



GOVERNMENT OF  
WESTERN AUSTRALIA

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# Final Report – Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0 – 18 years in WA





## Acknowledgement of Country

Taskforce respectfully acknowledges Aboriginal and Torres Strait Islander peoples as the First Nations people of Australia – they are the Traditional Owners and Custodians of the lands, islands and water. Taskforce pays its respect to Aboriginal and Torres Strait Islander Elders past, present and future in maintaining Culture, Countries, Language and Law.

Taskforce celebrates the proud history of Aboriginal and Torres Strait Islander healers, including traditional and clinical healers, and their past, present, and future impact on the wellbeing of all peoples. Taskforce recognises the protective value of connection to family, Country, Culture, Language and Law on Aboriginal and Torres Strait Islander lives.

Taskforce also acknowledges the benefit of Aboriginal and Torres Strait Islander people and their shared wisdom on the wellbeing of all Western Australians. The contribution of Aboriginal and Torres Strait Islander people to our society – including through their care of environments, relationships, and social leadership – benefits all, contributing to improved wellbeing.

Taskforce would also like to acknowledge the invaluable contributions made by Aboriginal and Torres Strait Islander people to the insights and recommendations of this report. The expertise and knowledge of Aboriginal and Torres Strait Islander people with lived experienced, clinicians, community leaders and policymakers has been generous and profound.



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# 1. Lived experience foreword and acknowledgement

**In honour of Kate Savage and her family, whose courage and vulnerability has not only honoured the life of their daughter Kate, but has selflessly enabled the voices of lived experience to reform the future of ICA mental health, for the benefit of other children and their families in Western Australia (WA).**

**Taskforce would also like to honour those who have contributed their voices and acknowledge the courage that it takes for these people to share their most intimate and vulnerable experiences in the hope that others won't experience what they have.**

Every child and family have hopes and dreams for a future life full of promise. When mental ill-health appears, these aspirations can quickly turn into fear. Presenting the never-ending question of what the future will bring. Overnight, mental ill-health can present the dreaded question of whether there will be a future for that child at all. For those with lived experience, these questions never go away and ripple silently through their lives and the lives of their family.

It is at these times that our children, families and carers look to the public mental health system to understand, support and reassure them that recovery and a future is possible.

Taskforce has heard from those with lived experience that this has all too often not been the case. Rather, at a time when people are at their most vulnerable, depleted, frustrated, and often in crisis, they have faced the reality that getting help has meant negotiating a system fraught with rejections and handballs.

They have all spent endless hours making phone calls, learning a new vocabulary to try and meet eligibility for services and trying to present themselves in a manner where they will be responded to positively. They have done this whilst still managing their own, or their loved

one's ill-health alone at home on top of their own family and personal duties.

Taskforce consulted and heard from numerous children, families and carers who have a lived experience of mental ill-health.

Every person with lived experience has spoken of:

- Having to become resilient to a system that has failed them at different times.
- Other people with lived experience who are unable to advocate for change as they do not have the capacity, time, or ability to tell their painful stories.
- Special individuals, in a broken system, who listened to them, treated them with respect and dignity and partnered with them for short periods of time, and how this made an enormous difference to them in their recovery. Unfortunately, these experiences were despite of, rather than because of, the system.
- How much they welcomed the opportunity to connect with other people who had different, but similar, experiences.
- Being the ones most impacted by any changes. It is they who will continue to support themselves and their loved ones after government, ministers, staff and services have come and gone.
- A determination that others' experiences will be better than theirs.

Although people with lived experience have felt let down by the public system, they are resourceful, determined, and hopeful that in the future, the system will meaningfully include them. A partnership in which they are supported to dream again of a life worth living.

Taskforce is mindful that there are many more unheard voices of lived experience and believe that these voices need to be actively sought out and joined with others to shape the future system. A system that will focus on outcomes that reflect individual needs and assist them to live a life that enables them to enjoy all the

milestones afforded to others. A system that identifies the individuals and families that may be vulnerable to experiencing mental ill-health. A system that provides the opportunity for our children to live a safe life that has social connections and opportunities for education and development that will give them the best chance of a 'good life' as they reach adulthood.

The need for change is urgent. It requires a commitment that our future mental health system for children is innovative and responsive to needs. It is only through true collaboration of all involved that this change will occur. It requires a system that understands the importance of meaningfully partnering with other services – government and non-government, formal and informal, clinical and lived experience.

The dream of those with lived experience moving forward is that they will be heard, respected, and a meaningful partner in their own care. That a future system is shaped with their active involvement, responds to their needs, and in which they are treated with dignity, compassion and empathy.

Taskforce has set the example of how to meaningfully bring together lived experience, clinicians and service providers, particularly through the Expert Advisory Groups. It is imperative that future collaborations like this occur. Lived experience voices need to continue to be sought out and provided with the safety and support to contribute to shaping the future mental health system and services.

Taskforce members have demonstrated how this can occur, despite the tight timeframe and challenges in putting this report together. We would like to acknowledge and thank Taskforce for ensuring that lived experience voices were heard in the same manner as those of other stakeholders.

The ongoing involvement of people with lived experience is critical to the implementation of this report. It is they who have the most to gain and to lose with any changes to the future public specialist ICA mental health system.

From two people who have been there, our greatest hope is that the implementation of these recommendations will enable all children, families and carers in WA not only to survive, but to thrive.

**Georgia Anderson**

Consumer Lived Experience representative,  
ICA Taskforce

and

**Wendy Cream**

Family/carer lived experience representative,  
ICA Taskforce



Members of the Expert Advisory Groups (October 2021)

## 2. Chair's foreword

The Western Australian Government's decision to develop a system-wide approach to infant, child and adolescent (ICA) mental health across the state in response to the tragic experiences of the Savage family and the death of their daughter Kate, was the right one. As described in Taskforce' [Emerging Directions Report](#), the problems faced by the Savage family are sadly not uncommon – children, families and carers across WA struggling with mental ill-health concerns, face many difficulties or are unable to get the help they need, and too many experience the heartbreaking loss of a daughter, son, sibling, niece, nephew, cousin or friend. The formation of the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in Western Australia (Taskforce) signalled that it was time to act.

Taskforce has engaged extensively with children, families, carers and others with lived experience, as well as with the child and adolescent mental health workforce across WA. We have listened deeply and humbly. The consistent message we have heard from children, families and carers was that they did not want others to experience the fear, anger, or despair that they all too often experienced when they sought help. In the face of growing demand, inadequate resources and significant workforce shortages, clinicians have shared their experiences of being overwhelmed, being traumatised themselves, and their frustration that they cannot provide the care they trained for; the care they want to provide to children. Everyone is desperate to ensure that going forward children, families, carers, and the workforce are safe.

### **The evidence from children, families, carers and clinicians, data modelling and our research points to an ICA mental health system in crisis**

The Emerging Directions Report acknowledged that the increased incidence, complexity, and early onset of mental ill-health in children is not unique to WA and is evident across Australia and other developed countries. Regardless, the trends in WA and the impact on children, families, carers and clinicians are deeply troubling and the need to reform ICA mental health services is urgent.

The number of children attending an emergency department seeking urgent help for their mental health has grown drastically in recent years, and the number of children presenting to hospitals with the risk of, or sadly having died from, suicide has increased by 50 per cent over the last four years. It has been impossible for Taskforce to view the current situation as anything other than one that requires immediate and sustained action supported by significantly increased investment.

Approximately 14 per cent of 4–17-year-olds in WA experience a mental health issue, with prevalence being even higher for children in regional areas and from vulnerable communities. More and more children are experiencing a severity of mental ill-health that means they need to be referred to a specialist service – an increase of more than 70 per cent since 2014. But funding of these services has not kept up with this increase in demand. Today, although children make up almost 25 per cent of the WA population only eight per cent of all mental health funding goes to services for infants, children, and adolescents.

The consequence is that these services are much harder to access than they were ten years ago, with less than one in five children being accepted into treatment programs. Increasingly, services are, in effect, rationing care to treat older children and those with more severe symptoms and at a higher risk.

We have also found that the system struggles to meet the needs of some children more than it does others. This has created a system in which access and outcomes for children from various communities are inequitable. Children in regional and remote WA are more likely to attend an emergency department regarding a mental health condition, however, are less likely to receive community treatment when referred and even less likely to access Perth-based specialised services. Many groups of children including Aboriginal children, children from ethnoculturally and linguistically diverse backgrounds, LGBTQIA+ children, children with neurodevelopmental conditions, children in care, and children in contact with the justice system are missing out and do not receive the specialist care they need.

### **Children, families and carers are being harmed – waitlists and negative experiences are growing**

Taskforce has met with hundreds of children, parents, carers, clinicians, system leaders and other important voices. Generously, many Western Australians have contributed their expertise and experience through interviews, workshops, public forums, and submissions. While many have acknowledged the hard work, professionalism and compassion of clinicians, the overall picture that is painted by those we have listened to is that services are failing children in need.

We have heard children tell us they felt rejected, that their experience was one of cruelty. We have heard from families exhausted by trying to seek help for their children, often being so deeply affected that their own mental health has been impacted. We have heard from clinicians, exhausted and desperate that every day they face the tough choice to provide care for one child ahead of another.

Each Taskforce member has been profoundly impacted about the scale of the challenge and the risks of not addressing the issue. At the same time, we were heartened by the very strong alignment between families, clinicians and system leaders about what needs to be done and specific changes that will make the biggest difference.

### **WA is falling behind other jurisdictions in ensuring that its children, families and carers can access high-quality, safe, and responsive mental health care**

Governments across Australia, including WA, have recently made much needed and significant investments in youth and adult mental health services. Child mental health services, however, are a distinctly separate set of services often delivered by different health providers and clinicians. There is no flow down effect – funding of youth and adult services will not make a difference to our children.

The Commonwealth Government and some states, including New South Wales and Victoria, are leading the way with ICA mental health reform. The consequences of not taking immediate action in WA are substantial in both human and economic terms; last year the Productivity Commission showed the benefits of significant investment in mental health, particularly early in life, are indisputable. Although lagging behind now, the WA Government has the opportunity to become a leader in ICA mental health, working with the Commonwealth to invest in a vital program of reform.

### **A system wide ICA Mental Health Strategy is critical, ensuring that all children in WA have access to care and achieve optimal wellbeing**

Taskforce is proposing an ICA Mental Health Strategy and Roadmap, outlined in this report, to build a system wherein the mental health of all infants, children and adolescents is identified, supported, and treated early in life and early in illness. This will ensure that all WA children, families and carers have timely, enduring and equal access to integrated and high-quality public mental health care.

The ICA Mental Health Strategy and Roadmap aligns with existing WA policy commitments, and reflects the urgency, scale, and nature of change necessary to address the immediate ICA mental health crisis. It describes how to build a truly integrated system for children and families, who themselves will play a key role in shaping future services and evaluating progress towards its six aims:

- Optimal outcomes for children and families and carers
- Greater equity of access to service and outcomes

- More responsive services, providing the right care at the right time
- Fewer gaps between services including with our schools and youth detention
- Increased utilisation of expert resources and sustainability in services
- Ultimately, a humane experience for all children, families and carers who need care.

**The ICA Mental Health Strategy will transform the way in which services are provided, improve outcomes for children, families and carers, and improve system performance**

The ICA Mental Health Strategy and Roadmap presents how services are resourced, organised, and connected. When implemented it will achieve many changes, including:

- Existing metropolitan and country community mental health services will be expanded and reconfigured into regional multidisciplinary networks that support more younger children, children with less severe needs and children with complex needs.
- Specialist and statewide services will be more accessible to children, families and carers through greater distribution of expertise, particularly in regional and remote areas.
- Specific services for children with complex needs, including neurodevelopmental conditions, children in care, children in contact with the justice system, and others.
- The ability for each region to support children requiring urgent or intensive support without having to go to emergency departments.
- Greater support for children, families and carers as they transition to other services, as they complete their treatments, and as they move to youth or adult services.
- Better investment in and integration of services which support Aboriginal children, families and communities, including support to Aboriginal-led services.
- Greater collaboration with schools to assist in the early identification and response to mental health support for children, families and carers.

- Joint planning and funding with Commonwealth funded community programs and primary health care including the Commonwealth's proposals to reform headspace services and introduce Head to Health Kids services.

**Change must and can be achieved; however, it will take time and require a fully resourced program of reform**


Change will not happen overnight, but it must begin today. The ICA mental health system needs fundamental reform. Small changes to the current system will not address the issues identified; neither will simply adding more resources or piecemeal changes to services. Taskforce has defined a comprehensive set of recommendations and a sustainable plan to deliver the change needed. Assurance is needed that government is going to commit to oversee and fund the long term change needed.

Immediate investment to start to address critical gaps, drive system changes, and collaboratively design future services is needed. These proposed changes will need to be introduced at a time when demand is already very high, vacancy rates growing, and staff experiencing considerable pressure. Experience from previous reforms confirms the importance of investing in dedicated resources to provide the capability to successfully plan and implement significant reforms – in this case encompassing national, state and community. And to closely monitor its progress on both a programmatic and system wide basis.

We also need a clear plan for the future workforce we need and how we are going to build this workforce. Our recent experience with COVID-19 has shown us how fragile we are in WA, in overly relying on interstate staff and the importance of growing and providing developmental support for the local workforce. Contemporary workforce models, which maximise the impact of peer workers and Aboriginal mental health workers, need to be progressed that allow staff to work to their full scope of practice. Further, we must grow and strengthen ICA mental health leadership, and recognise the importance of ICA clinical expertise in decision-making roles. New roles need to be developed with the authority to lead decision-making, including executive roles in mental health nursing and allied health.

Clear accountabilities between the Mental Health





Commission (MHC), WA Primary Health Alliance (WAPHA), the Department of Health, WA's Health Service Providers and other key agencies will be key. These accountabilities need to be enhanced by monitoring implementation and publicly reporting progress; recognising the importance of broader government and community efforts to address the health and social determinants that will help improve mental health outcomes.

### **I want to thank many people**

My final thought is to thank all those who have generously shared their time, experience and expertise and provided critical advice on the way forward. My thanks to the members of Taskforce and the many staff from the MHC, WA Health, and other key organisations, including Treasury, Department of Education, Department of Communities and Department of Justice. So many people want to see the current situation change. I only hope our work does justice to their courage.

**Robyn Kruk AO**

### 3. A note on language and terminology

Language matters. Taskforce has learned through its work that using terms incorrectly can be re-traumatising and cause long-term harm. Equally, using the right words can help to heal, and show empathy, understanding and compassion. The intention of Taskforce has been to use language that is clear, safe, and inclusive. Where terms are used, the intention is not to judge or stigmatise any person or persons. Taskforce recognises that the language associated with infant, child and adolescent mental health is often contested. It is also continuously

evolving, as we learn more about the impact that words can have on different persons and communities.

Below is a list of terms that are used within this report and their intended meaning. A more expansive glossary and list of acronyms is provided in Appendix A Glossary. In some places, alternative terms to those listed below have been used. This has been the case if they have a specific meaning for the person or persons providing the information. For example, an individual that is quoted or a specific data source.

Term	Its intended meaning and use
0-17 year-olds	The scope of Taskforce relates to mental health services for infants, children and adolescents aged 0-18 years. In this report, we have used the term '0-17 year-olds' to refer to children from birth to their 18th birthday.
Aboriginal children and families	Children and families who have Aboriginal ancestry, identify as Aboriginal, and are accepted as such by the Aboriginal community. Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait colleagues and community.
Autistic child	A child who identifies and/or has a diagnosis of autism spectrum disorder. We note that for some, person-first language is preferred, such as 'child with autism' or 'child with autistic spectrum disorder'.
Carer	A person who provides care to another person, such as a child who is living with mental ill-health. They may have statutory responsibility for a child, be a family member who supports a child in their family or be another peer or community supporter.
Child/Children	Any person who is under the age of 18. This term is sometimes used to describe all infants, children and adolescents aged 0-17 years of age.
Children, family and carers	The term children, family and carers is sometimes used in this report and is inclusive of children, family, carers, supporters, and community members.
Child with disability	A child who lives with a physical and/or intellectual disability; a condition which impacts a person's mental, sensory, or mobility functions. Taskforce celebrates the abilities, talent, and potential of children with disability.
Child with neurodevelopmental or neuropsychiatric condition	A child who identifies and/or is diagnosed with a group of disorders that impact the development of the nervous system and brain. Taskforce recognises that some children identify as 'neurodivergent'.

Term	Its intended meaning and use
Children in care	Children who are in out-of-home-care, who do not reside with their family of origin and who's safety and wellbeing are the responsibility of the CEO of WA Government child protection services.
Children with complex, co-occurring, or specialised needs	A child who has multiple needs, including but not limited to co-occurring mental ill-health issues, neurological and physical health needs, needs associated with alcohol and other drug use, psychosocial needs, and needs associated with a social characteristic.
Children with contact with youth justice	Children who have had experiences of police, police orders, courts, youth (ages 10-17) justice services and/or youth detention.
Clinicians	Professionals engaged in the provision of mental health services, including but not limited to Aboriginal mental health workers, administrative staff, allied health workers, nurses, paediatricians, psychiatrists, psychologists, and others.
Co-design	The collaborative design and development of services alongside those with lived experience and clinicians.
Community mental health services	Services that are provided in a non-residential, community-based setting, including but not limited to community-based clinics, schools, homes, and other locations. They are sometimes described as being 'outpatient' services.
Community-managed services	Mental health and related health and human services provided by not-for-profit organisations, community organisations, Aboriginal community-controlled organisations and others.
Ethnoculturally and linguistically diverse (ELD) children and families	Children, families and carers who identify as being ethnically, culturally, and/or linguistically diverse. The use of this term is not intended to 'other', but to recognise unique needs. [Note: ELD is the preferred term used instead of CALD]
Family	A child's family of origin and/or their family of choice. It may include but not be limited to a child's immediate family, extended family, adoptive family, peers, and others that share an emotional bond and caregiving responsibilities.
Health service provider or HSP	Provider of state-funded health services, including Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, and WA Country Health Service.
ICA mental health system	The public specialist infant, child and adolescent mental health services. Namely, this relates to services funded and provided by the WA Government.
Lesbian, gay, bisexual, transgender, queer, intersex, and asexual or LGBTQIA+	Persons who identify as lesbian, gay, bisexual, transgender, queer, intersex, and asexual. It is understood that gender, sex, and sexuality are separate concepts.
Mental ill-health	This is a broad term that is used to include mental health issues, mental health needs, and mental ill-health. It relates to an experience of mental health issues impacting thinking, emotion, and social abilities, such as psychological distress, in addition to diagnoses of specific mental health disorders, such as depression and anxiety.
People with lived experience	A child or young person who is or has lived with the impacts of mental ill-health and a person who is or has provided care to a child who is living with mental ill-health.
Specialised services	Mental health services which target very specific mental health issues and/or groups of children, for example eating disorders services or gender diversity services.
Specialist services	Clinical services that relate specifically to mental ill-health and are funded by the WA Government. These are distinct from primary care services, such as GPs. Encompasses Community services and Specialised services.

## 4. Executive summary

### Purpose of Taskforce and report

**The Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18-years in Western Australia (Taskforce) was established to outline a whole of system plan for the public specialist infant, child and adolescent (ICA) mental health services in Western Australia (WA) to meet the mental health needs of children – from their day of birth to their 18th birthday (referred to as children aged 0-17).**

Led by an Independent Chair, Taskforce is a 10-member group including senior leaders and clinicians from the WA public health and mental health systems, and people with lived experience. Taskforce is accountable to the WA Ministers for Mental Health and Health. Taskforce has been supported by over 100 Expert Advisory Group (EAG) members, including people with lived experience, clinicians and service providers, and other system leaders.

Taskforce's findings, recommendations and plan have all been shaped by extensive engagement with stakeholders throughout WA. This has included interviews, focus groups, workshops, submissions, and other engagements with a broad range of important voices. Taskforce's work has also been shaped by deep research into current ICA mental health services and good practices, and robust analysis of current and future demand for ICA mental health services in WA.

### Why things have to change

Mental health is arguably the biggest challenge facing children, families, and carers in WA. Taskforce has found that current ICA mental health services are unable to meet increasingly high levels of need among children across the state. This has been the case for a prolonged period of time. More children are being referred to

community services; more children are being admitted to hospital for mental ill-health conditions; and more children are presenting to emergency departments when facing a crisis, including many that self-harm or seek to take their own lives. As services struggle to respond to growing demand, children, families, and carers are having increasingly negative experiences and some receive little or no care until they become severely unwell.

