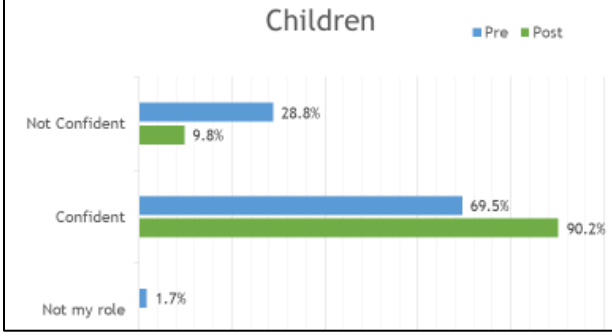


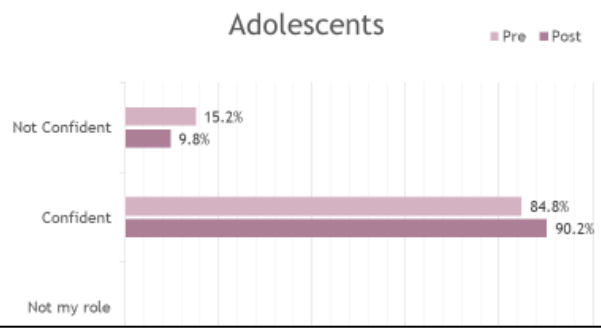
Pre and Post Clinician Survey Results
How Paediatric MH care - Diagnose



