Dr. Anderson is an Australian expert in pediatric neuropsychology, and one of the worlds known researchers in childhood brain injury. She is currently the head of Psychology department at The Royal Children's Hospital, Professorial Fellow, Paediatrics & Psychology at the University of Melbourne, and Director of Clinical Sciences Research at Murdoch Children's Research Institute. With over 500 peer reviewed publications and $40M in competitive grant funding, her primary research and clinical interests are in child development and mental health. Her recent work has focused on translating her early career findings into clinical practice to optimize child outcomes from brain injury and chronic illness.

COPC is honored to have her as a speaker at the annual training of COPC's section of Neuropsychology with her talk entitled "Neuropsychological Rehabilitation for childhood brain injury, and relative focused e-health intervention as a way to Maximize Rehabilitation outcomes training activity on daily activities" that will be held online on May 7th at 9am (Central European Summer Time - Barcelona). Before the appointment we have interviewed her to know more about her work and experience into some topics she will talk about during her presentation.

• Is neuropsychology recognized in Australia as a health specialty such as neurology, psychiatry or pediatrics? Which training is necessary to become a neuropsychologist? And if it is considered a specialty, is there a differentiated recognition for pediatric or child neuropsychology?

Yes it is. Training is a 4 year degree (arts or science), a one year honours course, and a masters in clinical Neuropsychology (2 years – clinical placements, lectures, research thesis). After that to become registered requires an additional 2 years of supervised practice, which can be done while employed. There is no difference in training for adult versus child neuropsychology.

• One of the main therapeutic objectives is that patients gain maximum autonomy and get a reasonable quality of life. Which are the benefits of "telemedicine" in this regard?

This is a very new field for clinical practice, with telehealth being non-existent prior to COVID for clinicians. WE have been doing research developing and testing video-conferencing approaches to therapies for 5-6 years now and the benefits are: better access and less burden for families, more involvement of fathers. Challenges are – harder to gain rapport and read the non-verbal cues, not really appropriate for really severe clinical problems.

• Based on your experience and your teams, what advantages and disadvantages have you found in the intervention at home through "telemedicine"? advantages are listed above, but also its helpful to be able to observe the family context and interactions in their familiar environment. Some disadvantages especially for adolescents = difficult to ensure privacy; young kids are very hard to assess if they have attentional problems or disability. Technology problems

are also quite common and frustrating for all. Overall I think, for clinicians, telemed takes more time.

• What is the role of parents in your parent-focused interventions?

Many roles for parents, from modelling, through to assisting with parenting skills, through to supporting their mental health. Also, building partnerships between parents and clinicians is key to success.

• What are the main intervention components of your parent-focused programs?

Psycho-education, and then a variety of treatment modalities – CBT, ACT, Mindfulness.

• Do you think that an effective intervention can be delivered exclusively by parents?

No, but I think parents are important in following through with clinician guidance. Also, the knowledge that they gain through working with clinicians and their child is valuable to reduce anxiety and build competence.

• What other factors do you consider are essential in recovering from brain injury in childhood?

Gold standard acute care and early intervention (physical, speech), good communication with schools during reintegration and after.

• How can the society improve the quality of life of these children? Are there any known initiatives in Australia that you could share?

I don't think we do all that well, but multidisciplinary models and family centered care are key. Appropriate funding levels are useful as are reviews at key transition points (eg return to school, preschool to school entry)**.**

• Which role does the school play in childhood brain injuries in Australia or specifically in Melbourne (in case there is any remarkable particularity)?

School is critical, as is home, as we try very hard to return kids to their 'normal' environments as soon as possible. Getting back to friends and social interactions is also a key role of return to school.

• Throughout your career you have contributed to social awareness and scientific dissemination by writing more than 500 publications. How do you think we could deliver scientific evidence to better nurture the clinical practice of community public services?

Well, that is such an important question, which I've only really addressed in the latter part of my career. I think it's critical to work in partnership with clinicians and families to make sure the research we do is what they want and is feasible for implementation. I will talk about this in my lecture.