Vulnerable groups of children are not receiving equitable care and outcomes. Regional and remote children have higher rates of mental ill-health, yet disproportionately lower access to services. Aboriginal children face increasingly high-levels of vulnerability to mental ill-health, including high rates of suicide, but face many obstacles to accessing care. Children with complex needs, including those with neurodevelopmental or neuropsychiatric conditions, those in care, and those in contact with the justice system, struggle to access care. LGBTQIA+ children and children from ethnoculturally and linguistically diverse (ELD) backgrounds face unique risks and challenges receiving care.

Currently, due to resource constraints, ICA mental health services have narrowed their focus to meeting the needs of older children who have more severe symptoms and/or are higher risk, through increasingly episodic, fragmented and hospital-based treatment. Infants (aged 0-4) and younger children (aged 5-11) have limited, if any, access to services, while children with moderate mental ill-health needs are often told they are 'not unwell enough'. Meanwhile, primary health and other services do not have the capacity to meet the needs of children in the community and other services that play a critical role in a child's life (e.g. schools) are not supported to best help children with mental ill-health needs.

As the number of children seeking mental health services has risen over the years, growth in the funding of services has been minimal and has not kept up with demand. The workforce is under capacity, under stress, and does not have the capabilities, diversity and support

structures required to meet the needs of all children, families and carers safely and effectively. The scale and skill base of the workforce needs to grow and diversify significantly, but capacities to attract, support and retain clinicians are underdeveloped. In many instances, infrastructure is not appropriate for children, families and carers, and information and digital technology does not adequately support the information and care needs of children, families, carers and clinicians. Taskforce has concluded that services do not operate as a system – they work in siloes with little connection or collaboration, and without common governance, strategy, service models and resources.

### Key insights on the current system

- During 2014 and 2020, the number of referrals to community mental health treatment services have grown by 70.1 per cent.
- The acceptance rate of these referrals for metropolitan community mental health treatment services reduced from one in three in 2014 to only one in five in 2020.
- During 2014 and 2020, 75 per cent of acceptances for community mental health services in metropolitan Perth were for those aged 12–17-years.
- During 2014 and 2020 the number of inpatient admissions with a principal diagnosis of mental health have grown by 79.5 per cent.
- Every day in 2020, there was an average of 6.9 admissions of 0-17-year-olds to hospitals across WA with a principal diagnosis of mental health.
- During 2017 and 2020 there has been a 168 per cent increase in eating disorders admissions to CAHS inpatient units and a 200 per cent increase to WA Country Health Services (WACHS) hospitals.
- During 2014 and 2020 the number of attendances to Emergency Departments for a mental health reason have grown by 64.9 per cent.
- Every day in 2020, there was an average of 24.5 presentations by 0-17-year-olds to an Emergency Department across WA for a mental health reason.
- During 2017 and 2020, the number of admissions to an emergency department regarding a suicide attempt and suicide risk has increased by 50 per cent.
- During 2015 and 2019, 31 per cent of school pupils who accessed a specialist mental health service had an attendance rate below 60 per cent.
- During 2015 and 2019, one in five children who access mental health services also had contact with police, of whom 51 per cent were prosecuted.
- During 2009 and 2018, 60 per cent of children who died by suicide had been subject to a child protection report.

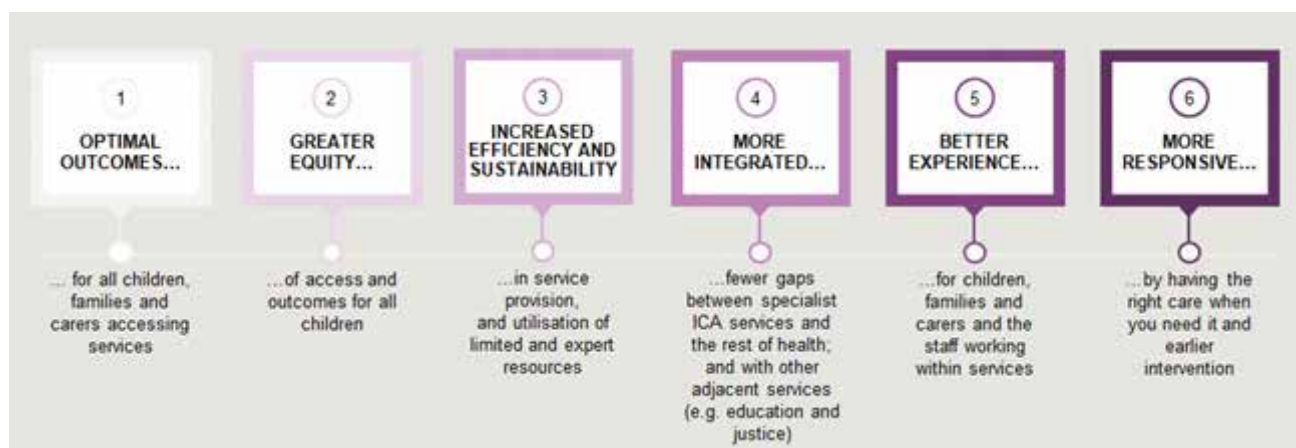


Figure 1: Six critical reform objectives

The Strategy describes what the future ICA mental health system should look like, how it needs to work, and how children, families and carers will be involved at each step of its planning, design, and delivery. The Strategy is comprised of three components, which are summarised below:

- a shared vision, purpose and principles to underpin the future system
- eight key actions and associated recommendations to drive implementation and enduring reform
- a plan to deliver reform and evaluate its outcomes.

## Shared vision, purpose and underlying principles

The vision of the future ICA mental health system is that **all children, families and carers are empowered to achieve and maintain their best possible mental health and wellbeing**. To achieve this, the purpose of the ICA mental health system **is to ensure that all children, families and carers in WA have timely, enduring and equal access to holistic, integrated and high-quality public mental health care**.

The future ICA mental health system will be underpinned by the principles that care will be: enduring, high-quality, holistic, timely, focused on prevention and early intervention, and integrated.

## The future ICA mental health system

The future ICA mental health system needs to look and work in a profoundly different way. New services will need to be collaboratively designed as part of a joined-up ICA mental health system that ensures that all children who require mental health care can access timely and quality care that is tailored to their needs, and available close to where they live. The future ICA mental health and wellbeing system will have five pillars, shown in Figure 2 and described below:

### Prevention and early intervention

will be elevated as a priority of the future system, building on existing national and WA government priorities. Across schools, early childhood services, and the broader community, the system needs to be able consistently identify signs of mental ill-health earlier in life, and provide targeted and immediate support

### Enhanced primary care

services need to be partners in care with specialist mental health services and will be enhanced to do more and work differently with children and families, driven by a closer partnership between the WA and Commonwealth Governments.

### Community ICAMHS

is the re-imagined and full-resourced evolution of current Community CAMHS services. Delivering state-wide through hub-and-spoke service delivery models, Community ICAMHS will be the 'engine-room' of the ICA mental health system, connecting and supporting local services that support children and families through new consultation liaison and shared care functions, and providing continuous, flexible, and assertive care for children throughout their childhood.

### Statewide services

are the reconfigured and enhanced specialised services. They are a radical transformation from current services. They will be re-designed to provide a stepped service model in partnership with Community ICAMHS teams across the State.

### Acute and intensive responses

will be provided in the community wherever safe and appropriate. Acute Care and Response Teams will be established in all Community ICAMHS Hubs across the State to provide mobile, highly-intensive, and timely care to children that are in a mental health crisis or who require intensive support.



Figure 2: The five pillars of the ICA mental health system

# Key actions to deliver reform

The Strategy defines eight key actions, which step out what needs to happen, and when, to reform the ICA mental health system, in order to realise the vision, purpose and principles. To deliver the eight key actions, Taskforce makes 32 recommendations to the WA Government.

<p><b>KEY ACTION 01</b></p> <p>Improving the experience and ensuring the involvement of children and families</p>	<p>1. Establish a 'service guarantee' that defines what all children, families and carers should expect to experience in all interactions with the ICA mental health system</p>	<p>2. Ensure that children, families and carers and others with lived experience are meaningfully involved in all aspects of the ICA mental health system</p>	
<p><b>KEY ACTION 02</b></p> <p>Creating an integrated and person centered ICA mental health system</p>	<p>3. Strengthen the multi-agency focus on prevention and intervention early in life and early in illness</p>	<p>4. Address the gap between primary care services and the specialist mental health system</p>	<p>5. Align all specialist community services into regional 'hub and spoke' networks that can deliver more care locally</p>
	<p>6. Integrate the ICA mental health system with services that support Aboriginal children, families, and communities</p>	<p>7. Establish integrated pathways and supported transitions for children moving between ICA services, and youth and/or adult mental health services</p>	<p>8. Address barriers to service integration</p>
<p><b>KEY ACTION 03</b></p> <p>Collaboratively developing new models of care for all parts of the specialist ICA mental health system</p>	<p>9. Establish an assertive and flexible model of care for Community Infant, Child and Adolescent Mental Health Services (Community ICAMHS)</p>	<p>10. Reconfigure the state-wide models of care for all new and existing specialised services to ensure they are accessible for all children</p>	
	<p>11. Establish new services to address critical gaps within the current range of specialised services</p>	<p>12. Establish Acute Care and Response Teams within Community ICAMHS Hubs in metropolitan, rural and remote WA</p>	<p>13. Establish an ICA-specific model of care for mental health emergency department presentations, and safe places in the community</p>

**Figure 3:** Key actions of the ICA Mental Health Strategy



**KEY ACTION 04**

Collaborating with other government and community services to ensure that they can appropriately support children and families

**14.** Ensure that there is an integrated, multi-agency care coordination process to support children, families and carers with complex and co-occurring needs in place

**15.** Support schools to increase their capability to address mental health and wellbeing in schools

**16.** Support vulnerable and at-risk children and families who are in contact with the police and justice system

**17.** Support the Department of Communities to meet the mental health needs of vulnerable and at-risk children in care

**KEY ACTION 05**

Investing in the capability and wellbeing of the ICA mental health workforce

**18.** Implement training and development opportunities that maximise and grow the capabilities of the ICA mental health workforce

**19.** Establish clear roles, capabilities, and career pathways for peer workers

**20.** Establish clear roles, capabilities, and career pathways for Aboriginal mental health workers

**21.** Increase the overall capability of the ICA mental health workforce to appropriately support the diversity of all children across WA

**22.** Ensure that staff feel safe, supported and connected across the ICA mental health system

**KEY ACTION 06**

Growing and sustaining the capacity of the ICA mental health workforce to better meet needs

**23.** Invest immediately in the core capacity of the workforce, especially for services in regional and remote WA

**24.** Grow and sustain the pipeline of the ICA workforce to meet needs

**25.** Increase the capacity and diversity of the ICA mental health workforce

**KEY ACTION 07**

Deploying ICA mental health services with contemporary infrastructure, technology and research

**26.** Expand the function and availability of virtual care across the ICA mental health system

**27.** Establish new integrated ICA mental health facilities in all regions to support more flexible, responsive and expert care

**28.** Update digital systems, technology, and data to better support the delivery and quality of ICA mental health services

**29.** Establish dedicated structures for research, learning and innovation that translate to improved and sustain outcomes

**KEY ACTION 08**

Driving the sustained performance of the ICA mental health system through governance and leadership

**30.** Establish clear accountabilities and transparent governance arrangements for the ICA mental health system

**31.** Establish a data- and outcomes-driven approach to system-wide planning and commissioning of the ICA mental health system

**32.** Strengthen the oversight and public reporting of clinical quality and safety in ICA mental health

## **Immediate and long-term investment in the workforce**

Addressing the critical gaps within current services, and meeting the needs of children, families and carers requires significant investment, both in the immediate and long-term.

In the immediate term, there are some issues that need attention now. This includes targeting specific workforce issues, such as the disparity between the frontline workforce in regional and remote WA compared with metropolitan Perth, and lack of Aboriginal mental health workers and peer workers. It also recognises there are some specific service issues that need attention, including – but not limited to – the recent and significant increase in children with complex issues, including eating disorders, and delays for children being ‘stuck’ in emergency departments whilst awaiting access to a service. The set of immediate priorities identified by Taskforce are below.

### WORKFORCE CAPACITY

- Establish increases to staff currently being recruited by CAHS
- Increase WACHS workforce to address disparities
- Invest in more peer workers, Aboriginal mental health workers, cross-cultural experts; and resources in the CAHS Refugee Health Service
- Develop an ICA mental health workforce plan
- Foster and leverage partnerships with universities and TAFEs
- Establish workforce models that includes executive-level mental health nursing roles
- Pilot National Human Services Workforce Framework for the ACCO Sector
- Assess opportunities to improve workforce efficiency

### WORKFORCE CAPABILITY

- Dedicated ICA mental health expertise in the WACHS Command Centre
- Establish dedicated consultation liaison positions within Community ICAMHS for ACCHOs and AMSs
- Ensure all HSPs include INSPIRE ELD training within Mandatory Training packages
- Collaboratively design and implement a peer workforce model and an Aboriginal workforce model
- Establish a dedicated ICA mental health workforce development function
- Undertake a training needs analysis
- Undertake a literature review to identify actions, initiatives and models to support staff wellbeing

### REDEVELOP SERVICES

- Collaboratively design a 'service guarantee' for what services should provide for those with lived experience
- Undertake dedicated collaborative design processes with Aboriginal peoples and communities
- Expand CAMHS Crisis Connect and WACHS MH ETS to support those waiting to access services, as an interim measure
- Identify opportunities to increase capacity of ACCHO and AMS-provided mental health and social and emotional wellbeing services
- Collaboratively redesign the model for Community ICAMHS, including Acute Care and Response Teams
- Collaboratively design new models for; infants; children with intellectual disability and/or neurodevelopmental or neuropsychiatric conditions; children with early psychosis and children with complex trauma
- Collaboratively design new models for Head-to-Health Kids and enhanced headspace and child safe places
- Collaboratively design updated models for EDS; Touchstone; and Pathways

### WIDER COLLABORATION

- Collaboratively design collaboration models to define how Community ICAMHS will work with schools and child protection services
- Develop and implement an ICA forensic mental health model of care, in line with the election commitment
- Further develop model of care at Banksia Hill Detention Centre, including an uplift to its mental health workforce
- Work with Graylands Reconfiguration and Forensics Taskforce to identify need for adolescent forensic beds
- Broaden eligibility criteria of all public specialist ICA mental health services
- Increase capacity of MHC funded programs and supports providing prevention, early intervention and postvention support to schools

### GOVERNANCE

- Implement system and implementation governance structures
- Ensure that ICA mental health system reform is a standing item on proposed Directors General Health and Human Services Group's agenda
- Clarify and articulate role of System Manager
- Establish joint ICA mental health leadership models in CAHS and WACHS
- Align ICA mental health commissioning model with forthcoming National Mental Health and Suicide Prevention Agreement and State Commissioning Strategy
- Collaboratively design outcomes and outcome measures for a system performance monitoring framework

### INFRASTRUCTURE

- Prepare strategic asset plans and associated business cases to meet infrastructure needs
- Prepare, publish and communicate guidance to increase information sharing between ICA mental health services
- Integrate community mental health (prioritising ICA mental health services) into scope of Stage 1 of Electronic Medical Record through implementation of the WA Health Digital Strategy

In the long-term, the ICA mental health system will require an expanded and enhanced workforce, resources, and infrastructure to effectively address needs and proposed changes to models of care. Taskforce undertook significant modelling work to understand the scale of future investment required, and the potential return on investment. This modelling identified that the current level of unmet need among children in WA is substantial and to address this gap will require a significant increase to the current workforce. This is an urgent priority, but the workforce needed does not currently exist. A key feature of Taskforce's implementation Roadmap is to establish a sustainable workforce pipeline that will build on the existing skills of the current workforce to develop the additional frontline staff needed to support new models of care over the next five to ten years.

While the expenditure needed for reform is substantial, the costs of no reform are likely to be higher. The way the ICA mental health system currently operates is unsustainable and the cost of mental ill-health for this age group is substantial and will continue to rise.

Without reform and investment over the next five years, the current ICA mental health crisis will worsen, and more children, families and carers will be left without care. More children will attend emergency departments in crisis, more children will require admission to hospital, fewer children will access the care they need in the community, and more children's lives will be at risk. This report highlights that there are humanitarian, health and economic benefits to investing in an enhanced future ICA mental health system.

As highlighted by the Productivity Commission, there is a strong case for investing in child mental health, including reduced progression of ill-health, life-long benefits throughout a child's lifetime and longer-term cost offsets for government. Evidence from longitudinal studies have shown high returns on investment, extending beyond improved mental health outcomes, to improved health, social, education, employment and economic outcomes over time. Economic analysis undertaken by Taskforce shows that the net benefits of reform are positive.

## Investing in implementation

For the Strategy to be successful, implementation needs to be well-planned and resourced. Given the scale and complexity of the reforms, a phased approach to implementation should be taken. There is a need to provide immediate targeted support, as above, but in parallel, work needs to start on collaboratively designing new models for ICA mental health services with those with lived experience and clinicians, and building the system's capability and capacity – in relation to workforce, infrastructure, technology, and research. Implementation needs to also be effectively governed, be appropriately resourced, and meaningfully involve clinicians and people with lived experience.

Realising the ambitions set out in the Strategy requires changes to be made to monitoring, reporting and evaluation arrangements. There needs to be a major shift in how system performance is monitored and reported on – greater focus on the outcomes which matter most to those who use, work in, commission and fund, and oversee and regulate the system is required. Moving forward, evaluation must be embedded into the 'core business' of the system.

## Recent government developments

Concurrent with the work of Taskforce, the WA Government has made a wide range of commitments or initiated actions to further meet the needs of children, young people, families and carers. A number of these commitments are outlined in Appendix H.

## 5. The background and purpose of Taskforce

In late 2020, the Chief Psychiatrist reviewed the care of Kate Savage, a 13-year-old who tragically died while under the care of the Child and Adolescent Health Service (CAHS). The review recommended that a taskforce be formed to rebuild specialist public child and adolescent mental health services across WA. In early 2021, the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents in Western Australia was launched by the then Minister for Mental Health and Health.

The purpose of Taskforce is to articulate a vision for public specialist ICA mental health services across WA. Specifically, Taskforce's objective is to develop a whole of system plan for the WA Government funded (i.e. public) specialist ICA mental health services in both metropolitan and country areas. Its aim is to provide recommended actions to achieving better mental health outcomes for children aged 0 to 17 years of age in WA that are practical and sustainable.

Taskforce is led by an independent chair, together with nine system leaders, clinician experts and lived experience experts, and is accountable to the Minister for Mental Health and the Minister for Health.

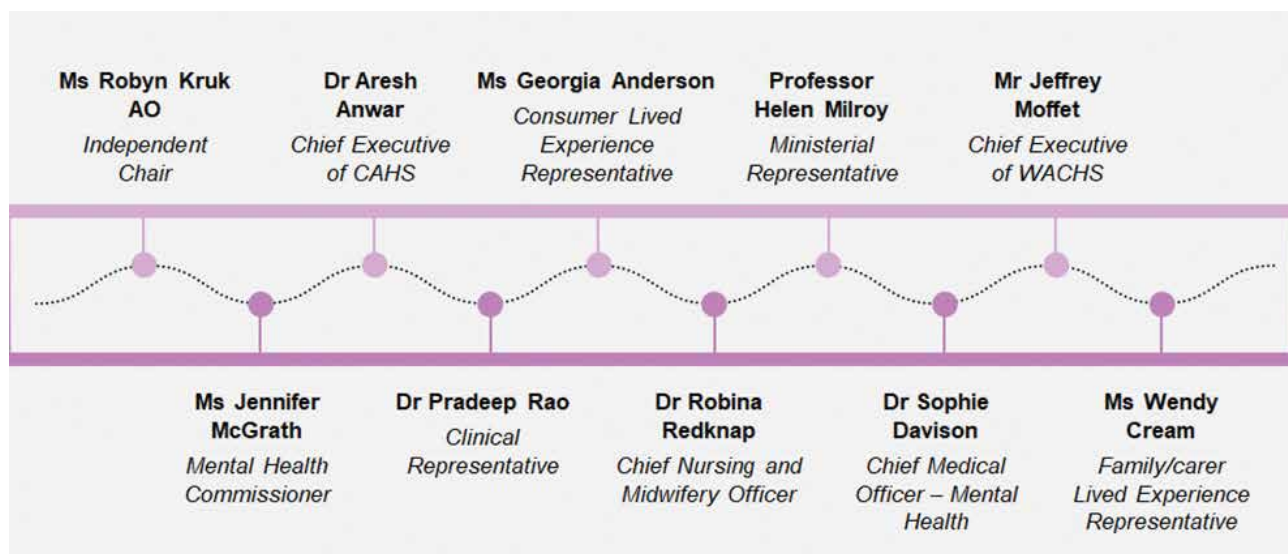


Figure 4: Taskforce members

Taskforce was supported by three EAG's – lived experience, clinical and interagency EAG. The lived experience EAG included 28 members, including children, families and carers from diverse backgrounds. The clinical EAG included 36 members from the public, private, academic, and other sectors. The interagency EAG included 46 members from government, non-government and Aboriginal community-controlled organisations.