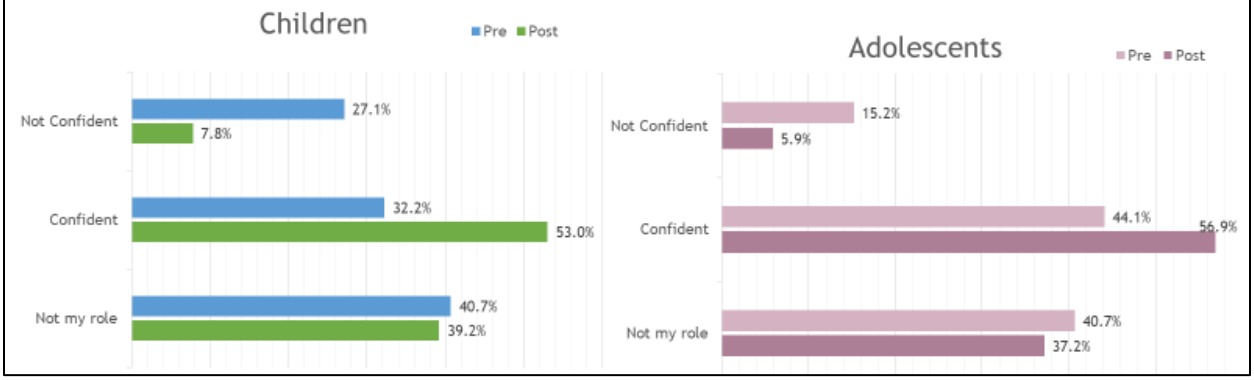


Pre and Post Clinician Survey Results
Paediatric MH care services - Refer

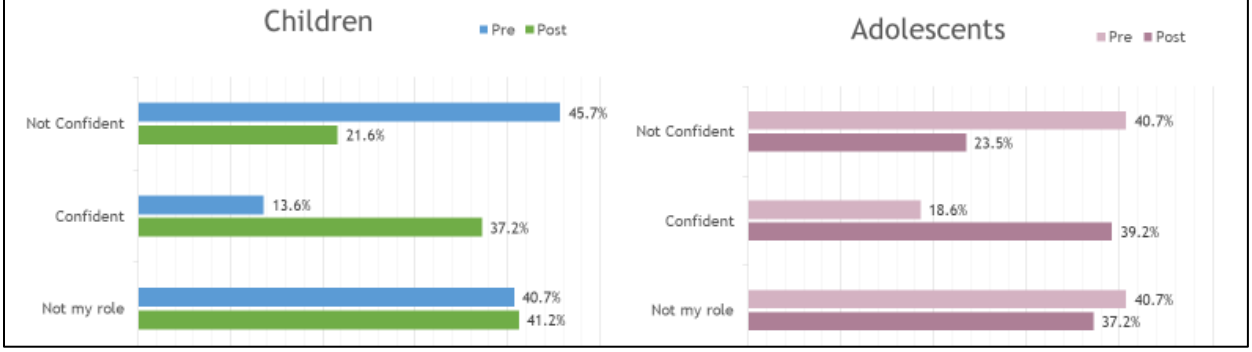




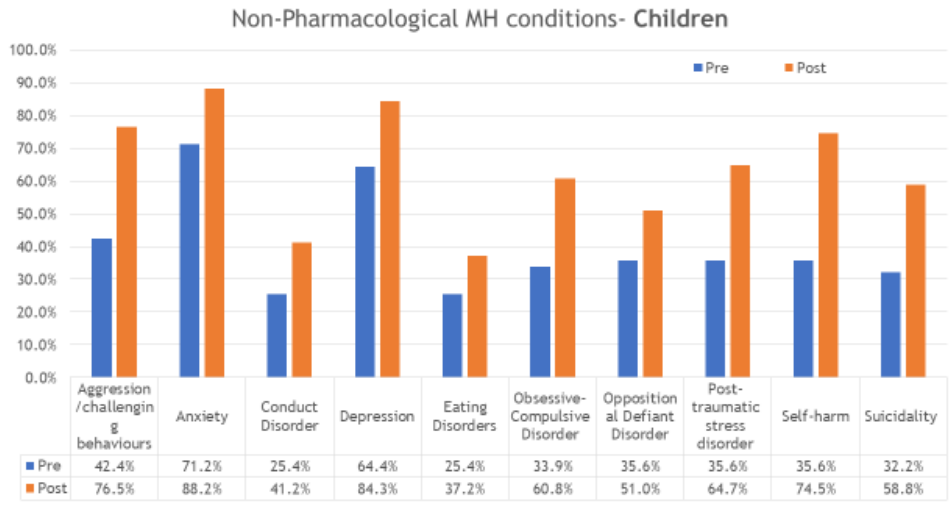
Pre and Post Clinician Survey Results
First-line psychotropic meds



Pre and Post Clinician Survey Results
Second/third line psychotropic meds



Pre and Post Clinician Survey Results
Confidence in Non-Pharmacological Management



	Aggression /challenging behaviours	Anxiety	Conduct Disorder	Depression	Eating Disorders	Obsessive-Compulsive Disorder	Oppositional Defiant Disorder	Post-traumatic stress disorder	Self-harm	Suicidality
Pre	42.4%	71.2%	25.4%	64.4%	25.4%	33.9%	35.6%	35.6%	35.6%	32.2%
Post	76.5%	88.2%	41.2%	84.3%	37.2%	60.8%	51.0%	64.7%	74.5%	58.8%

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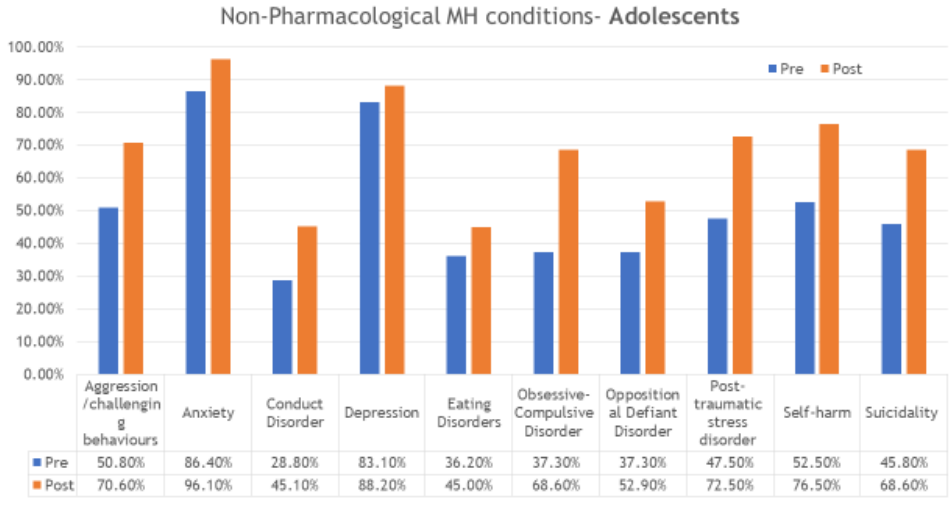
Pre and Post Clinician Survey Results
Confidence in Non-Pharmacological Management



	Aggression /challenging behaviours	Anxiety	Conduct Disorder	Depression	Eating Disorders	Obsessive-Compulsive Disorder	Oppositional Defiant Disorder	Post-traumatic stress disorder	Self-harm	Suicidality
Pre	50.80%	86.40%	28.80%	83.10%	36.20%	37.30%	37.30%	47.50%	52.50%	45.80%
Post	70.60%	96.10%	45.10%	88.20%	45.00%	68.60%	52.90%	72.50%	76.50%	68.60%