The findings, recommendations and plan have all been shaped by broad engagement with stakeholders throughout WA. This included consultation with stakeholders to validate and enhance the findings of the [Emerging Directions Report](#), and interviews, workshops, submissions, and other engagements with a very broad range of voices. Overall, Taskforce has heard from approximately one thousand children, families, carers, members of the community, clinicians, and service providers from across all regions of WA.

*See the appendices for a summary of stakeholder consultation and engagement.*

Taskforce has also conducted a review of over 120 contemporary reports relevant to ICA mental health in WA and Australia; and has investigated national and global good practices of ICA mental health care to understand the key principles and specific models of care that are most appropriate to address the needs of children, families and carers in WA. Taskforce has also undertaken a wide range of data analysis (see summary in Appendix C - An overview of the public specialist ICA mental health system), needs-based modelling and economic modelling, guided by the National Mental Health Service Planning Framework (see Section 17).<sup>1</sup>

## The objectives and scope of this report

The purpose of this report is to describe Taskforce's vision for the future ICA mental health system. Specifically, this report seeks to achieve the following objectives:

- Outline the case for change (Section 6), based on the findings of Taskforce developed through research, analysis and consultation.
- Articulate a way forward, including a future vision, purpose, principles and strategy of the future system and the experiences of children, families and carers (Section 7).
- Outline a series of actions for change, including specific recommendations to guide implementation of future services (Key actions 1-8).
- Outline a strategic method of implementation (Section 16)
- Propose an approach to outcomes-focused monitoring and evaluation (Section 18).

The report is the product of work conducted by Taskforce during February to November 2021.

## Limitations

The scope of this report has some important limitations: it does not assess the performance, efficacy, and outcomes of specific services; it does not recommend specific clinical interventions; it does not provide comprehensive recommendations regarding youth and adult services; it does not provide specific recommendations regarding the private and community sector mental health services, including Commonwealth funded services.

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<sup>1</sup> The needs based modelling utilises the National Mental Health Service Planning Framework (NMHSPF) - an integrated planning tool that estimates the resources required to deliver the optimal mix of mental health services to a population.

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## 6. Why things have to change

### **Mental health is arguably the biggest challenge facing children, families and carers across WA**

Half of all adults with enduring mental health issues had these issues develop during childhood and adolescence<sup>2</sup>. Collectively, mental ill-health and substance use disorders cause the largest disease burden (of all ill-health) for young people in WA; with approximately 14 per cent of children aged 4-17 experiencing mental health issues of some form or another.

Whilst the majority of these are mild cases of mental ill-health, which can be addressed without requiring specialist mental health treatment, in 2020 over 14,000 0-18-year-olds across WA had some form of contact with a specialist mental health service. This is approximately 2.3 per cent of all 0-18-year-olds in WA and increasing at a rate much higher than the population is growing.

Not only is this having a significant impact on the health and wellbeing of every child and family involved, it is also having a long-term impact on other aspects of society. Children whose mental ill-health requires specialist treatment are disproportionately more likely to have contact with the Police and are much more likely to be less engaged at school. It is clear that there is an immediate need to act to improve child mental health across WA.

### **Current ICA mental health services are failing to meet increasingly high-levels of demand across the state – more and more children cannot access or are being excluded from the care and treatment they need**

*Current public specialist ICA mental health services (see Appendix C).*

An overview of the public specialist ICA mental health system) across the state are failing to meet the mental health needs of WA's children, families, carers, and communities. Although this is not a phenomenon unique to WA, with many governments struggling to respond to growing mental health needs of children, the trend over several years in WA signals a 'system' that is unsustainable and is not meeting the care and treatment needs of children, families and carers across WA.

Since 2014, the population of children aged 0-17 has risen by 5.5 per cent, but during that same period:

- attendances to emergency departments for a mental health condition have risen by 64.9 per cent
- admissions to hospital for mental health have risen by 79.5 per cent
- referrals to community mental health treatment services have risen by 70.1 per cent.

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**“Over ten years, the number of children seeking mental health services has doubled. In a few years it could double again.”**

- Clinician

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<sup>2</sup> The World Health Organisation has determined that 50% of adults with an enduring mental health issue had issues prior to the age of 14.

The capacity of ICA mental health services has not kept up with growth in demand or complexity. This has led to services prioritising children in crisis and those with the most severe needs; and deprioritising those with less severe needs. This also means infants aged 0-3 years of age and children aged 4-11 years of age have been less likely to have access to treatment to address early and emerging issues. However, as their needs are unmet, the severity of their symptoms and scale of risk grows as they become older. In effect, we are trapped in a vicious cycle of not meeting the needs today ultimately creating greater demands into the future.

This is particularly concerning, given the potential impact of COVID-19 on future ICA mental health in WA. While the increase in demand for mental health services precedes COVID-19 and its impact, global, national, and local trends indicate a future surge in mental ill-health issues for children, including a greater prevalence of anxiety, depression, and eating disorders. Even predating COVID-19, eating disorder admissions across WA have increased significantly between 2017-18 and 2020-21.<sup>3</sup>

The majority of mental health support and treatment for children should be provided by community treatment teams. Children should only be in hospital as a last resort, but the main issue with lack of capacity is the ability for community treatment teams to meet the growing demands placed upon them. This has made it much harder for children to access the right care at the right time:

- In 2014, in Perth, about one in three 0–17-year-olds who were referred for community treatment were accepted into a treatment program.
- In 2020, in Perth, about one in five 0-17-year-olds who were referred for community treatment were accepted into a treatment program.

The impact on children is that they feel that they are being 'rejected' from care. They have been told they are too unwell to be supported by their GP (or a service such as *headspace*) only to be then told by specialist services that they are 'not unwell enough' or their needs are 'too complex'. Often this happens after months of waiting for treatment they have been told they need. Further,

where children have received care, many have faced experiences of feeling dismissed or unsupported, often fearing that they will be transferred to unfamiliar and often unavailable services; or discharged from a service before they are ready. Many children feel unheard, unseen, and unsafe when they seek help from services.

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**“After almost 18 months of trying to get help for my son, I was diagnosed with depression and put on medication. The whole experience has changed me, I used to be a completely different person.”**

– Parent

For many parents, carers and supporters, the challenges of seeking help for a child is overwhelming. In some cases, families and carers feel powerlessness to help their child. The experience of seeking help from multiple services, navigating a complex system, and experiencing long wait lists, coupled with the impact on their child's mental ill-health and distress takes a toll on the wellbeing of parents and carers, and, in some instances, the cohesion of families. Overwhelmingly, families, careers and supporters feel that they carry the burden of a system that has failed them.

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**“The system feels cruel to me. We are turned away when we are most in need. It's just cruel.”**

– Young person with lived experience

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<sup>3</sup> Taskforce analysis using unpublished data provided by WACHS; although note that this data includes hospital admissions for those under 20 year-olds.



## Increasingly, children have more complex needs and are at a higher risk of harming themselves

More children are seeking support in a crisis than 10 years ago but struggle to access the care they need. The number of children that have attended an emergency department for a mental health reason has increased by almost 50 per cent since 2014. Children, families and carers report that emergency departments are not child-friendly, trauma responsive or sufficiently accessible for seeking support during a crisis. Currently there are no alternatives to emergency departments for ICA mental health crises.

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**“You are told you are not sick enough – so what options do you have? I have hurt myself to get help.”**

– Child

The inability of services to meet the needs of children is contributing to more children seeking to hurt themselves, or worse. The number of times in which a child has presented to an emergency department regarding a suicide attempt or at risk of suicide has increased by 50 per cent over just the past three years. Many fear this trend will worsen. The loss of life of children who die by suicide has a permanent impact on their families, carers, community and our society. Taskforce has heard from many young people that they resorted to harming themselves just so they could get access to treatment.

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**“In effect, the system operates worse for some than it does for others – you get a different service depending on who you are and where you are.”**

– System leader

## Access to care is not the same for all children – vulnerable groups of children are missing out from receiving equitable care and outcomes

While access is challenging for all children, there are specific groups that face additional obstacles to equitable care. This relates to a number of barriers to accessing care, including service geography, workforce capability, culture, stigma and models of care; specifically:

- **Regional and remote children, families and carers** have disproportionately lower access to generalist and specialist services, particularly in remote and very remote locations. In effect, there are three tiers of service access in WA: metropolitan, regional, and remote.
- **Aboriginal children, families and communities** face disproportionately high levels of vulnerability to mental ill-health, however, have lower access to care and have limited access to culturally-safe services.
- **Children from ethnoculturally and linguistically diverse communities** face unique obstacles to accessing culturally-safe care, including community stigma, and limited cultural capability of services.
- **LGBTQIA+ children** are at greater risk of mental health issues due to their experiences of discrimination, exclusion, and stigma.
- **Children with co-occurring neurodevelopmental or neuropsychiatric conditions** and mental health issues struggle to access public ICA mental health services and in some cases are excluded by current service eligibility criteria – and often have to seek private treatment as a last resort and at great expense.
- **Children in out of home care** often have very complex mental health needs and often face unique barriers to accessing care – and almost 40 per cent of children who have had some form of contact with child protection services are accessing specialist mental health treatment.
- **Children in contact with the youth justice system**, including those within youth detention, often experience limited or disrupted mental health care.

## **The workforce is under capacity and under stress, and has been for a number of years**

The ICA mental health workforce does not have the capacity to meet the needs of children in WA. As the demand for mental health services and complexity of need has risen, the increase in the number or diversity of front-line staff treating children has not increased at the same rate. Modelling commissioned by Taskforce, to look at the gap between current service capacity and the capacity required to meet the needs of children across WA, has identified a significant gap in the current capacity of the workforce.

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**“We have some amazing staff – but they are exhausted, feel unsafe and we are losing them from the service – at a time when we need them the most.”**

– Service leader

This is not solely a question of funding, in its current form the pipeline for new front-line staff will not be sufficient to meet the current and predicted future mental health needs of children in WA. Therefore, the current deficit will require both sustained funding increases over several years, as well as the creation of a sustainable new workforce pipeline.

Of equal concern is the wellbeing of the workforce. Taskforce has heard from staff across WA who all tell the same story. That of a workforce constantly under pressure, having to ration care and with no respite in sight. Many are leaving the service or scaling back their hours.

At a time when front line health workers across all health services are reporting similar issues, it is important to note that these issues predate COVID-19 and should not be seen as a short-term or recent issue.

## **There is no organised ICA mental health ‘system’ – ICA mental health services, policy and resources are not centrally governed and primarily operate as standalone services**

ICA mental health services are not organised as a coordinated health system. For children, families and carers, the system is experienced as discrete services lacking cohesion and coordination at population and individual level. Consequently, children, families and carers struggle to find and access the services that they require, and experience transitions between services as abrupt and often premature. Ultimately, this limits the effectiveness and efficiency of services and outcomes for children.

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**“What system? I stopped referring children to other services because almost every time they were turned away.”**

– Clinician

There is no dedicated ICA mental health system oversight, and ICA mental health services are overshadowed by the pressures on the health system, and greater focus on adult mental health and youth mental health services. Where governance structures do exist for services, they typically lack sufficient clinical and/or lived expertise. Similarly, mechanisms to drive performance and accountability are not established across the system, and support for research has been negligible. As such, the system has no ability to monitor and adjust to population needs through investment, legislative, policy or other reform.

All aspects of the current system are experiencing increasing demand, however, system leaders across multiple sectors are not working together to address current and future mental health needs. Specialist treatment services are not connected to GPs or community services so there is a lack of continuity of care. Schools require additional support, resources and

expertise to proactively address the mental health needs of children and limited connection with specialist mental health expertise. Community-managed and Aboriginal community-controlled services faced increased demand, are under supported and are not at the scale required to reach enough children. Child protection, justice and mental health services, do not work closely together to provide care to vulnerable children with mental health needs.

An integrated system needs to bring together state, Commonwealth and community-managed services to ensure better outcomes and the efficient use of human and financial resources.

### **Despite a history of reviews, change has been limited, resulting in children, families, carers communities and services losing confidence in future reform**

Many calls for systemwide reform in WA have been made by policymakers, service providers and, most importantly, children, families and carers throughout the past decade. Changes recommended have not been resourced or implemented at the scale required and many of the issues found in past reports are consistent with those presented in this report. What Taskforce is saying here is not new.

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### **“The mental health needs of children and young people have not been afforded sufficient priority and there is an urgent need for reform.”**

- Inquiry into the mental health and wellbeing of children and young people in Western Australia (2011)

Children, families, carers, communities, clinicians and service providers have expressed fear that the reforms outlined by Taskforce in this document will be delayed and, even then, will be watered down and under-resourced. Limited investment in reform, including in

the change process itself, is considered by many as the biggest barrier to achieving better outcomes. The full scale of change required will need to bring together state and Commonwealth governments, and broader community sector, requiring significant planning, cultural and behavioural change at a time when the system is under significant pressure.

### **Other governments are driving reforms in ICA mental health – WA is falling behind**

Commonwealth, state and territory governments are increasingly recognising the underinvestment in ICA mental health, and taking action to address it. In October 2021, the National Mental Health Commission published the National Children’s Mental Health and Wellbeing Strategy, [National Children’s Mental Health and Wellbeing Strategy](#), which aims to help ensure that Australia has a nationally consistent mental health and wellbeing system in place to support all children, and their communities to thrive. At a state and territory level, Victoria and New South Wales have announced significant investments. For example, the Victorian Government has recently committed \$842 million to child, adolescent and youth mental health.

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### **“We can’t blame this on COVID – this crisis has been developing for years. Now it may get worse.”**

- System leader

The Australian Government has committed \$2.3 billion over four years to mental health across Australia, some of which will contribute to future ICA mental health services, such as enhancements to headspace and the piloting of Head to Health Kids centres for 0-12-year-olds.

Although the WA Government has recently made several welcome commitments that will benefit young adults aged 16-24-years of age, the impact of these commitments will be negligible for children – youth mental health services and ICA mental health services operate in distinctly separate service systems. Children require specific expertise, models of care, environments, and other capabilities.

## The benefits in investing in ICA mental health are significant and tangible – there is an economic and sustainability imperative to invest more, particularly, earlier in life and the onset of ill-health

In WA, the estimated economic cost of mental ill-health and suicide is between \$4–\$7 billion and the cost of disability and premature death to those with mental ill-health is approximately \$16 billion per year.<sup>4</sup> The life path for children is changed dramatically if mental ill-health onsets during their formative years. It impacts education, employment, social and health outcomes throughout life and shortens life expectancy significantly.<sup>5</sup>

The benefits of immediate action to change the life path of children with mental ill-health are considerable. It will mean less adult mental ill-health, less drug use and incarceration, better education and employment outcomes, better support for parents, a reduction in intergenerational trauma, fewer children in out of home care, and a greater capacity for children to be contributing community members throughout their lifetime.

Investing in the early years is also the most cost-effective and sustainable strategy to promote optimal mental health.<sup>6</sup> Major reform of the capacity and capability of ICA mental health services will have a long-term positive economic impact by improving outcomes and reducing the need for long-term intensive health care and other support services.

## The consequences of doing nothing will amplify pressure on the health system and push more children, families and carers to crisis and loss

If significant reform is not achieved over the next five years, the current crisis is expected to worsen, with more children left without mental health care, retention of existing staff becoming more challenging, and acute health services placed under additional performance and financial pressure. Based on trends from recent years, it is predicted that a failure to reform services may result in:

- **Increased presentations of children in crisis to emergency departments:** ED presentations could increase from ~9,000 per year in 2020 to ~14,700 in 2026.
- Increased admissions of children to hospital meaning new beds will be required: Admissions could increase from ~2,500 a year in 2020 to ~4,500 a year in 2026.
- **More children experiencing suicidal ideation and self-harming:** Presentations to EDs associated with a risk of suicide could increase from ~3,000 in 2020 to 8,000 in 2026.
- **Less likely that children referred for community treatment will be accepted for treatment:** Referrals could increase from ~16,000 a year in 2020 to ~27,700 a year in 2026, of which only around one in seven will be accepted (currently this is one in five).
- An increased number of children requiring support within schools, youth justice and child protection. More children could experience low school attendance and have contact with Police.

<sup>4</sup> Applying the WA population share to national estimated costs by the Productivity Commission 2020, Mental health, report no. 95, Canberra.

<sup>5</sup> Firth J, et al. The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. *Lancet Psychiatry*. 2019 Aug;6(8):675-712. doi: 10.1016/S2215-0366(19)30132-4. Epub 2019 Jul 16. PMID: 31324560.

<sup>6</sup> McDaid, D. (2011). Making the long-term economic case for investing in mental health to contribute to sustainability from a health, public sector and societal.

## 7. A way forward for ICA mental health

### A Strategy for enduring reform

This report provides a strategy to reform WA's **ICA mental health system – the ICA Mental Health Strategy (the Strategy)**. The Strategy describes what the future system should look like, how it needs to work, and how children, families and carers will be involved at each step of its planning, design, and delivery.

The Strategy reflects the aspirations of children, their families and carers, young people, and the dedicated staff that work tirelessly with children, families and carers – for a system that works better and does more for all children, families and carers across our state. The Strategy is comprised of three primary components:

- a shared **vision, purpose** and principles that underpin the future ICA mental health system
- eight **key actions** and associated **recommendations** to drive enduring reform
- an implementation plan to deliver reform and evaluate its outcomes.

### A vision for the future ICA system

The future system needs to ensure that all children experiencing mental ill-health are identified, supported, and treated as soon as possible – so that all children are empowered to live mentally healthier lives. Working alongside people with lived experience, clinicians, and system leaders Taskforce has defined a shared vision, purpose, and principles to guide the planning, design and implementation of a future ICA mental health system for children, families and carers across WA (see next page).

Through this vision, children, families, carers, clinicians, and the community have every reason to be optimistic about the direction that has been set for the ICA mental health system. There is, however, a significant amount of work ahead to achieve this ambition. It will require considerable investment, and the collective effort and will of those responsible for leading the system, those that work in the system, and those that the system aims to support.

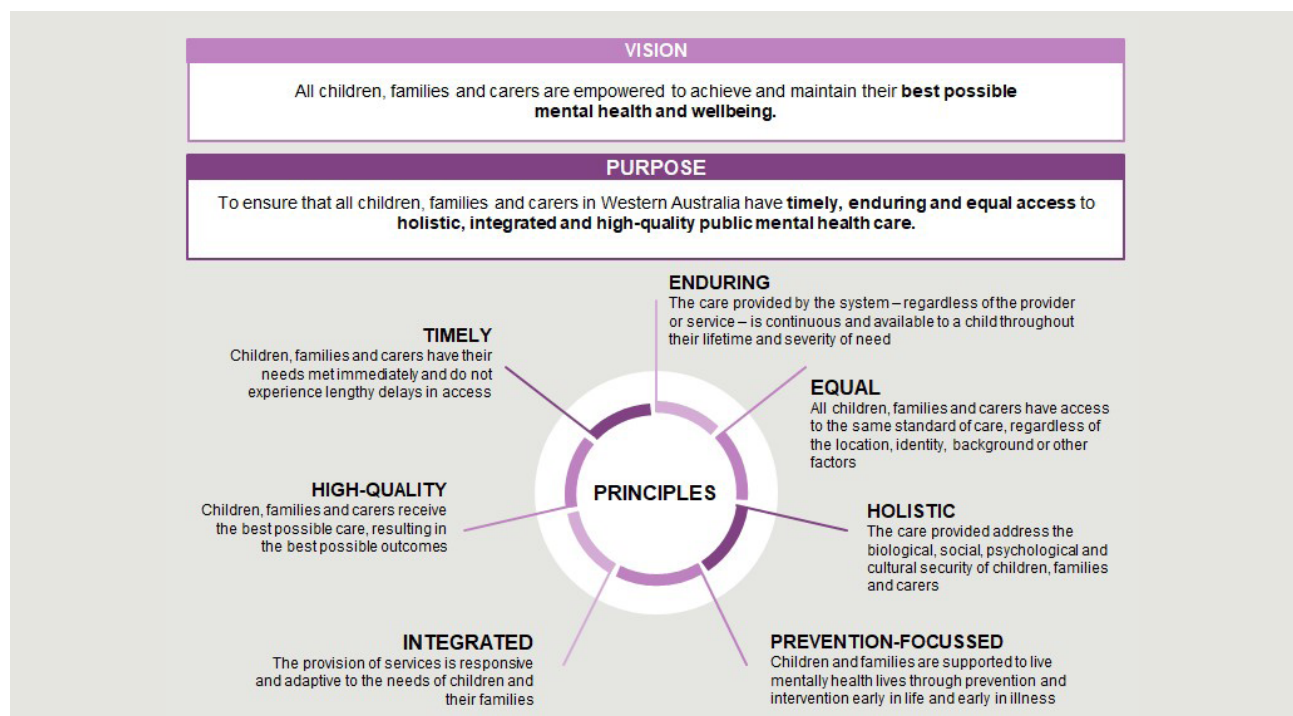


Figure 5: The vision, purpose and principles for the future ICA mental health system

## Reform objectives

The Strategy calls for a staged and practical transformation of the entire ICA mental health system, including important interfaces with other national, state and community services. The way that services support children, families and carers and the way that they work together must fundamentally change to meet the aspirations that underpin the shared vision. Key actions

and recommendations made in this report are oriented toward achieving the vision for the future system, so that all children, families and carers across WA can have timely, enduring, and equal access to holistic, integrated, and high-quality public mental healthcare.