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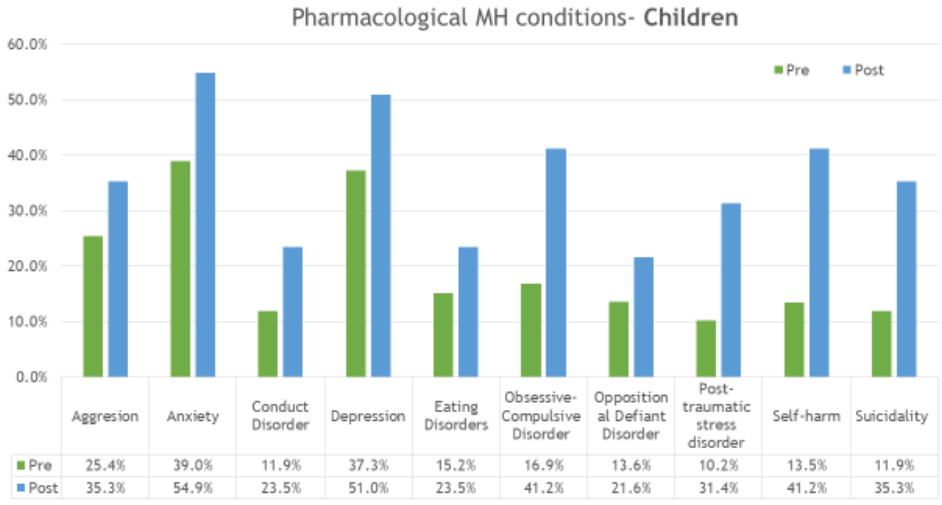
Pre and Post Clinician Survey Results
Confidence in Pharmacological Management



	Aggresion	Anxiety	Conduct Disorder	Depression	Eating Disorders	Obsessive-Compulsive Disorder	Oppositional Defiant Disorder	Post-traumatic stress disorder	Self-harm	Suicidality
Pre	25.4%	39.0%	11.9%	37.3%	15.2%	16.9%	13.6%	10.2%	13.5%	11.9%
Post	35.3%	54.9%	23.5%	51.0%	23.5%	41.2%	21.6%	31.4%	41.2%	35.3%

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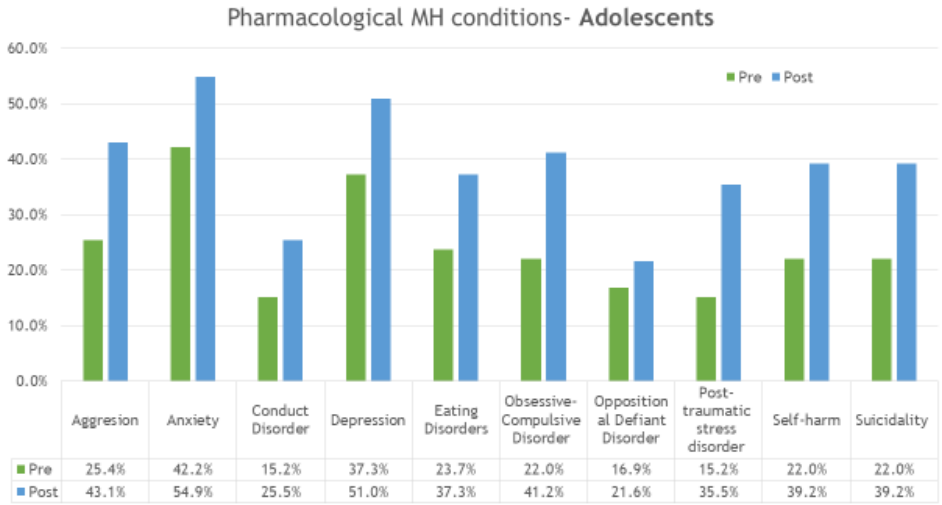
Pre and Post Clinician Survey Results
Confidence in Pharmacological Management



	Aggresion	Anxiety	Conduct Disorder	Depression	Eating Disorders	Obsessive-Compulsive Disorder	Oppositional Defiant Disorder	Post-traumatic stress disorder	Self-harm	Suicidality
Pre	25.4%	42.2%	15.2%	37.3%	23.7%	22.0%	16.9%	15.2%	22.0%	22.0%
Post	43.1%	54.9%	25.5%	51.0%	37.3%	41.2%	21.6%	35.5%	39.2%	39.2%

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APPENDIX 3

Appendix 3. Community of practice Qualitative interview guide

Interview Guide: Health Practitioners

Name: _____ **Date & Time:** _____

Study ID: _____ **Setting:** _____

Profession: _____

Interviewer Initial: _____

SECTION 1 – Experience of the Community of Practice Model

Question	Question complete
1. Can you describe your experience of the Community of Practice Model?	☐