The Strategy has been developed to achieve six **reform objectives**. These are set out in Figure 6 and expanded on after.

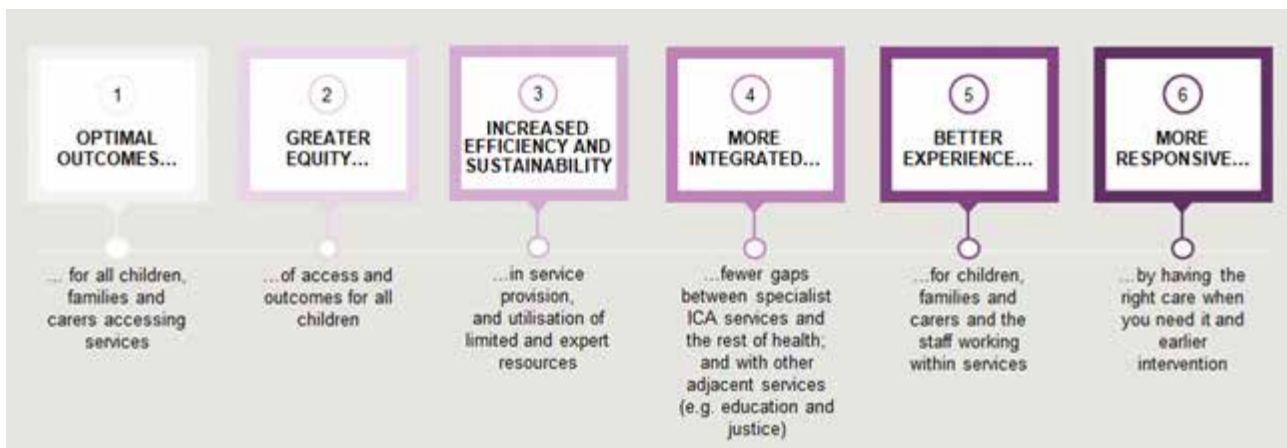


Figure 6: Reform objectives of the ICA Mental Health Strategy

The objectives of future reform should focus on those actions that achieve:

- Optimal outcomes – children, families and carers will experience better mental health outcomes, including improved safety and wellbeing.
- Greater equity – children, families and carers will be able to access suitable and high-quality care and treatment regardless of where they live, their identity, cultural background, or their age.
- Increased efficiency and sustainability – The workforce will have increased capacity, capability and diversity and will adapt and be empowered to maximise the reach and impact of its expertise.
- More integrated – children, families and carers will experience wrap-around, holistic, and integrated care, regardless of which service they first access, and where they live.
- Better experience – children, families and carers and loved ones, and the staff that provide care, will experience a safe, compassionate, and trauma-responsive system
- More responsive – Children will be able to access care early in life, and earlier in ill-health, and will receive help the first time they seek out support.

## The future ICA mental health system

Although some of the components of the future system exist today, the future ICA mental health system needs to look and work in a profoundly different way. New services will need to be collaboratively designed as part of a joined-up ICA mental health system that ensures that all children who require mental health care can access timely, quality care that is tailored to their needs, and available close to where they live. Existing

services will also progressively need to demonstrate their responsiveness to needs of children, families and carers and alignment with best practice.

The future ICA mental health system is not complex. Rather it seeks to ensure that integration and collaboration are a primary function and accountability of all services.

The five pillars of the future ICA mental health system are shown in Figure 7, and described below.

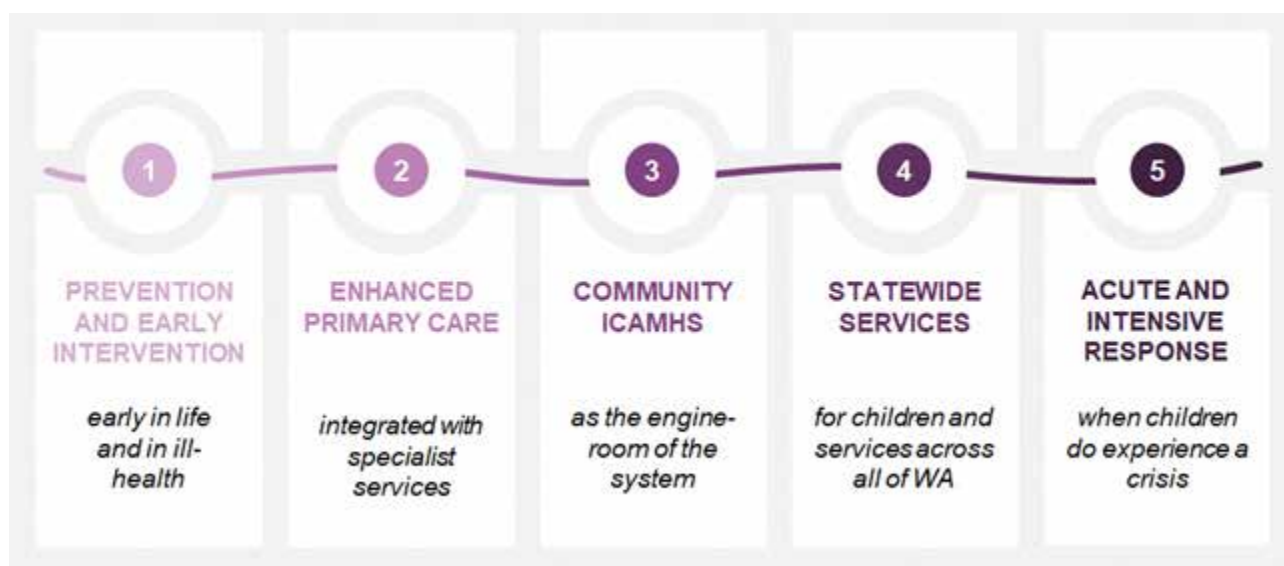


Figure 7: The five pillars of the ICA mental health system

### Prevention and early intervention

Prevention and early intervention will be elevated as a priority of the future system, building on existing national and WA government priorities. Across schools, early childhood services, and the broader community, the system needs to be consistently able to identify signs of mental ill-health earlier in life, and provide targeted and immediate support. The system needs a considerable boost to the provision of education and support to assist parents with supporting their child's mental health, and fostering family wellbeing. It will also work with children from a young age to build life skills and resilience, significantly expanding the role of early childhood services and schools in supporting the mental health and wellbeing of children in their care.

### Enhanced primary care

The Strategy outlines a vision shared with the Commonwealth for a considerably enhanced primary mental health sector. In the future system, primary mental health services need to be partners in care with specialist ICA mental health services and will be enhanced to do more and work differently with children, families and carers. This will require effective state and Commonwealth partnership. Head-to-Health Kids centres and headspace centres will be safe and welcoming 'front-doors' to the ICA mental health system for children. They need to be equipped to do more, and support children with more complexity, and acuity. They need to work in partnership with local GPs, who themselves need to be trained and supported to provide more support, coordination and treatment for children, families and carers, and participate in more shared and joint care approaches. Finally, the system needs to have a stronger community-managed and

Aboriginal-controlled sector, one that is equipped with the capacity and partnerships to provide culturally safe and responsive care to children and families in their communities.

## **Community Infant, Child, and Adolescent Mental Health Service (ICAMHS)**

The Strategy details the high-level design of a new model of community mental health services for children, families and carers – or Community Infant, Child, and Adolescent Mental Health Service (Community ICAMHS). Community ICAMHS are a re-imagined and fully-resourced evolution of the current Community CAMHS services – delivered by CAHS and WACHS to provide local, consistent, and integrated care across the state.

Each Community ICAMHS needs to have a 'hub' located in a regional centre, linked to existing and new local clinics working across each region, delivering care close to home for children, families and carers. The model of care for Community ICAMHS represents a wholesale change. They need to become the 'engine-room' of the ICA mental health system, connecting and supporting local services that support children, families and carers through new consultation liaison and shared care functions. They need to be reconfigured to deliver three new core functions. Each of these functions need to be provided by the local clinics, which need to be based in, and be part of their local communities, with responsibility for providing care closer to people's homes, and in remote communities:

- A consultation liaison and shared care function, providing care in partnership with primary mental health services, child development services, school-based mental health services, and other services that support children with mental ill-health.
- A continuous, flexible, and recovery-oriented approach to that would see children remain in the care of ICAMHS throughout their childhood, as long as is necessary, and with an assertive care philosophy for children that are 'harder to reach'.
- Significantly enhanced capability to support children with complex, co-occurring, and specialised needs, including for example, children with intellectual disabilities and/or neurodevelopmental or neuropsychiatric conditions, children with co-occurring

alcohol and drug issues, and children with complex personality, behavioural or conduct disorders.

Current 'eligibility criteria' need to be replaced with a more flexible solution – and child-focussed approach to responding to the needs of a child, identifying the care that is needed, and working in partnership with other services to provide that care.

Integral to Community ICAMHS, is each regional 'Hub'. These hubs need to be integrated facilities that provide a one-stop-shop for children, families and carers needing mental health care. Each Hub will have:

- A single entry point to support children, families and carers to access and navigate the ICA mental health system in their community; supported by virtual services that can provide a 24/7 response to children, families and carers.
- Child and family friendly hours and ways of providing services, including partnerships to create all hours support options that can be accessed in a range of ways.
- Co-location with services that support the local population such as GPs, headspace, Head-to-Health Kids, child development services, early childhood services, and child protection, etc.
- Acute Care and Response Teams (see below).
- Clinicians with skills in complex and specialised fields, including for example, cross-cultural mental health workers, dual-skilled mental health and alcohol and other drug (AOD) workers, and specialists in eating disorders, personality disorders, and complex neurodevelopmental or neuropsychiatric conditions.

Hubs and local clinics need to work as 'one' integrated and holistic service, and be responsible for leading, not just participating, in the integration of the ICA mental health system.

## **Statewide services**

Statewide services are the reconfigured and enhanced specialised services that are currently Perth-based; such as the eating disorder and gender diversity services. These services need to radically change to support more children, families and carers across the state in different ways. This can be achieved by progressively



implementing a stepped service model for all new and existing statewide services.

Statewide services need to work with Community ICAMHS teams to deliver stepped service models, where children can seamlessly 'step up' or 'step down' along a care pathway based on their needs. This care pathway includes, from least intensive to most intensive care:

- care in a Community ICAMHS clinic
- care in a Community ICAMHS clinic with consultation liaison support provided by the statewide service
- shared care between the Community ICAMHS and the statewide service
- intensive support in a statewide service as a last resort.

The stepped model of service can ensure that statewide services can reach and support more children than they have before, including regional and remote children, becoming centres of knowledge and expertise in their respective specialised fields.

In addition to the existing specialised services, the Strategy outlines a case to establish new statewide services where there are identified gaps in the current system.

### **Acute and intensive response**

In addition to the strong focus on community interventions, the future ICA mental health system needs to still have the capability to provide safe and intensive responses to children in crisis. The system needs to have a new dedicated response for children in a mental ill-health crisis, or who require highly-intensive support – Acute Care and Response Teams. These teams will provide mobile, highly-intensive, and timely care to children that are in a mental ill-health crisis or who require intensive support. Children, families and carers in need of this care need to be able to access it when they need it, and be supported at home, in school, in a community setting, or in a hospital setting, as appropriate.

The system needs to respond very differently to children presenting to emergency departments. Children need to receive care that is immediate, delivered in safer, calmer,

and more child-friendly environments. They also need to receive ongoing care once they leave emergency departments.

Children need to have the option of attending a 'child safe place'. These can be new environments, located near emergency departments, that provide an option for respite, assessment, low-intensity treatment, therapeutic counselling, and follow-up support for children who do not need an emergency department, but who need a 'safe haven' to go to.

### **A new experience for children, families and carers**

Children, families and carers need to have a very different experience when seeking help from the future ICA mental health system. When a child, their family and/or their carers first seek help, the system needs to come together to respond with a safe, timely and wrap-around response. Each child and their family need to be supported to make informed choices about their own care and how it is provided.

The response to the needs of children, families and carers – including treatment, support, transitions and more – needs to be tailored to the unique needs of each child and family; with the intensity of the response increasing or decreasing based upon the changing needs of each child; with sustained support throughout childhood if required.

Below are examples of a different, better experience for children, families and carers in the ICA mental health system, driven by need and outcomes. These are the experiences that Taskforce believe should be the outcomes that all children, families and carers should expect. They are based upon the 'model' for the future ICA mental health system described above, and briefly summarise how it is envisaged that the system needs to work in practice, using five examples of consumer experiences.<sup>7</sup>

These examples reflect the aspirations of the Strategy and assume the implementation of all recommendations, achieved through a staged program of reform. The intention of these examples is to be aspirational, and show the future system working as intended.

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<sup>7</sup> Taskforce has not undertaken a detailed journey mapping exercise to develop these examples. These examples are intended to be illustrative, and to show how the new system should function for children and families in different contexts.

## A child with a complex neurodevelopmental condition is experiencing suicidal ideation, and has presented to an emergency department in a metropolitan hospital

The child and their carer go to the **local emergency department**, which is in a metropolitan hospital. They are immediately identified as experiencing a mental health crisis.

1

The child and their carer are brought to a **separate low-stimulation space** for immediate assessment and treatment from a trained child and adolescent mental health nurse. They are listened to and believed, treated respectfully and compassionately, and supported to develop a safety plan that draws on family, peer and clinical supports.

2

The child and their carer are supported to leave the emergency department, and are immediately put in touch with the **Acute Care and Response Team** at the local Community ICAMHS.

3

The Acute Care and Response Team visits the child and their carer **at home** to conduct an **initial assessment**. The child does not have to repeat unnecessary elements of their story. The Acute Care and Response Team believes that support is required from the **statewide neurodevelopmental or neuropsychiatric condition service**. A safety plan is developed and regular review times are agreed with the child and their family.

4

Over the next few months, the child receives **shared care** from the Acute Care and Response Team, and the statewide neurodevelopmental or neuropsychiatric condition service.

5

During this time, the **child's carer** is provided with information on how to manage concerns at home, the details of someone that they can contact if their situation changes, and referrals to **support and wellbeing services**.

6

As the child's mental health improves, they begin to receive support from their **local Community ICAMHS**. This support endures for the remainder of their childhood, increasing and decreasing in intensity, based on their needs.

7

## A child in a small regional town is experiencing intense emotional feelings, facing conflict within their relationships, and has started engaging in self-harm and substance use to help them to cope

During an **interagency meeting**, a school representative raises concerns about the child. It is agreed that a **Community ICAMHS clinician** would work with the school to reach out to the child's family.

1

The family is aware of Community ICAMHS through a recent program of community-led prevention activities. The child and their family consent to attending sessions with their **local Community ICAMHS**.

2

The local Community ICAMHS team conducts an **initial session** with the child at a **recreation centre**. The child is identified as having the early signs and symptoms of a **personality disorder**.

3

After consulting with the child and their family, a clinician from **Touchstone**, a statewide service, is asked to join the next session with the child via telehealth. A **more comprehensive assessment** is undertaken.

4

A decision is made that the child will be **jointly cared for** by a team from their local Community ICAMHS, with Touchstone clinicians joining sessions via telehealth and periodic face-to-face appointments.

5

The shared care arrangement continues for **nine months**, with the joint team providing structured therapy and treatment for the child and their family, including in their home, which is telehealth-enabled.

6

7

As the child's mental health improves, they **'step down'** to being primarily supported by their local Community ICAMHS, with less frequent support from Touchstone.

## A child is in secondary school, and their teacher notices that they have lost interest in participating in class and extracurricular activities

A teacher in a secondary school notices that one of their students has **lost interest** in participating in class and extracurricular activities. The teacher is also aware that the child's family is experiencing some **social and financial challenges**, including housing distress.

1

The teacher supports the student to begin seeing the **school psychologist** regularly. Overtime, the student's mental health appears to worsen, so the school psychologist seeks support from the **liaison clinician** at the **local Community ICAMHS**.

2

After a number of joint sessions, a decision is made, in partnership with the child and their family, that their care will be **transitioned** to the **local Community ICAMHS**.

3

The child is supported by a **multi-disciplinary team**, including peer workers, from the local Community ICAMHS. The child and their family is supported intensively over a **12-month period**, including sessions in the evening and on weekends, so that the child's parents can participate.

4

5

The child's family is connected with **local organisations** that can help to address their **priority areas of need**, particularly those which impact their child's wellbeing.

6

As the child's mental health improves, they are supported to return to seeing the **school psychologist**.

7

The school psychologist works with the child, their family and teachers to develop a **long-term education plan** to support the child's mental health and wellbeing, along with their attendance and attainment.

## A three-year-old infant, who shows signs of intense emotional distress, and their parents are supported at home

Following the recent birth of their baby, parents are visited at home by a **local child health nurse** for a routine check-up.

1

The child health nurse notices that the baby's sibling, aged three, is showing **signs of intense emotional distress**. It is revealed that the child has been experiencing challenges when leaving to attend childcare, and when interacting with other children.

2

During their next visit, the child health nurse is accompanied by their colleague from the **local Community ICAMHS**, who has qualifications in infant mental health. Together, they identify that the young child is experiencing **emotional dysregulation and attachment difficulties**.

3

It is agreed with the young child's parents that the **local Community ICAMHS** would provide ongoing support and treatment to the child and their parents. This treatment endures for **more than 12 months**. It is mostly provided in their home, on weekends, so that the parents can be present.

4

5

A local Community ICAMHS clinician observes **one parent** feeling increasingly distressed, and connects both of the young child's parents with **parenting support programs and counselling services**.

The young child's mental health begins to improve, and they experience **less distress** when leaving to attend childcare and **improved relationships** with other children.

6

7

Over the next 12 months, the local Community ICAMHS **progressively decreases** the intensity of the support provided to the child and their family, until the child no longer requires support.

## Key Actions to deliver reform

The Strategy has eight **Key Actions**, and 32 **associated recommendations to guide implementation of the vision**. Each Key Action is a critical piece of the reform needed for the ICA mental health system and are summarised in Figure 8 below.

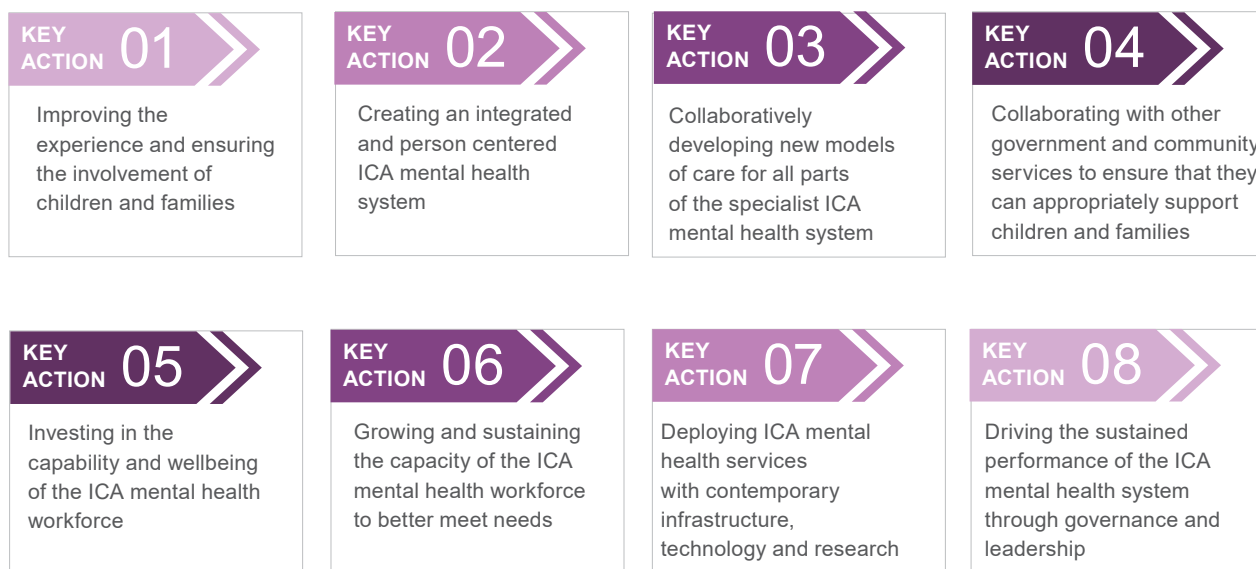


Figure 8: Eight Key Actions of reform

## A Roadmap for reform

The reforms required are wide-ranging. Realising their full extent and impact that these reforms will have on children, families and carers will take several years. The Strategy aims to deliver the full set of reforms in a staged manner over five years. However, it is expected that attracting and developing the capacity of the workforce to its required levels may take longer. This is recognised and reflected in the Strategy's implementation Roadmap.

An implementation Roadmap is outlined in Section 16, which sets out how the eight Key Actions can be achieved. This Roadmap envisages a reform that with six areas of focus:

- growing and sustaining the **capacity** of the workforce
- building and maintaining the **capability** and **wellbeing** of the workforce
- transforming **services** across the full continuum of care
- **collaborating** with government and community services from other systems
- strengthening **governance**, leadership, and oversight over the system
- enhancing the **infrastructure and technology** underpinning the system.

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## 8. Key Action 1: Improving the experience and increasing the involvement of children, families and carers

### What is it?

Key Action 1 represents a commitment to improving the experience and increasing the involvement of children, families and carers. This signals a decisive shift in the role of children, families and carers within the public specialist ICA mental health system – away from ‘top down’ and ‘do to you’ practices of system design and service delivery, towards a system based on genuine partnership between services and those they serve. Children, families, and carers must have a strong voice that drives the direction of the future system. They need a seat ‘at the table’ across all levels of system leadership and service delivery, including governance bodies. The successful reform of the ICA mental health system and better outcomes will be achieved if it is undertaken in partnership with children, families and carers.

### Why is it important?

The ICA mental health system has not been sufficiently responsive to, nor embracing of the diverse and powerful voices of people with lived experience; oftentimes, complaints are relied on as an indicator of poor experiences and outcomes, rather than guides to ongoing improvements. Collaboratively designing and delivering systems and services with people with lived experience leads to better health and wellbeing outcomes, aids service users’ recovery, and achieves better experiences for service users and providers.<sup>8</sup> The future system needs to ensure that children, families and carers feel listened to, as partners in their care, and where their experience and feedback directly contributes to the way services are monitored, reported and improved.

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**“It feels like parents aren’t listened to, when we’re the ones taking care of our children most of the time and know what’s going on. It’s so frustrating.”**

– Family member or carer

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<sup>8</sup> National Mental Health Commission, Sit beside me, not above me: Supporting safe and effective engagement and participation of people with lived experience, 2018.

## Recommendations for Key Action 1

Key action 1	Recommendation 1
Improving the experience and increasing the involvement of children, families and carers	Establish a 'service guarantee' that defines what all children, families and carers should expect to experience in all interactions with the ICA mental health system

The future ICA mental health system needs to ensure that all children, families and carers – regardless of where they live or who they are – have a universal experience. A 'service guarantee' similar to the National Disability Insurance Scheme (NDIS) Participant Service Guarantee (outlined in Case Study 1) supported by public reporting will establish a set of minimum expectations for what all services and providers need to meet, and what children, families and carers should expect from the ICA mental health system. Children, families, carers, and others with lived experience have developed a draft 'service guarantee' that proposes six high-level expectations for the future system, depicted in Figure 9.

Further work is required to collaboratively develop a more detailed 'service guarantee' with those with lived experience and clinicians. All services will progressively need to reflect this guarantee, as well as the cultural needs of all children, including Aboriginal, ethnoculturally and linguistically diverse, and LGBTQIA+ children; and be available in all metropolitan, regional and remote areas. Once established, the 'service guarantee' needs to be embedded into all aspects of the future ICA mental health system, including: the models of care underpinning all services, job descriptions, performance agreements, service agreements, monitoring and evaluation frameworks, and professional development and training. This will be an important driver of cultural change.

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**“We’re not being listened to by clinicians. They don’t trust that we understand our disability or mental illness.”**

- Family member or carer





Figure 9: The future experience of children, families and carers of ICA mental health services

## Case Study 1 | NDIS Participant Service Guarantee

### NDIS PARTICIPANT SERVICE GUARANTEE

#### AUSTRALIA-WIDE

##### Description

The NDIS Participant Service Guarantee details clear timeframes for key NDIS processes.<sup>9</sup> The NDIA must then make decisions about access, plan approvals, plan reviews and nominee changes within the specified timeframes. This gives participants, families and carers greater certainty regarding the processes involved and expected timeframes.

The Participant Service Guarantee is part of the NDIS Services charter which aims to ensure services are transparent, responsive, respectful, empowering and connected.

The details of the Participant Service Guarantee will be set out in the new Participant Service Guarantee Rule. The new rule will:

- set the timeframes for key NDIS processes, including access decisions, plan approvals, plan reviews and amendments
- set engagement principles, describing how the NDIA works with people with disability
- set requirements for how NIDA reports its performance against the Participant Service Guarantee.

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<sup>9</sup> National Disability Insurance Agency, 2021, Participant Service Guarantee, accessed 23 November 2021, available from: <<https://www.ndis.gov.au/about-us/policies/service-charter/participant-service-guarantee>>.

Key action 1	Recommendation 2
Improving the experience and increasing the involvement of children, families and carers	Ensure that children, families and carers and others with lived experience are meaningfully involved in all aspects of the ICA mental health system.

Children, families and carers should be provided with opportunities for co-production, in line with the MHC's *Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-25 (Engagement Framework 2018-25)*, and recognised best practice. This means that they need to be equal partners in the planning, design, delivery and evaluation of activities, programs, services and supports in ICA mental health system, see Figure 10

**“It would be better to have support from people that have lived it – they know what you’re going through, they’ve been there.”**

- Young person

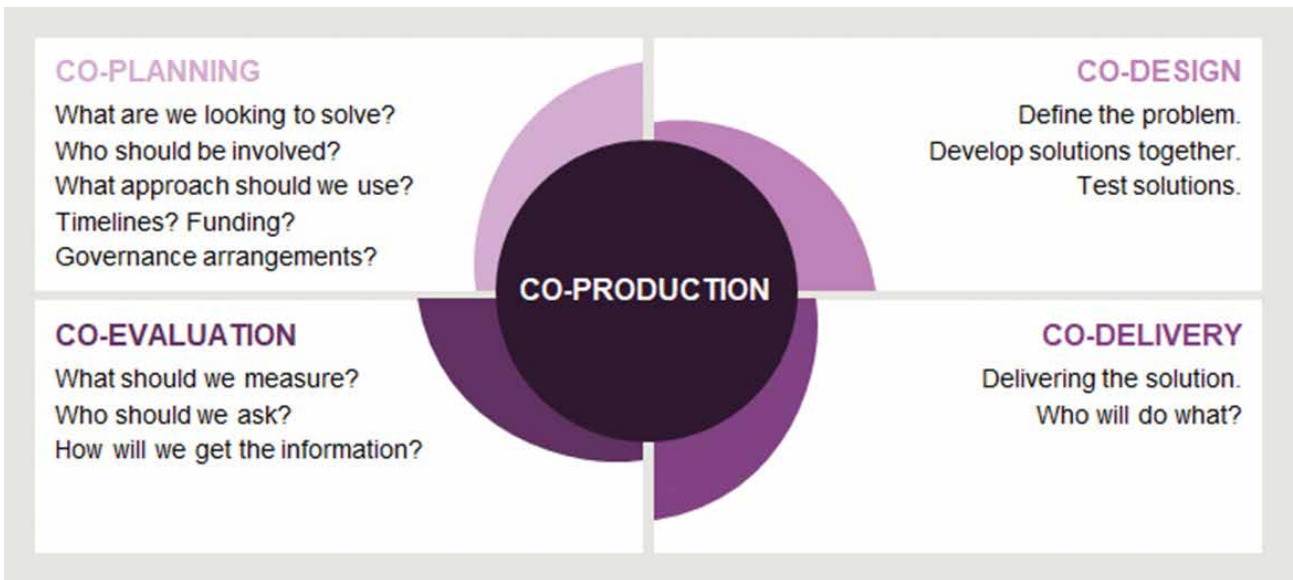


Figure 10: Four aspects of co-production<sup>10</sup>

<sup>10</sup> Cath Roper, Flick Grey and Emma Cadogan, *Co-Production: Putting Principles into Practice in Mental Health Contexts*, 2018, p. 2.

Meaningful involvement should occur across the ICA mental health system, from individuals being partners in their own care, all the way through to systemic reform.

- **Individual involvement:** Studies have shown a strong link between involving consumers in their care, and improved consumer experiences and outcomes.<sup>11</sup> Children, families and carers need to be at the centre of the care that they receive, and shared decision making about their treatment. They also need to have ample opportunity to provide feedback on their care, including complaints and this feedback needs to be used to inform future service planning, design and delivery.
- **Service involvement:** Children, families, carers and others with lived experience are involved in planning, designing and evaluating services; this ensures that services address their needs. They also need to be involved in the delivery of services through participation in consumer advisory committees or the peer workforce.
- **System involvement:** Children, families, carers and others with lived experience need to be involved in system leadership and governance. This would include playing a role in monitoring, evaluation and research activities, as well as system level reforms.

The greatest impact of this recommendation will rest on deliberate effort to expand the opportunity and access for children, families and carers to participate in co-development activities. This needs to be considered essential in future funding of services; including identifying new and innovative ways to engage with children, families and carers that may not have historically engaged through 'traditional' mechanisms for participation, such as Expressions of Interest. Further support for the capability building of lived experience experts to partner in co-production activities is also needed.

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<sup>11</sup> Australian Commission on Safety and Quality in Healthcare, Patient-centred care: Improving quality and safety through partnerships with patients and consumers, 2011.

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## 9. Key Action 2: Creating an integrated and child-centred ICA mental health system

### What is it?

Key Action 2 presents the need to achieve an integrated and child-centred system, where the needs of children, families and carers are met safely and responsively, close to home. When this is working well, collaboration and partnerships become 'business as usual'. The system works coherently, in partnership with other services and systems. This includes Aboriginal community-controlled organisations, early childhood services and schools, and a range of other government and community service providers.

The aim is to ensure that children, families and carers can access the care they need, when they need it, tailored to their unique health, cultural and personal needs, and this is only achieved when those parts of the system work together. Achieving this will require collective effort from the WA and Commonwealth Governments, and community-managed services, working alongside children, families and carers.

### Why is it important?

Public specialist ICA mental health services in WA do not work as a coherent and unified system. This has led to existing constraints and gaps in the system appearing even larger, with more children, families and carers receiving care that does not meet their needs, or not receiving care at all. They are also being left to navigate the system themselves, with many bouncing from service to service, attempting to find help.

Further, the way the system is structured is failing the ICA mental health workforce, who are under immense pressure to support more and more children, with increasingly severe and complex needs, in an environment which is characterised by high staff turnover rates and low morale. The future system needs to support children, families and carers, whoever they are, and wherever they live, to have equitable access to supports, throughout their journey, including transition between services, and while on waitlists.

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**“Services do not speak to each other or work together enough. They have different criteria, requirements and pathways – it’s so fragmented.”**

– Family member or carer

## Recommendations for Key Action 2

Key action 2	Recommendation 3
Creating an integrated and child-centred ICA mental health system	Strengthen the multi-agency focus on <b>prevention and intervention early in life and early in ill-health</b>

Investing in prevention and early intervention has been identified as a priority in intergovernmental health agreements, numerous plans, policies, reports and strategies, dating back to the National Mental Health Policy published in 1992 and the First National Mental Health Plan published in 1993. More recently, the National Children’s Mental Health and Wellbeing Strategy made prevention and early intervention a critical focus. There are four areas where the WA and Commonwealth Government need to strengthen their focus and investment:

- **Screening and early identification:** Mental health screening is key to preventing mental ill-health, and intervening earlier in life and earlier in ill-health. Mental health screening should be undertaken during the perinatal period (expectant and new parents), as well as at children’s developmental health check points between 0-5-years of age (0-14 days, eight weeks, four months, 12 months, two-years and the School Entry Health Assessment).

- **School based prevention programs:** There are a number of evidence-based prevention programs being delivered in schools across WA, including the Response to Suicide and Self Harm in Schools Program (Schools Response) and Aussie Optimism, among others. There needs to be an increase in the capacity of MHC-funded programs and services that provide prevention and early intervention support to schools (see Recommendation 15).
- **Awareness and mental health literacy:** Awareness of mental health and wellbeing more generally has risen over the last decade, it remains particularly low in some communities where mental health can be associated with stigma, including ELD communities. A campaign to raise awareness of and literacy in ICA mental health needs to be developed and rolled out across WA.

### *Recent commitments to prevention and early intervention in WA*

Work relating to prevention and early intervention is already underway. In July, the WA Government announced over \$1 million in funding for seven new perinatal mental health pilot programs to address service gaps in the metropolitan and South West regions. This builds on the investment being directed towards enhancing support provided through mother and baby units in hospitals, postnatal depression support programs, and through parent-infant support groups.

## “Parents want education on how to best support our children.”

– Family member or carer

- **Education and support for parents:** Children’s parents and carers can have a significant influence on their mental health and wellbeing. It is critical that they are equipped with the knowledge and skills that they require to support their children to be mentally healthy. Parent-infant support groups need to be expanded to educate parents and carers on how they can support their children’s mental health and wellbeing. Parenting programs need to be able to address common misconceptions and myths regarding mental health and wellbeing to combat stigma.

## Key action 2

Creating an integrated and child-centred ICA mental health system

## Recommendation 4

Address the gap between **primary care services** and the specialist mental health system

The WA and Commonwealth Government are jointly pursuing many initiatives to enhance primary mental health services for children through the new National Mental Health and Suicide Prevention Agreement, to address the 'missing middle' gap. This includes improving care coordination and establishing 'gateways' into the mental health system to improve navigation. Children need to be supported by both primary and specialist mental health services, working better together. There are a number of areas for the WA and Commonwealth Governments to focus on, as they progress the commitments made to expand primary mental health services.

### Collaboratively develop the models of service for the Head to Health Kids mental health and wellbeing centre and headspace centres

Funded by the Government and commissioned by the WAPHA Head to Health Kids mental health and wellbeing centres will supplement headspace centres in WA by addressing a critical gap for primary mental health supports for children aged 0-12. The new and enhanced services will need to be co-developed with children, families, and carers, as well as other service providers, including early childhood services, GPs and child health nurses, schools, and specialist mental health services. This will help to ensure that the centres are integrated into the broader system of services which support children, families and carers, improving responsiveness and service efficiency.

#### *Head to Health Kids and headspace centres – a snapshot*

Across WA, there are 19 **headspace centres**,<sup>12</sup> providing one-stop-shops for young people aged 12-25 who require support for mental health, physical and sexual health, alcohol and other drug issues, and study and work.

**Head to Health Kids** mental health and wellbeing centres will provide multi-disciplinary support to infants and children aged 0-12, and their families and carers. The Commonwealth has announced a series of pilot centres, in partnership with the state and territory governments.<sup>13</sup>

A collaborative design process should also be undertaken to re-develop the model of service for headspace centres across WA. Recently, the Commonwealth Government has committed \$278.6 million to "strengthening, enhancing, and expanding the headspace network."<sup>14</sup> This represents a timely opportunity for the model of service underpinning WA's headspace centres to be re-visited to ensure that it is integrated with the broader ICA and youth mental health systems, and to increase the complexity of children they are able to support so that the gap between headspace services and state provided ICA mental health services is bridged. It provides the opportunity for joint assessments, shared care and data sharing between headspace centres and their local ICAMHS teams (see Recommendation 5). A co-design process that is undertaken by a collaboration of WAPHA and the MHC will better ensure this integration can happen.

<sup>12</sup> This includes the yet-to-be-established headspace Kununurra.

<sup>13</sup> Australia launches world's first children's mental health and wellbeing strategy, accessed: <https://www.mentalhealthcommission.gov.au/News/2021/October/first-childrens-mental-health-wellbeing-strategy>

<sup>14</sup> Australian Department of Health, Budget 2021-22: Prioritising Mental Health and Suicide Prevention (Pillar 3) – Treatment, 2021, p. 1.

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**“Everyone here calls headspace the ‘waste of space’. You can’t get an appointment to be seen by them and once you do eventually get your child seen, they tell you that they can’t help them because they are too high risk.”**

– Family member or carer

### **Establish training programs to build GPs’ capability to support children presenting with mental ill-health and participate in shared care**

GPs are commonly the first time that children, families and carers raise concerns about a child’s mental ill-health. It is essential that WA and Commonwealth Government’s collectively invest in strengthening the capability of GPs to support children first presenting with a mental ill-health issue. This means moving away from a ‘prescribe and refer’ approach, to more ongoing support, and involvement in care coordination and treatment, including:

- Designing and delivering training programs to build GPs’ capability in ICA mental health, including assessment, care coordination, and low-intensity treatment on an ongoing basis.
- Advocating for a review of the Medicare Benefit Schedule (MBS) items, to ensure that GPs and all private mental health practitioners have access to, and are aware of, the mechanisms that can support them to participate in shared care with ICA mental health services.

### **Identify opportunities to uplift the capability and capacity of the community-managed sector**

There is an opportunity for the WA and Commonwealth Governments to support and strengthen the community-managed sector to do more, in more places. This includes co-commissioning more community-managed organisations in regional and remote WA, particularly in places with few, or no primary mental health services, and services that can provide support and treatment for children with less severe or complex needs.

Further, there is a clear need to enhance the provision of primary mental health services for vulnerable and at-risk groups of children.



## Key action 2

Creating an integrated and child-centred ICA mental health system

## Recommendation 5

Align all specialist community services into **regional 'hub and spoke' networks** that can deliver more care locally

The ICA mental health system needs to be re-organised around an enhanced Community ICAMHS. Community ICAMHS would comprise of the current WACHS CAMHS and CAHS Community CAMHS teams, re-organised into regional 'hub and spoke' teams as the foundation of the future system, responsible for integration across the ICA mental health system, and across the broader landscape of services that support children, families and carers.

Community ICAMHS teams represents an evolution from the current configuration of community mental

health services. They need to be the front door to the ICA mental health system ensuring that children will not be turned away and will receive the care they need. It is a change that cannot occur in one 'big bang', but it will lay the groundwork for a system with more capacity and capability to care for children, families, and carers, closer to their homes.

The high-level design of the Community ICAMHS model is set out in Figure 11.



Figure 11: High level design of the Community ICAMHS model

### **Comprehensive Perth North, South and East, and Country Hubs, each delivering:**

- a single entry-point (for each Hub) to support children, families and carers to access and navigate the ICA mental health system
- capability to support children with complex, co-occurring, and specialised needs
- Acute Care and Response Team to provide emergency and intensive support and treatment
- ideally, co-location with GPs, *headspace* and *Head-to-Health Kids* centres, child development services, early childhood services and education support services.

### **Local clinics ('Spokes'), each delivering:**

- specialist mental health care coordination, support, and treatment
- shared care and consultation liaison with primary mental health services, schools, and other services
- co-location with primary mental health services and GPs.

Each regional ICAMHS model needs to be designed in detail and in collaboration with local children, families and carers, clinicians and service providers, to ensure that each service is tailored to address the unique needs and local context of the children, families and carers they intend to serve, including consideration of individual and community diversity.

### **The Community ICAMHS hub need to be the single point of entry into the specialist ICA mental health system**

Community ICAMHS hubs need to be the single entry point into the specialist ICA mental health system, and support children, families and carers to navigate it. They will also:

- coordinate and drive consistency across the Local Clinics in their region
- lead the provision of care in their region, working with primary mental health services
- 'house' the Acute Care and Response Teams (see Recommendation 12), and clinicians with specialised capability in supporting children with complex and co-occurring needs (see Recommendation 10)
- be the primary interface with statewide services,

emergency departments and inpatient services provided in local hospitals

- be supported by a virtual care service that supports service delivery locally and also provides a 24/7 response when needed.

#### **Locations for Community ICAMHS hubs**

A Community ICAMHS needs to be established in each 'area' across the State.

- Metropolitan WA: Community ICAMHS need to be organised into Perth North, Perth South and Perth East catchments.
- Regional and remote WA: Community ICAMHS need to be organised at either a 'region' or 'district' level, but it will ultimately be a decision to be made locally by WACHS and partners in regional service delivery, to ensure the best support can be provided to country children and families.