SECTION 2 – Feedback

Question	Question complete
2. Do you have any feedback on the Community of Practice Model? a. What worked well? b. What was challenging? c. How could this be improved	

SECTION 3 – Impact on Clinical Practice ☐

Question	Question complete
3. Did your involvement in the Community of Practice Model lead to changes in your clinical practice? a. If so, how? b. Which domains of clinical practice were affected (diagnosis, management or referral)?	☐

APPENDIX 4

Appendix 4. Child psychiatry secondary consultation data log

RCH Secondary Consultation log						
	How contacted	Who contacted	Patient gender/ age	Type of consultation	Reason for consultation (tick as many as relevant)	Outcome
Patient 1	☐ Clinic appt ☐ Phone ☐ Email ☐ Other:	☐ GP ☐ Paediatrician ☐Psychologist ☐ Other	☐ Male ☐ Female ☐ Other Patient age: _____	☐ Primary Consultation ☐ Secondary Consultation	☐ Medication advice ☐ Diagnostic review ☐ Treatment resistance needing comprehensive MH review	☐ sent back to referrer ☐ Referred to CAMHS ☐ Other: _____
Patient 2	☐ Clinic appt ☐ Phone ☐ Email ☐ Other:	☐ GP ☐ Paediatrician ☐ Psychologist ☐ Other	☐ Male ☐ Female ☐ Other Patient age: _____	☐ Primary Consultation ☐ Secondary Consultation	☐ Medication advice ☐ Diagnostic review ☐ Treatment resistance needing comprehensive MH review	☐ sent back to referrer ☐ Referred to CAMHS ☐ Other: _____
Patient 3	☐ Clinic appt ☐ Phone ☐ Email ☐ Other:	☐ GP ☐ Paediatrician ☐ Psychologist ☐Other	☐ Male ☐ Female ☐ Other Patient age: _____	☐ Primary Consultation ☐ Secondary Consultation	☐ Medication advice ☐ Diagnostic review ☐ Treatment resistance needing comprehensive MH review	☐ sent back to referrer ☐ Referred to CAMHS ☐ Other: _____
Patient 4	☐ Clinic appt ☐ Phone ☐ Email ☐ Other:	☐ GP ☐ Paediatrician ☐ Psychologist ☐Other	☐ Male ☐ Female ☐ Other Patient age: _____	☐ Primary Consultation ☐ Secondary Consultation	☐ Medication advice ☐ Diagnostic review ☐ Treatment resistance needing comprehensive MH review	☐ sent back to referrer ☐ Referred to CAMHS ☐ Other: _____
Patient 5	☐ Clinic appt ☐ Phone ☐ Email ☐ Other:	☐ GP ☐ Paediatrician ☐ Psychologist ☐Other	☐ Male ☐ Female ☐ Other Patient age: _____	☐ Primary Consultation ☐ Secondary Consultation	☐ Medication advice ☐ Diagnostic review ☐ Treatment resistance needing comprehensive MH review	☐ sent back to referrer ☐ Referred to CAMHS Other

APPENDIX 5

Appendix 5 HeadtoHelp and RCH collaboration survey

As you may be aware the Royal Children's Hospital and Head 2 Help have partnered to increase access to and quality of mental health care for infants, children and adolescents. Part of this involves a Mental Health Clinician from RCH working alongside Head 2 Help to support the mental health care that the service provides. Below is a survey to gain some feedback into the effectiveness of this partnership and to help inform the direction of this collaboration.

Your participation in this survey is entirely voluntary and all responses will be treated with respect and confidentially. You can return the completed questionnaire to Harry Gelber, RCH Community Development coordinator (harry.gelber@rch.org.au).

What is your current profession?	Counselling ☐	psychology ☐	Nursing ☐	Social work ☐	Other ☐

How long have you worked in your current profession?	1 – 2 years ☐	3 to 5 years ☐	6 to 10 years ☐	> 10 years ☐
Which team do you work within?	Intake ☐		Hub clinician ☐	

***Please rate the following statements in relation to the helpfulness of the collaboration with the Royal Children's Hospital Mental Health Clinician**

	Not at all	A little	Quite a bit	A great deal
My knowledge has increased in relation to the mental health needs of children.	☐	☐	☐	☐
My knowledge of treatment approaches for children with mental health needs has increased.	☐	☐	☐	☐
My awareness of services available for children and families in the region and their referral pathways has increased.	☐	☐	☐	☐
My confidence level has increased in responding to and treating the mental health needs of children and families?	☐	☐	☐	☐

Any other comments: _____