### **Local clinics (or 'spokes') need to provide treatment and care to children, families and carers within their communities**

Existing Community CAMHS clinics and WACHS CAMHS services need to be re-organised into the 'spokes' of Community ICAMHS. These services will continue to be located in their local communities. They have developed a strong understanding of the local context, and cultivated important relationships within their communities. The Local Clinics need to:

- provide care coordination, support and treatment to children, families and carers
- undertake shared care with and provide consultation liaison to other services, including schools
- potentially be a site for co-location with primary and enhanced primary mental health services (e.g. GPs, *headspace* centres and *Head to Health Kids* centres) where they are provided locally.

## Key action 2

Creating an integrated and child-centred ICA mental health system

## Recommendation 6

Integrate the ICA mental health system with services that support **Aboriginal children, families, and communities**

It is widely recognised that being culturally responsive is key to attracting Aboriginal children, families and carers, and ensuring that they feel safe and included, and stay engaged. Yet many ICA mental health services are not safe or culturally responsive, impacting their accessibility to Aboriginal children, families and communities. A fundamental change in how the system meets the needs of Aboriginal children, families and communities is required. The future ICA mental health system needs to:

- Collaboratively develop new models of care with Aboriginal children, families, and communities: New models of care for community mental health services (see Recommendations 5, 9 and 10) need to integrate social and emotional wellbeing principles and practices, and inter-disciplinary care involving children, families and communities. To achieve this, they need to be designed in partnership with the Aboriginal-controlled sector, and Aboriginal children, families and community members. The development of the model of care should explore opportunities to partner with Aboriginal-controlled services in the provision of care.

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**“Aboriginal clients have had problems when interacting with staff. The first interaction that an Aboriginal family has with mental health services can ‘make or break’. If we don’t get it right – for example, if an inexperienced staff member who doesn’t have the contextual knowledge – we will lose these people early.”**

– Clinician or service provider

- Conduct a pilot of the National Human Services Workforce Framework for the Aboriginal and Torres Strait Islander Community-Controlled Sector: The Framework aims to guide investment, planning and policy decisions relating to building the Aboriginal health and social care workforce. Consideration should be given to piloting the Framework as part of the ICA mental health system reform, using it to inform efforts to grow the Aboriginal mental health workforce.
- Establish consultation liaison positions dedicated to Aboriginal service providers: Consultation liaison roles for Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Community Controlled Organisations (ACCOs) and Aboriginal Medical Services (AMSs) need to be established within Community ICAMHS. These roles would help to promote shared care to address the cultural and treatment needs of Aboriginal children, families and communities, and support capability transfer between the two services.
- Expand the capacity of the Aboriginal-controlled sector in ICA mental health: A strong, supported Aboriginal-controlled ICA mental health sector is key to ensuring that Aboriginal children, families and communities have access to culturally responsive care, and achieve better and more equitable outcomes. Not all ACCHOs, ACCOs and AMSs currently have the capability nor capacity to meet the more intensive treatment needs of some Aboriginal children, families and communities. There is a need to invest in strengthening Aboriginal-controlled ICA mental health services in WA. In the long term, the aim is for ACCHOs and AMSs to be equipped to holistically meet the cultural and treatment needs of Aboriginal children, families and communities, supported by specialist ICA mental health services where and when necessary.

### ***Understanding social and emotional wellbeing***

Concepts of social and emotional wellbeing for Aboriginal peoples and communities are not new in dialogue on mental health. More recently, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* articulates the history and evidence base for social and emotional wellbeing. It also articulates a culturally appropriate model of mental health service delivery, underpinned by an interdisciplinary approach to care.

## Key action 2

Creating an integrated and child-centred ICA mental health system

## Recommendation 7

Establish **integrated pathways and supported transitions** for children moving between ICA services, and youth and/or adult mental health services

An effectively integrated ICA mental health system will provide children, families and carers with support, which is flexible, responsive and appropriate to their needs. Within an effectively integrated ICA system, children, families and carers waiting to access a service, moving between services within the ICA mental health system, or leaving ICA mental health services (e.g. leaving an emergency department, transitioning to youth or adult services) need to be well-supported and not experience any interruptions in their care. It is critical that the ICA mental health system is not only better integrated within itself, but also integrated with the acute youth and adult mental health systems.

### **Provide support, including counselling and crisis responses, to children, families and carers who are waiting to access services**

Children, families and carers waiting for an appointment following an initial referral to an ICA mental health service need to be supported while they wait, particularly if during extended periods of time. CAMHS Crisis Connect and WACHS Mental Health Emergency Telehealth Service need to be expanded, as an interim measure, to provide support to children, families and carers while they wait to access ICA mental health services. This needs to include checking in regularly, providing brief intervention, supporting them through crises, and linking them with other services or supports. The ultimate aim, however, is that no child or family will have to wait to access any public mental health services.

As more peer workers are employed by the ICA mental health services (see Recommendation 23), providing non-clinical support to children, families and carers on wait lists needs to form part of their role.

### **Agree on age cohort definitions for ICA, youth and adult mental health services**

The Government and MHC have committed to establishing an expert youth mental health system in Perth, supporting young adults from age 16 to 24. As a consequence, there is a need for the WA Government to define the age eligibility requirements more clearly and consistently for ICA, youth and adult mental health services. These currently vary and are not clear to children, families and carers. Agreed age cohort definitions should be used to inform the design or re-design of new models of care for ICA and youth mental health services.

Once age cohort definitions have been agreed, clinicians need to be empowered to make flexible decisions about when and how children should transition between services. For example, a child engaged in an ICA mental health service for 0-16 year-olds should not be automatically transferred to a youth mental health service on their 16th birthday. Their treatment team, together with the child and family, should make informed decisions to determine if and when their treatment should transition to a youth service.<sup>15</sup>

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**“Not all 18-year-olds are at the same developmental stage. Some are moving to adult services before they are ready, which can be harmful.”**

**- Family member or carer**

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<sup>15</sup> It is acknowledged that for a child living in regional or remote WA, there are no youth specific services, as there are in metropolitan Perth. As a result, it is common for these children to transition directly into adult supports when they 'age out' of ICA mental health services.

## Establish clinical guidelines to govern transitions between ICA, youth, and adult mental health services

Once age cohort definitions for ICA, youth and adults services have been agreed, clinical guidelines need to be established to inform transitions between these services. To ensure that transitions are considered, safe and supported, they need to be gradual, and involve shared care between the service that the child is transitioning from and the service that the child is transitioning to. The practice of warm handovers – in which care is progressively transferred with face-to-face multiagency sessions – should be common practice. How shared care could work during the transition period is shown in Figure 12. The clinical guidelines need to provide ICA, youth and adult mental health services with clarity on how shared care arrangements will work, and what their roles and responsibilities will be.

**“Stepped transitions, particularly between inpatient and outpatient care, would be great. At the moment, there’s none of that.”**

– Family member or carer

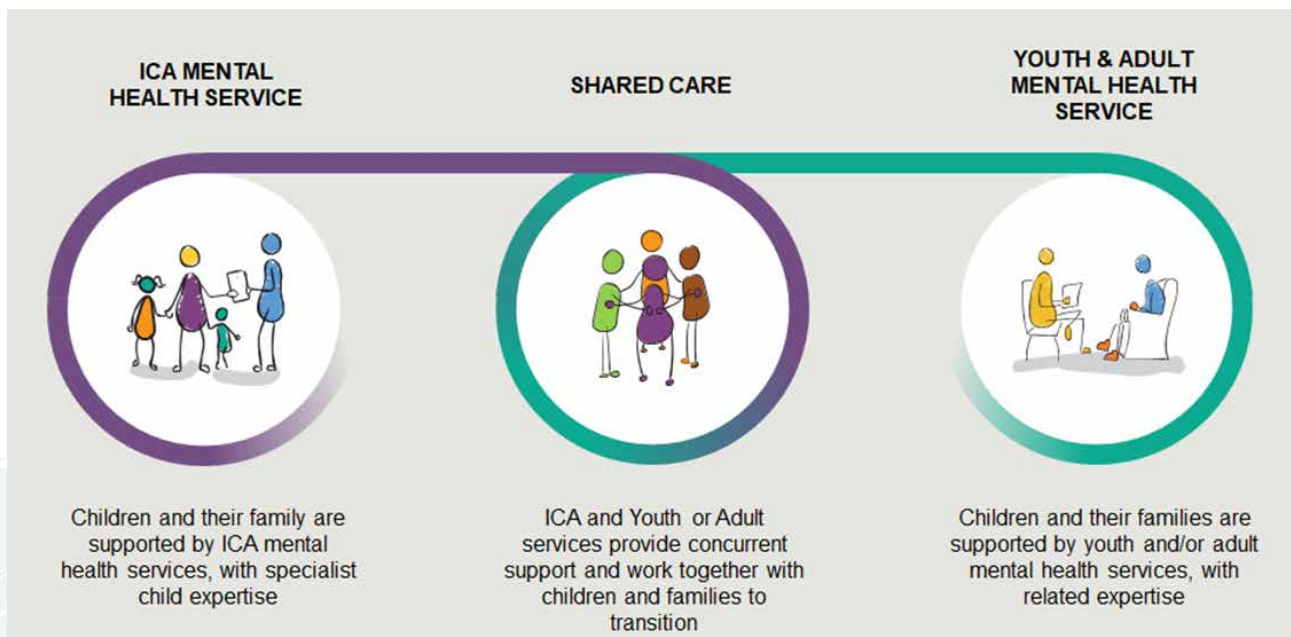


Figure 12: Shared care arrangements in young adulthood

<b>Key action 2</b>	<b>Recommendation 8</b>
Creating an integrated and child-centred ICA mental health system	Address barriers to <b>service integration</b>

The complexity and acuity of mental ill-health in children is driving a need for more coordinated action between ICA mental health services, and between ICA mental health services and services from other systems, including child protection, disability, education, housing, justice, and police. Policy settings and accountability measures need to bring these services and systems together. Governments needs to target changes that are under their control, including the way that services are funded, commissioned and managed, to make it easier and expected that services are better coordinated.

**Establish service- and system-level mechanisms to share and use data and information more seamlessly**

Taskforce has observed that many clinicians and service providers do not have a clear understanding of the policies and processes which govern the sharing of personal information between services. To resolve this, clear guidance needs to be developed and published to ensure that all ICA mental health services, and the staff in those services, understand how and when to share the information of children in their care.

Additionally, all health and human services state government agencies, in partnership with WAPHA, need to explore system-level mechanisms to simplify and streamline information sharing between services. This may include establishing agency-level Memorandums of Understanding (MOUs) or supporting services to establish formal and informal arrangements across systems. Legal advice is required to ensure that arrangements established do not infringe upon any of the legislation and regulations governing the sharing of personal information.

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**“The history of ‘siloing’ rather than collaborating needs to be urgently acknowledged and addressed at a systemic level, to ensure that children aren’t falling between the gaps.”**

- Service provider

**Establish a simplified and streamlined approach for providing ‘consent’ to sharing information**

It is important that when people share their personal information with a service, they understand, and feel as though they have control over, how and when it can be used. The current processes by which children, families and carers consent to having their personal information shared between services needs to undergo a review to simplify and streamline the process, while ensuring that appropriate safeguards are in place to protect the privacy and integrity of the information being shared.

# 10. Key Action 3: Collaboratively developing new models of care for all parts of the specialist ICA mental health system

## What is it?

Key Action 3 focuses on the fundamental transformation in how public specialist ICA mental health services are delivered. New models of care are required for all existing services as well as the introduction of new services being proposed to address gaps in the system. It is critical that these models of care enable services to work as a coherent and cohesive system (as per Key Action 2).

Detailed models of care have not been developed. Rather, this report articulates the role and relationship that services need to have as part of the future system. It also outlines the core attributes of each type of service. Building on the foundation presented in this report, collaborative design processes need to be undertaken with children, families, carers and others with lived experience, as well as those who work within services, to develop the new models of care.

## Why is it important?

Currently, ICA mental health services are disconnected and focused on the most acutely unwell children – leaving too many with no support at all. Whilst a lot of this is due to a lack of capacity in services, there are structural issues within services that contributed to the issues faced. Future services need to differ from current services in six critical ways, which are set out in Figure 13.

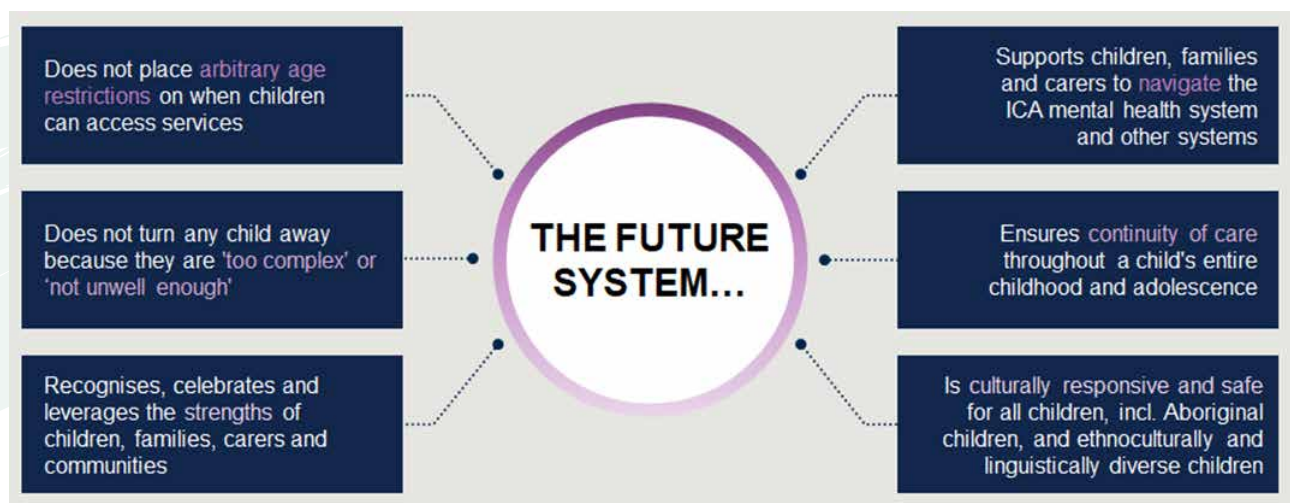


Figure 13: Six ways that future services will differ from current services



## Recommendations for Key Action 3

Key action 3	Recommendation 9
Collaboratively developing new models of care for all parts of the specialist ICA mental health system	Establish an assertive and flexible model of care for <b>Community ICAMHS</b>

Specialist community mental health services<sup>16</sup> should be the engine room of the ICA mental health system. Other international jurisdictions call these services ‘Comprehensive CAMHS’, recognising that most of the care provided to children with mental ill-health should be provided in the community. In WA, a new model of care for specialist community mental health services – Community Infant, Child and Adolescent Mental Health Services (Community ICAMHS) – needs to be developed, to enable all types of care to be provided in the community, rather than in hospitals, to the extent which is safe and appropriate.

Community ICAMHS needs to be adequately resourced and radically differ from current services in a number of ways, including:

- providing a safe and nurturing ‘front door’ to the mental health system
- being integrated across both the ICA mental health system, and all other systems which work with vulnerable children, families and carers
- being resourced and capable of supporting all children, regardless of how unwell, or ‘complex’ their circumstances
- being safe, appropriate and inclusive for children of all ages, backgrounds, cultures and beliefs.

The model of care of Community ICAMHS needs to be collaboratively designed<sup>17</sup>. However, at a minimum, it needs to have the three features set out below.

### Connect with and support ICA mental health and other services, through consultation liaison and shared care

Community ICAMHS needs to lead the integration of mental health, health and other services through the provision of consultation liaison and shared care.

- **Consultation liaison:** Community ICAMHS clinicians need to act as ‘liaisons’ between Community ICAMHS and other services, including other mental health services, child development services, child protection services, youth justice services and schools. They would enable collaborative practice and support capability transfer. Their role could include – but should not be limited to – providing clinical supervision, jointly assessing and treating children, families and carers (who are primarily cared for by another service), and providing advice, training and development.
- **Shared care:** Community ICAMHS need to engage in shared care arrangements with other services, including primary mental health services (e.g. headspace), GPs, schools and other services. In a shared care arrangement, Community ICAMHS and the other services jointly plan and provide care to a child, and their family or carers. This approach would enable a child to benefit from the clinical capability of a specialist, multi-disciplinary team, while being cared for in a less intensive setting, closer to, or in the home.

<sup>16</sup> In WA, ‘community mental health services’ refers to the 10 CAHS Community CAMHS clinics, and the WACHS CAMHS services delivered in WA’s seven country regions, and, outreaching to smaller towns and remote communities

<sup>17</sup> In developing a new model of care, consideration needs to be given to what referral, assessment and engagement approach would best complement the new functions of Community ICAMHS. This should include consideration of adapting the current Choice and Partnerships Approach (CAPA) or developing a bespoke approach to complement the new model of care.

## **Adopt a flexible, continuous, and assertive model of care that endures through childhood where appropriate**

Community ICAMHS needs to provide continuous, recovery-oriented care throughout the lifetime<sup>18</sup> of a child. This would see a child remain in the care of Community ICAMHS. As their mental ill-health improves, they may receive less intensive contact with the service or be supported to 'step down' into primary care. As a child's mental health worsens, the intensity of their care would increase, and they may be supported to 'step-up' into a more acute setting, including state-wide services (see Recommendation 10) or an Acute Care and Response Team (see Recommendation 12), without repeated assessments, delays or referrals.

Community ICAMHS needs to adopt a flexible approach – it should not be bound by administrative boundaries in relation to where and when care is provided. Community ICAMHS should operate within 'family' hours – meaning the hours during which children, families and carers need, and are able to access care. This needs to include flexibility to support children at home, at school, or in different places in the community.

Community ICAMHS also needs to deliver an assertive model of care to support children with complex needs, and those supported by multiple agencies. Rather than 'wait' for referrals, they should proactively work with partner agencies to identify and engage with children that may be vulnerable and at-risk, and assertively engage with those children, their families and carers.

## **Enhanced capabilities in supporting children with complex, co-occurring, and specialised needs**

Community ICAMHS needs to be able to support children with complex, co-occurring and specialised needs. To be able to support these children, Community ICAMHS needs to have a wide range of clinical and other capabilities, including capability to work with children from diverse backgrounds. Much of this capability would be centralised within the Community ICAMHS Hubs and deployed to support clinicians in Local Clinics, as needed (see Recommendation 5). Capability that is needed in all Hubs include:

- Aboriginal Health Workers and Aboriginal Mental Health Workers
- cross-cultural mental health workers
- dual-skilled mental health and AOD (including volatile substance use) clinicians
- clinicians with expertise in each specialised field, including eating disorders, gender diversity, neurodevelopmental or neuropsychiatric conditions, personality disorders, conduct disorders, infant mental health, complex trauma, early psychosis, and forensic mental health.

Where these capabilities cannot be deployed within a hub, then the hub needs to be supported by other hubs or specialised resources via virtual care.

In addition to these capabilities, there needs to be mandatory ongoing professional development for all Community ICAMHS staff, in working with Aboriginal children, ethnoculturally and linguistically diverse children, children with disability, and LGBTQIA+ children.

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<sup>17</sup> In developing a new model of care, consideration needs to be given to what referral, assessment and engagement approach would best complement the new functions of Community ICAMHS. This should include consideration of adapting the current Choice and Partnerships Approach (CAPA) or developing a bespoke approach to complement the new model of care.

<sup>18</sup> The 'lifetime' of a child in the context of a continuous care model means until the child turns 18.

### Key action 3

Collaboratively developing new models of care for all parts of the specialist ICA mental health system

### Recommendation 10

Reconfigure the **statewide models of care** for all new and existing specialised services to ensure they are accessible for all children

The ICA mental health system needs to be equipped to safely, sustainably, and appropriately respond to children with complex and co-occurring needs.<sup>19</sup> The current system has several specialised services with narrow and specific remits.<sup>20</sup> With the exception of Complex Attention Hyperactivity Deficit Service (**CAHDS**), which already delivers a consultation liaison model, the models of care for all specialised services should be re-designed as statewide services that are based on a 'stepped' care approach. This approach would increase the amount of care that is provided by Community ICAMHS, and ensure the expertise of these specialised services is utilised to support more children in all parts of WA.

An additional benefit of this approach is the 'pooling' of expertise, combining local knowledge (particularly in regional and remote WA) with specialised expertise.<sup>21</sup>

The detailed model of care for every statewide service will need to be redesigned (in collaboration with

clinicians and those with lived experience) to utilise a stepped model of care that will see significantly more of the service delivered within the community rather than in a centralised location.

The stepped model of care for statewide services is underpinned by the principle that the 'least intensive' intervention should be first provided to a child, and their family or carers, where and when it is safe to do so. The child would access care at the most appropriate step of the pathway of care, then 'step up' or 'step down', according to their needs or in response to the care that they receive. Each step of the pathway needs to be designed to provide children, families, and carers with a seamless and uninterrupted experience.

A high-level overview of the stepped model of care for statewide services is shown in Figure 14 and detailed below.

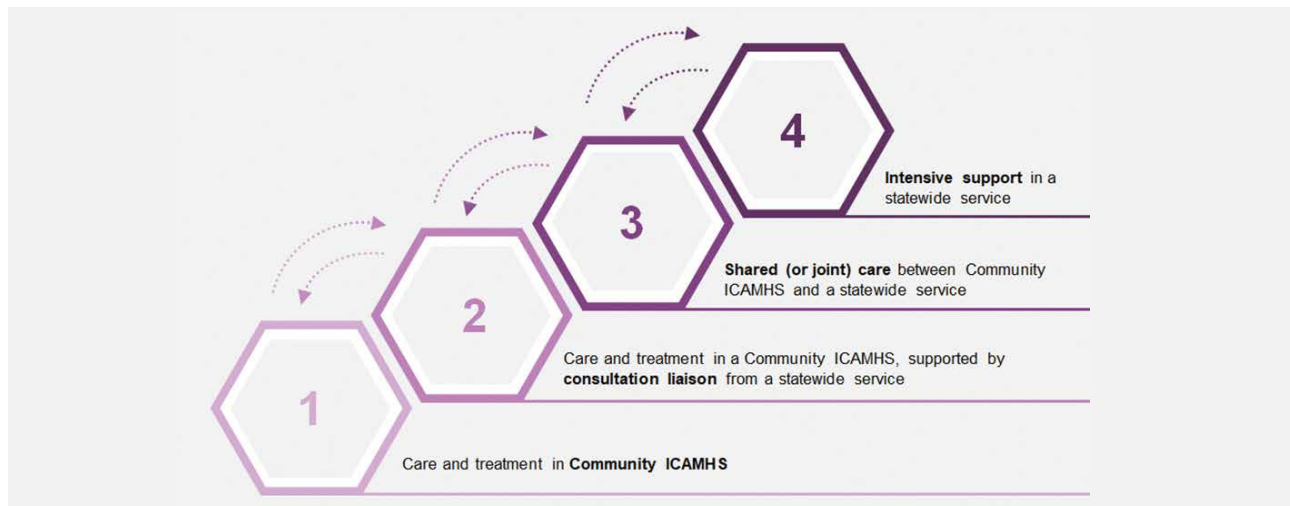


Figure 14: Four components of a 'stepped' care approach

<sup>19</sup> For the purposes of this paper, we mean children that may have: (1) more than one mental health condition (i.e. an affective disorder and a co-occurring eating disorder); (2) children that may have a mental health condition and co-occurring physical or neurological health needs (i.e. an affective disorder and a co-occurring intellectual disability); or (3) a mental health condition that is related to, or caused by a personal or social characteristic (i.e. an affective disorder in a LGBTQIA+ child).

<sup>20</sup> Specialised services are provided by CAHS, and include the Eating Disorder Service (EDS), Gender Diversity Service (GDS), Complex Attention and Hyperactivity Disorder Service (CAHDS), Multisystemic Therapy (MST), Pathways, and Touchstone.

<sup>21</sup> Helen Lester, Shared care for people with mental illness: a GP's perspective, *Advances in Psychiatric Treatment*, 2018.

- **Care in Community ICAMHS:** Community ICAMHS should provide assessment, care coordination and low intensity treatment to children with less severe needs.
- **Care in Community ICAMHS, with consultation liaison provided by a statewide service:** All statewide services need to provide consultation liaison to Community ICAMHS. The provision of consultation liaison will be particularly critical in the short-term, as the capability of Community ICAMHS is progressively built. Statewide services need to also be able to provide both ad-hoc and planned advice to Community ICAMHS staff, to support them with face-to-face and/or virtual assessment, care coordination and treatment.
- **Shared or joint care with Community ICAMHS:** For children with more complex and/or severe needs, Community ICAMHS and statewide services need to engage in shared care arrangements. This would involve the Community ICAMHS and statewide services teams jointly planning and providing care to the child, and their family or carers.
- **Intensive support provided by a statewide service:** Some children will have a level of complexity or severity which warrants specialised, intensive support in a structured and planned environment. For those children, the 'stepped' care approach should enable a seamless handover of responsibility to statewide services. The nature of this care is that it is more temporary, intensive, and accessible for a smaller proportion of children who require a 'circuit-breaker' to enable their long-term recovery. In most cases, the statewide service will have a relationship with the child prior to this step, so will be familiar to the child and family. The local Community ICAMHS team should also remain in regular contact with the child and the statewide service to ensure a continuous relationship with their local service and treating team, and a seamless transition of care back to the Community ICAMHS team.

All existing specialised services will need to be redesigned in this model with three services a priority for immediate development.

- **Eating Disorders Service.** Between 2017 and 2020 there has been a 168 per cent increase in admissions to an inpatient ward at Perth Children's

Hospital (PCH) for children with an eating disorder. Regional hospitals have experienced a similar trend. In response to the current situation, both the Eating Disorders Sub-Network within the MHC, and the Eating Disorders Service within CAHS have separately undertaken work to develop new models of care. There is an urgent need for CAHS, WACHS and the Eating Disorders Sub-Network to come together, as a priority, to participate in a co-design process to develop a single 'stepped' statewide model of care for eating disorders.

- **A children's service that supports 5-11 year old's.** As detailed in the case for change, 5-11 year-olds with mental health issues have increasingly experienced difficulties accessing public mental health services due to being perceived as 'lower risk'. Whilst the existing Pathways service is dedicated to supporting this age cohort, it is limited to supporting a very small number of children that are very 'high risk'. There is an urgent need to develop a stepped model of service 5-11 year-old's that brings together the expertise of Pathways in supporting young children, with Community ICAMHS to better support this cohort in the community.
- **An enhanced personality disorders service.** In 2020, the personality disorders sub-network developed a new set of guidelines and model of care for the treatment of personality disorders. This model of care was developed following concerns with the current treatment guidelines and responses for people with personality disorders when presenting in crisis to hospital emergency departments. In the Chief Psychiatrist's targeted review, these concerns were re-stated, and a recommendation was made to review the guidelines for supporting children with Emotionally Unstable Personality Disorder. Care and treatment for children with personality disorders continues to be a State priority. There is an urgent need to build on the work done to-date and transform the existing Touchstone service through the development of a statewide, stepped care model of care for personality disorders.

In addition to these three existing services that need to be enhanced as a priority, Recommendation 11 identifies four statewide services that need to be newly established.

Key action 3	Recommendation 11
Collaboratively developing new models of care for all parts of the specialist ICA mental health system	Establish <b>new statewide services</b> to address critical gaps within the current range of specialised services

Currently, some of the State’s most vulnerable and at-risk children are unable to access care which meets their needs. To bring WA in-line with other national and international jurisdictions, the system needs to be able to support the four groups outlined in Figure 15.

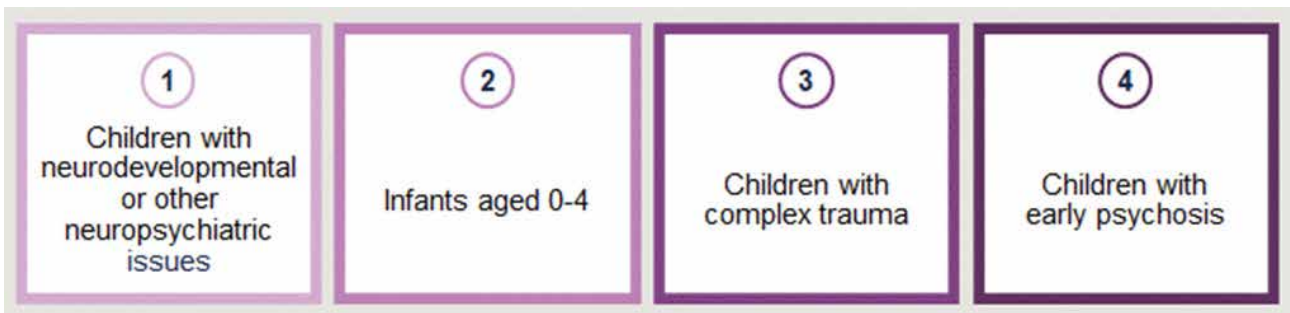


Figure 15: Four groups that the future system needs to be able to support

### Collaboratively design a new intellectual disability and neurodevelopmental or neuropsychiatric condition service

Currently, ICA mental health services **exclude** autistic children, and those with an intellectual disability or neurodevelopment or neuropsychiatric condition from accessing care. A new statewide service for children with a primary condition of an intellectual disability, and/or neurodevelopmental or neuropsychiatric condition but with co-occurring mental health issues needs to be collaboratively designed. This service should provide consultation liaison and shared care and be designed and delivered in collaboration with the Child Development Service. It should improve the access of these children to specialist mental health care, including Community ICAMHS; and enhance the capacity of other services to meet these children’s needs within the community.

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**“We were rejected from CAMHS because my son has ASD. They said that his behaviour was because of his ASD, not because he had mental health issues. They said that there’s nothing they could do to help us.”**

– Family member or carer

## Case Study 2 | Sydney Children's Hospital Mental Health Intellectual Disability Hub

### SYDNEY CHILDREN HOSPITAL'S MENTAL HEALTH INTELLECTUAL DISABILITY HUB

NEW SOUTH WALES, AUSTRALIA

#### Description

The Sydney Children's Hospital Network Mental Health and Disability (MHID) Hub is a statewide tertiary service that aims to improve the mental health of children and adolescents with a neurodevelopmental condition under 18 years of age.<sup>22</sup> It does this by:

- improving access (statewide) to specialist mental health services
- enhancing the capacity of local services to provide mental health care.

The MHID Hub is a short-term consultation service. It provides advice to local treating clinicians by sharing expertise in assessment, diagnosis, and treatment for co-occurring mental health issues in children with intellectual disability and/or autism. It also provides specialist expertise when a medical professional or mental health team have had unsuccessful treatment attempts.

The consultation services differ depending on the clinical complexity of referred cases. For example, consultations can occur face-to-face at a hospital or via telehealth.

### Collaboratively design a new infant mental health service

In infant mental health in other jurisdictions, including Queensland and Victoria, have established dedicated public specialist perinatal and infant mental health services. Currently, infants are eligible for ICA mental health services in WA; however, these services do not provide specialist interventions for this age group. WA requires a new infant mental health service which is able to intensively work with babies and young children aged 0-4, whose social, emotional, or developmental wellbeing is at risk. The new service should adopt a 'stepped' care approach, including consultation liaison and shared care, and be delivered by a multi-disciplinary team.

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**"If your child has a mental ill-health issue under the age of 12, they are stuffed. All services are for children over the age of 12 – but it's too late."**

– Family member or carer

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<sup>22</sup> The Sydney Children's Hospitals Network 2021, Mental Health Intellectual Disability hub, accessed 30 August 2021, available from: <<https://www.schn.health.nsw.gov.au/find-a-service/health-medical-services/mental-health-services/sch-chw-mhid>>.

### Case Study 3 | Zero to Four Child and Youth Mental Health Service

#### ZERO TO FOUR CHILD AND YOUTH MENTAL HEALTH SERVICE

QUEENSLAND, AUSTRALIA

##### Description

Zero to Four Child and Youth Mental Health Service (Zero to Four CYMHS) is a specialised mental health service for babies and young children from zero to four years, whose social, emotional, or developmental wellbeing is at risk. Services are provided by a multi-disciplinary team of mental health clinicians including psychiatrists, psychologists, mental health nurses, social workers, speech pathologists, and occupational therapists.

Zero to Four CYMHS works with babies and young children, and those who care for them, to help the whole family manage and recover from infant mental ill-health issues, such as emotional distress or behavioural issues. The service also works with new parents and pregnant women struggling to form a relationship with their infant or unborn baby.

#### Identify opportunities to augment existing services for children with early psychosis and complex trauma

A more systemic approach, enhancing the care that is provided in primary and specialist mental health settings, should be taken to support children with early psychosis and complex trauma. For early psychosis,

the WA Government should partner with the Australian Government and WAPHA to expand the capacity, and clinical capability of the headspace Early Psychosis program. This should include consideration for a jointly commissioned service which can provide more intensive interventions.

### Case Study 4 | Early Psychosis Prevention and Intervention Centre

#### EARLY PSYCHOSIS PREVENTION AND INTERVENTION CENTRE


VICTORIA, AUSTRALIA

##### Description

The Early Psychosis Prevention and Intervention Centre (EPPIC)<sup>23</sup> works with young people to facilitate the early identification and treatment of psychosis, and reduce the disruption to the young person's functioning and psychosocial development. EPPIC provides:

- case management, which may include home visits
- specialised treatments, including psychological therapy, medication and family work
- psychosocial recovery options such as group programs, vocational and educational supports/services, youth and family participation
- neuropsychological and occupational therapy interventions
- referral and liaison with other community agencies (e.g. AOD, employment services)
- support to families and carers.

<sup>23</sup> Early Psychosis Prevention and Intervention Centre, Orygen, Accessed 30 August 2021, available from: <<https://oyh.org.au/our-services/clinical-program/continuing-care-teams/eppic-early-psychosis-prevention-intervention>>



Children with complex trauma tend to require a system-wide response, reflective of the fact that they are more likely to have close contact with the child protection and justice systems, and have an array of other cultural, social and developmental issues. Future models of care for children with complex trauma, including intergenerational trauma, need to move away from the 'medical model' which is constrained to 'diagnosis and treatment', towards a model that can respond holistically and therapeutically to children, families and carers.

These services will need to be culturally safe and responsive for Aboriginal children and children from ELD communities, including refugees and asylum seekers. To better meet the needs of children with complex trauma, consideration should be given to:

- Embedding trauma practitioners in all Community ICAMHS Hubs and EDs and committing to trauma responsive care service models.
- Increasing the capacity and clinical capability of the Refugee Health Service to provide specialist care to children, families and carers, including through dedicated clinical psychologists and consultation liaison from Community ICAMHS Hubs.
- Expanding the role of Pathways in providing services to children with complex trauma and providing consultation liaison to Community ICAMHS to support the safe treatment of children with complex trauma, including in partnership with AMS-led services.





### Key action 3

Collaboratively developing new models of care for all parts of the specialist ICA mental health system

### Recommendation 12

Establish **Acute Care and Response Teams** within Community ICAMHS Hubs in metropolitan, regional and remote WA

The future ICA mental health system needs to respond very differently to the State's most acutely unwell children. These children should be able to access intensive and responsive support in the community, to the extent that it is safe and appropriate. This was recognised by the Chief Psychiatrist in his review of the care provided to Ms Kate Savage. He recommended the establishment of intensive treatment services in Perth to provide intensive and timely care in the community for children in crisis, and children with severe and enduring mental ill-health. In line with this recommendation, Acute Care and Response Teams – which would be based in Community ICAMHS Hubs across WA – need to be established.

The model of care of the Acute Care and Response Teams needs to be collaboratively designed with those with lived experience and with clinicians. It needs to provide the two services below.

### Mobile emergency support to children in a mental ill-health crisis

Acute Care and Response Teams need to be capable of responding to children in crisis, who can be safely, appropriately, and effectively supported in the community. For children in crisis, these need to:

- provide extended-hours to respond to children in crisis, and partner with the CAMHS Crisis Connect, WACHS ETS and EDs to ensure an all-hours response to children in crisis.
- be able to respond to children wherever they are, including their homes, their schools, and in hospital settings (e.g. EDs or inpatient wards)
- be multi-disciplinary, including Aboriginal Mental Health Workers, nurses, peer workers, psychiatrists, social workers and other allied health workers
- deliver services through multiple modes, including face-to-face, via phone and via virtual care systems
- be adapted to suit the local context, particularly in regional and remote WA. This may involve partnering with local services, including Aboriginal-controlled services, to ensure that Acute Care and Response Teams are culturally safe and appropriate.

## Case Study 5 | Safeguard Child and Adolescent Response Teams

### SAFEGUARD CHILD AND ADOLESCENT RESPONSE TEAMS

NEW SOUTH WALES, AUSTRALIA

#### Description

The Safeguard Child and Adolescent Mental Health Response Teams (Safeguard Teams) are a proposed NSW CAMHS extension designed to deliver best practice care to children and adolescents aged 0-17-years experiencing moderate to severe mental health distress. These teams have been designed following a funding commitment by the NSW Government in 2021.

The Safeguard Teams will:

- Use a stepped care approach to deliver intensive acute care to support community-based child and adolescent mental health services and tertiary acute child and adolescent inpatient units.
- Provide rapid, mobile, intensive, and flexible short-term crisis care 24-hours a day, seven days per week.

The Safeguard Teams will deliver face-to-face and telehealth crisis response to young people in their schools, homes and communities, and in hospital-based settings such as EDs and inpatient wards. Its flexible model will be adapted to the geographic needs of metropolitan, regional and remote communities.

The workforce is multidisciplinary with the clinical expertise to deliver crisis assessment, specialist clinical care and short-term therapeutic interventions to children, families and carers.

#### Provide intensive treatment to children with severe and enduring mental ill-health

Acute Care and Response Teams need to provide intensive treatment to children with severe and enduring mental ill-health. This needs to form part of a 'stepped' care response – children need to be supported to 'step up' and 'step down' from these Teams, as required. For children with severe and enduring mental ill-health, these Teams need to:

- provide a combination of clinic-based, in-home and telehealth care
- include the child's family or carers, where possible and appropriate

- partner and provide shared care with other services, including ACCHOs and AMSs, community-managed services, child protection services, and youth justice services
- be multi-disciplinary, including nurses, Aboriginal Mental Health Workers, peer workers and social workers and other allied health workers
- be adapted to suit the local context, particularly in regional and remote WA, utilising virtual care and local partner organisations.

## Case Study 6 | Youth Community Assessment and Treatment Team

### YOUTH COMMUNITY ASSESSMENT AND TREATMENT TEAM

WESTERN AUSTRALIA, AUSTRALIA

#### Description

The Youth Community Assessment and Treatment Team (YCATT), located in Fiona Stanley Hospital, is a community based service that provides youth-centred and recovery-focused mental health support for young people ages 16 - 24. YCATT's services include:

- community based assessment
- intensive care management
- school liaison
- establishing links with long-term community mental health supports.

The service, which is time limited, is delivered by a multi-disciplinary team which consists of psychiatrist, psychiatric registrars, mental health nurses, social workers and clinical psychologists.

YCATT also works to establish links with community mental health organisations to support long-term recovery. The YCATT team ensures continuity of care across both community-based and inpatient services, if required.

**Note:** *In 2021 the WA Government committed to expanding the YCATT service to the North and East metropolitan regions of Perth, and expand the capacity of the existing service in South metropolitan Perth.*

### Key action 3

Co-designing new models of care for all parts of the specialist ICA mental health system

### Recommendation 13

Establish an ICA-specific model of care for mental health **ED presentations**, and **safe places** in the community

Safe alternatives to EDs, which offer respite and stabilisation, are key parts of a safe, systemic response to children in crisis. However, for some children in crisis, EDs remain the most appropriate setting. It is critical that these children, who need to present to EDs, have a safe, therapeutic and culturally safe experience. The future system needs to have two levels of responses in place for children in crisis: an ICA-specific model of care for mental health presentations to EDs, and safe places in the community for respite and stabilisation.

### Collaboratively design an ICA-specific model of care for mental health presentations to EDs

A new model of care for children presenting to EDs in times of crisis needs to be collaboratively developed. The model of care should include:

- 'immediate' responses to children in crisis, and 'follow up' care provided in the days and weeks post-discharge
- a clinical pathway for any child presenting to an ED in crisis
- a staffing model that enables safer, more appropriate responses. ICA-trained psychiatric liaison nurses should be included in all major metropolitan and regional hospitals and alternative workforce models should be explored (e.g. nurse practitioner-led models)
- skills and capabilities required of all staff involved in responding to children in crisis, including staff responding via the CAMHS Crisis Connect and WACHS ETS
- an expansion of CAMHS Crisis Connect and WACHS ETS to support children (aged 0-17) waiting to access ICA mental health services, either following an emergency department presentation, or a community referral. This response should be the 'bridge' between EDs and Community ICAMHS, to ensure that children, families and carers have a seamless transition of care to Community ICAMHS.

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**“The emergency department was an awful experience. Why did I even say something?”**

- Young person

The future ICA mental health system has been designed so that no child or family should have to wait to access support. However, it is acknowledged that as the new system is implemented, there will be times where children will wait for support. During these times, the expanded capability and capacity of CAMHS Crisis Connect and WACHS ETS needs to provide interim support to children, families and carers. This will require dedicated ICA mental health expertise in the WACHS Command Centre, and investment into both WACHS ETS and CAMHS Crisis Connect to extend their ability to provide follow up to children who present to other Metropolitan EDs

The model of care needs to be accompanied by clear guidance on and investment in the establishment of safer, calmer, and more comfortable environments within, or adjacent to, emergency departments.

## **Collaboratively design safe places in the community for respite and stabilisation**

Some children in crisis do not need high-intensity, short-term psychiatric interventions, and can be safely and appropriately supported in the community. To support these children, 'child safe places' in the community need to be designed in partnership. Child safe places should:

- allow children, families and carers to self-refer or be referred following an emergency department presentation
- explore alternative workforce models, including nurse practitioner-led, and peer-led models
- be located adjacent or near to emergency departments
- deliver a therapeutic model of care focused on providing respite and stabilisation
- have the capability to provide assessment and diagnosis, immediate interventions, and referrals to the most suitable service for ongoing care, if required. The capability to provide follow-up is also required
- maintain close, complementary relationships with local EDs and Community ICAMHS teams.

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## 11. Key Action 4: Collaborating with other government services to appropriately support children, families and carers

### What is it?

Many children, families and carers experience a range of complex health, social and economic issues, beyond mental ill-health. These include AOD issues, disability, disengagement from education, family breakdown and conflict, financial stress, housing instability, and involvement with the police and justice systems. A child's mental ill-health cannot be separated from these issues. Key Action 4 focuses on how ICA mental health services need to work more collaboratively with government and community services from other systems, to ensure that all children, families and carers have their needs met 'as a whole'.

### Why is it important?

Services tend to operate in siloes, addressing discrete parts of a child and their family's issues. As a result, children, families and carers being supported by multiple services at the same time experience fragmented and poorly coordinated care, between services. The experience of these children, families and carers needs to be improved, by increasing collaboration between ICA mental health and other services. The future system needs to support greater coordination for those children, their families and carers who are engaged in multiple services, so they experience seamless care and services designed for teams to work together to jointly meet the needs of the child and their family.

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**“We need to adopt a model of care that brings all services together. Without this, children will continue to have a disjointed journey of care.”**

– Service provider

## Recommendations for Key Action 4

Key action 4	Recommendation 14
Collaborating with other government services to appropriately support children, families and carers	Ensure that there is an <b>integrated, multi-agency care coordination process</b> to support children, families and carers with complex and co-occurring needs in place

To improve the experiences and outcomes of children, families and carers, all the services that they are involved with need to work together to ‘wrap around’ them. To enable this, an integrated, multi-agency care coordination process needs to be established to support children, families and carers with complex and co-occurring needs. This will require the integration of agencies’ accountabilities, policies, protocols and tools, to ensure that clinicians and other staff are empowered to collaborate when supporting children and their families. The process needs to be based on the principles set out in Figure 16

**“We need to reinstate a process like Strong Families. Young people are having to share their story with so many agencies. This will eliminate the repetition.”**

– Service provider



Figure 16: Three principles to underpin the multi-agency care coordination process

The child, their family and carers need to be actively and meaningfully involved in the care coordination process. Empowering children, families and carers to make decisions about their care is critical to ensuring their needs are met appropriately, and promoting buy-in.

Collectively, all parties need to be involved in all phases of the child’s care, including assessment, planning, intervention, transition planning and closure.

<b>Key action 4</b>	<b>Recommendation 15</b>
Collaborating with other government services to appropriately support children, families and carers	Support <b>schools and early childhood services</b> to increase their capability to address mental health and wellbeing in schools

Outside of the home, schools and early childhood services have the most influence on a child’s development. Given this, these services need to have the capability to support the mental health and wellbeing of children. As shown in Figure 17, schools need to be capable of identifying and working collaboratively to address mental ill-health and wellbeing at three levels – the universal, targeted, and individualised<sup>24</sup>. This is because children’s mental ill-health can be addressed at various stages of severity and should be identified as early as possible. In Recommendation 3, we detailed the potential role of early learning and early childhood services in prevention and early intervention. Below, we consider how they could provide more targeted and individualised support. This model can also be broadly applied for early childhood services.

**Support schools to enhance their capability at the universal level**

Best practice models highlight the benefits of close collaboration between the Department of Education drawing on the expertise and support of the MHC, to support schools, including government and non-government schools, to lead this, drawing on the expertise and support of the MHC, and government and community services, where required.



Figure 17: Three levels of mental health and wellbeing supports in schools and early childhood services <sup>25</sup>

<sup>24</sup> As many school-based prevention programs are funded by the MHC, schools will require the support of the MHC to strengthen this component of their whole of school approach.  
<sup>25</sup> As many school-based prevention programs are funded by the MHC, schools will require the support of the MHC to strengthen this component of their whole of school approach.



## Support schools and early childhood services to enhance their capability at the targeted and individualised levels

Schools and early childhood services, have a critical role to play in partnership with ICAHMS to intervene early and potentially improving the mental health and wellbeing of children experiencing mental ill-health. Case Study 7 shows how the Victorian Government has supported schools to enhance their capability at the targeted and individualised levels.

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**“Families may not be engaging with the community, but they do send their children to school. Schools need to be targeted by educating their staff.”**

– Service provider

To ensure that schools and early childhood services across WA are equipped to fulfill this role, they require support to:

- **Enhance collaboration with community mental health services, including Community ICAMHS:**  
A collaboration model needs to be collaboratively developed to define how schools and early childhood services will work with Community ICAMHS, to better support children with mental ill-health. The model needs to create effective linkages with school-based and school-linked mental health services, and early childhood and early learning services that support infants and young children. There should also be consideration for increasing the number of community education liaison teachers in all Community ICAMHS.

- **Increase the availability of postvention support:**  
Suicide can have a profound and long-lasting impact on the wellbeing of bereaved people. The provision of support to bereaved people – postvention – is essential. Several postvention programs are delivered in schools across WA, including the Children and Young People Bereaved by Suicide Program (CYPRESS) and the Response to Suicide and Self Harm in Schools Program (Schools Response Program). The capacity of MHC funded programs and services which provide postvention support to schools needs to be increased.

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**“Community education liaison teachers are a great option. We have two roles in the Great Southern – they are our link to schools. They are teachers, but they are based within the CAMHS team.”**

– Service provider

## Case Study 7 | Enhancing Mental Health Support in Schools Program

### ENHANCING MENTAL HEALTH SUPPORT IN SCHOOLS PROGRAM

VICTORIA, AUSTRALIA

#### Description

The Victorian Department of Education and Training, the Victorian PHNs and headspace have partnered to deliver the Enhancing Mental Health Support in Schools (EMHSS) program. The objectives of the EMHSS program are to enhance access to mental health support for secondary school students; increase support for, and improve response to, mild to moderate mental health concerns through early intervention strategies; and build the capability and capacity of school workforces to support students with mental health issues. To achieve these objectives, the EMHSS program comprises of three components, delivered by headspace:

- One-on-one counselling for students with mild to moderate mental health concerns. Counselling is delivered at headspace centres throughout Victoria. For those who do not live near (within 60km) to a headspace centre, phone counselling is offered.
- Capacity building and training for school workforces. Training includes SAFEMinds and SAFEMinds train the trainer sessions, and suicide risk continuum training sessions.
- Psychological support sessions for Student Support Services staff. These sessions provide staff with a confidential, reflective space, with a focus on enhancing self-care, stress management and wellbeing.

The EMHSS program has enhanced the provision of mental health services to all 327 government secondary schools across Victoria.

## Key action 4

Collaborating with other government services to appropriately support children, families and carers

## Recommendation 16

Support vulnerable and at-risk children, families and carers who are in contact with the **police and justice system**

Children in the justice system are some of the most vulnerable and disadvantaged children in Australia. They are also more likely to experience complex and co-occurring issues including severe neurodevelopmental impairment including Foetal Alcohol Spectrum Disorder (FASD), complex trauma, alcohol and other drug misuse, and challenging family and social circumstances. For these reasons, better care is needed for children involved in the criminal justice system, including the accessibility of more intensive and specialised care. They can often express and externalise mental health issues in different ways. Additionally, the care provided needs to be tailored to the different settings that children may be in, and the legal and regulatory environment surrounding youth justice.

**“Young people can’t access the mental health services that they need while they’re in the care of the justice system.”**

– Service provider

### **Develop a new forensic child and adolescent mental health service**

A future forensic child and adolescent mental health service should be dynamic. It should have specialised forensic mental health, and child and adolescent mental health capabilities, and adopt a multi-disciplinary approach which can address the needs of a child in multiple settings, at multiple stages of their journey in the youth justice system. Considerations for the new forensic child and adolescent mental health service include:

- community- or home-based treatment, delivered through partnerships with Community ICAMHS and youth justice services. This may take the form of the forensic service caring for the child; sharing care

with a community mental health service; or providing consultation liaison to a community mental health service in a stepped care model

- in-reach care into Banksia Hill Detention Centre, working in partnership with health and custodial staff
- assertive wrap-around care in the transition between detention and the community
- ‘in-reach’ care in inpatient settings – for example, within Ward 5A or other PCH inpatient wards, using a secure bed
- dedicated forensic mental health inpatient services
- mental health assessments and support for children who appear before the Children’s Court.

**“At Banksia Hill, you may only see a psychologist for 30-minutes a week, with somebody you don’t know. They can often be a trainee.”**

– Young person

It is critical that the co-design of the new forensic child and adolescent mental health service is undertaken in partnership with the Department of Justice and WA Police to align with the review of the model of care at Banksia Hill, including an uplift to the mental health workforce at Banksia Hill. It should also be undertaken in tandem with the recommendations of the *Graylands Reconfiguration and Forensics Taskforce* to identify any need for adolescent forensic beds.

## Case Study 8 | North Queensland Adolescent Forensic Mental Health Service

### NORTH QUEENSLAND ADOLESCENT FORENSIC MENTAL HEALTH SERVICE QUEENSLAND, AUSTRALIA

#### Description

The North Queensland Adolescent Forensic Mental Health Service (NQAFMHS) is a specialist service providing mental health and alcohol and other drug services to young people between 10 to 18 years of age who are involved with the youth justice system.<sup>26</sup> The service aims to provide culturally sensitive clinical and practical support to Aboriginal and Torres Strait Islander young people. The following services are delivered through NQAFMHS:

- **Adolescent Court Liaison Service** provides mental health assessment, screening and diversion to young adults who are before the court, in custody or in the watch-house.
- **Supervised Community Accommodation Service** provides specialist mental health assessment and management of young people who are accommodated in short- and medium-term community accommodation and are supported by youth justice.
- **Consultation and Liaison Service** provides consultation and advice on forensic mental health issues in young people who are involved with mental health teams across North Queensland.

Consumers, their families, Youth Justice, Child Safety, and other Child and Youth Mental Health teams can refer into NQAFMHS.

#### Enhance the capability of youth justice services to support children with mental ill-health

The new forensic child and adolescent statewide service should work closely with youth justice services to provide consultation liaison, shared care, and capacity building. This may include co-location of mental health staff within youth justice services. Where Community ICAMHS or the forensic statewide service are working with a child in the justice system, they need to work in partnership with youth justice services to provide wrap-around care. In building this capability, ICA mental health services need to provide in-reach care into Banksia Hill Detention Centre.

It is also essential that there are early identification and mechanisms in place for children in contact with the justice system. All children who receive orders associated with a criminal prosecution and/or are detained at Banksia Hill Detention Centre need to be screened for mental ill-health.

#### Enhance diversionary programs for children in contact with the justice system

Diversion programs, which aim to re-direct children away from youth detention, towards mental health and other services, have been shown to reduce offending and recidivism. Mental health and drug diversion programs are being run in the Perth metropolitan area from the Perth Children's Court. These programs need to be expanded across metropolitan, regional, and remote WA.

<sup>26</sup> Queensland Government, 20221, North Queensland Adolescent Forensic Mental Health Services, accessed 23 November 2021, available from: < <https://www.townsville.health.qld.gov.au/services/mental-health/cayas/north-queensland-adolescent-forensic-mental-health-services/> >.

## Key action 4

Collaborating with other government services to appropriately support children, families and carers

## Recommendation 17

Support the Department of Communities to meet the mental health needs of vulnerable and at-risk **children in care**

Children in out of home care are one of WA's most vulnerable populations, and tend to require support from multiple services across multiple systems, including mental health services. The best outcomes are achieved for children in care when their care is shared across the ICA mental health and child protection systems.

### **Enhance collaboration between child protection and mental health services, including Community ICAMHS**

Collaboration between child protection and community mental health services is required to address the needs of children in care with mental ill-health. A collaborative design process needs to be undertaken to develop a collaboration model to enable shared care for the mental health of children in out of home care. The case study below describes an interagency service delivery model in Queensland for children in care with mental health and behavioural support needs. The service is integrated with child and adolescent mental health services, and delivered in partnership between Queensland Health, and the Queensland Department of Communities.

## Case Study 9 | North Queensland Adolescent Forensic Mental Health Service

### EVOLVE THERAPEUTIC SERVICES<sup>27</sup>

QUEENSLAND, AUSTRALIA

#### Description

Evolve Therapeutic Services (ETS) provides specialist intensive trauma-informed mental health services for children and young people aged 0-18 years. The children and young people who come to ETS are involved with the Department of Communities, Child Safety Services, or are on child protection orders and in out-of-home care. They experience severe and/or complex psychological and behavioural support needs.

ETS is a collaborative interagency partnership between the Department of Communities, Queensland Health, and the Department of Education and Training. ETS works within the interagency model to provide therapeutic interventions for children and young people in care. This includes:

- Comprehensive assessments, treatment plans and specialist therapeutic interventions and supports based on the bio-psycho-social-cultural needs of the child or young person and their support network.
- Medium- to long-term trauma informed therapy to facilitate a child or young person's ability to form secure attachments following ongoing abuse and neglect.
- Expertise in the understanding of complex trauma, abuse and neglect during childhood and its immediate and long-term impact.
- Psycho-education to the child or young person's support network.

The ETS teams are situated within Queensland Health, CYMHS to drive integrated service delivery. There are ten ETS teams located across Queensland.

### Build the capability and capacity of child protection services to address children's mental health

There is a need to build the capability of child protection workers and carers to identify and respond to the early signs of mental ill-health in children, to be better positioned to support the mental health of children in their care. There is also a need to establish child protection liaison workers within Community ICAMHS, and Community ICAMHS liaison workers within child protection teams. They will facilitate access to the respective services, enable earlier identification and intervention in children's mental ill-health, and support capability transfer between the services.

<sup>27</sup> Queensland Government, 2021, Evolve Therapeutic Services, accessed 28 November 2021, available from: <https://www.childrens.health.qld.gov.au/service-evolve-therapeutic/>

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## 12. Key Action 5: Investing in the capability and wellbeing of the ICA mental health workforce

### What is it?

The enduring reform of ICA mental health requires a significant and sustained investment in the development of a workforce that can consistently deliver high-quality treatment, care and support to children and their families and carers.

The future ICA mental health workforce needs to be supported to operate to the full extent of its potential. That is, in a resource constrained system, it is essential that staff have the opportunity to work to their full 'scope of practice' – their capabilities need to be leveraged to deliver the new models of care, with additional training and development and without the constraints they face today. Key Action 6 describes how the capacity and skill mix of the ICA mental health workforce needs to change to support contemporary models of care. The workforce needs to see a significant growth in the number and role of Aboriginal staff, peer workers, allied health workers and clinicians in training. Key Action 5, therefore, focused on the structures that need to be in place to ensure that all staff are empowered in their role, and provided with the support and training that they need to meet their full potential.

It is also important to recognise that the ICA mental health system needs to care for and support the workforce, so that all staff feel safe, trusted, and respected; and ultimately, to be proud advocates for working within the ICA mental health system.

### Why is it important?

To create a responsive, innovative, and integrated ICA mental health system, this Strategy has proposed a significant reform of how services are structured, delivered and how they interact with each other. As services adapt, and new models of care are introduced, the system needs the ICA mental health workforce and the way in which their wellbeing is managed to adapt. Workforce education and development for new and existing ICA mental health staff is essential for the reforms to deliver on the vision set out in this Strategy.

The workforce today is highly motivated to change the way that services work. They are driven by the same values and principles that have been described in this Strategy and have been a crucial voice that has underpinned the reforms that are being proposed. A workforce that is motivated and engaged is essential to providing high-quality and safe care to all children, families and carers in WA.

## Recommendations for Key Action 5

Key action 5	Recommendation 18
Investing in the capability and wellbeing of the ICA mental health workforce	Implement <b>training and development</b> opportunities that maximise and grow the capabilities of the ICA mental health workforce

The new models of care proposed in the Strategy require the development of staff across an extensive cross-section of mental health, health and social care fields. Delivering these models of care immediately will be a challenge. The system today has sizeable shortages across key professions, including child and adolescent psychiatry, nursing, allied health, and peer work.<sup>28</sup>

The future ICA mental health workforce cannot be static. It needs to enable all staff to work to their full capability and skillset, and progressively and proactively invest in the ongoing professional development of staff. This can be achieved through the establishment of an ICA-specific mental health workforce development function which can proactively identify the skill mix required of the workforce, and lead training, development, and deployment activities across the entire system. This would include:

- Designing core competency frameworks in all specialist and specialised fields<sup>29</sup> to inform the design and delivery of training programs for ICA mental health staff in Community ICAMHS and in statewide services.
- Ongoing 'skills audits' of the ICA mental health workforce; identifying the skills, capabilities, qualifications, and certifications of all staff.

- Coordinating and regularly updating a training needs analysis, identifying future capability needs as compared with current capability levels to ensure training and development can be targeted in the right places to deliver the models of care of the future.
- Reviewing and re-designing all staff role descriptions in line with future models of care to remove constraints and limitations on frontline staff, and empowering them to work to their full scope of practice within the context of the service they work within; this also includes ensuring role classifications are standardised across CAHS and WACHS services so staff can easily move between these services.
- Support staff to ring fence time for the purposes of accessing and participating in training and continuous professional development.
- Piloting new workforce roles to support changes in modes of care, such as utilising allied health workers for more complex care.

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**“We don’t support our workforce enough. With the right training and supervision, we can do a lot of things.”**

– Clinician or service provider

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<sup>28</sup> In some professions, such as peer work, there is work underway to establish the formal frameworks that guide the role of peers in mental health so that the workforce can grow and thrive with the appropriate supports in place.

<sup>29</sup> These core competency frameworks need to be developed for, at minimum, the treatment of eating disorders, personality disorders, conduct disorders, infants, children with intellectual disability and/or neurodevelopmental or neuropsychiatric disability, Aboriginal children, ELD children, and gender diverse children.



## Key action 5

Investing in the capability and wellbeing of the ICA mental health workforce

## Recommendation 19

Establish clear roles, capabilities, and career pathways for **peer workers**

Contemporary mental health workforce models are based upon building and sustaining a peer workforce as part of contemporary multidisciplinary teams. These models have recognised the importance that peers play in providing emotional and social support to others, sharing common, lived experiences, and embodying the possibility of recovery and overcoming adversity. Children, families, and carers have all advocated for the benefits that peer workers will have as part the future ICA mental health system – both young people and parents who can offer help, hope and inspiration to children from their own experience.

The National Mental Health Service Planning Framework includes peer workers as part of its ideal multi-disciplinary team mix and over recent years, peer workers have increasingly been used in the community sector, and primary mental health services. However, in WA, they remain an underutilised capability in the specialist mental health system. The future ICA mental health system needs a vibrant, diverse, and supported peer workforce into the future. This peer workforce needs to be recognised and respected, provided with adequate supervision and support, and pathways for ongoing professional development and career progression. Achieving this needs a considered and sustained effort by all levels of government, working in partnership with ICA mental health services and children, families, and carers and peer workers themselves, to create the conditions for a thriving and supported peer workforce.

### **Establish structures for supervision, support and recognition within service models**

Supervision is an essential part of supporting the ICA mental health workforce. It exists to support skills development, ensure accountability for quality care, and also to mitigate risk. Structures for the supervision and support of peer workers in ICA mental health need to be established to create the conditions for a high-performing peer workforce. This ensures that peer workers are able to regularly access support and receive and act on feedback to develop their skills and capabilities. Supervision and support can be provided by mental health professionals, and other peer staff, depending on the needs of each peer worker.

Supporting peer workers as part of a multi-disciplinary workforce also needs a cultural shift in the attitudes towards the value that peer workers bring in supporting children, families and carers. This needs investment in ongoing training and communications to all clinical staff to create a consistent understanding of the role and importance of peer workers and ensure that staff empower peer workers to be valued and valuable members of the multi-disciplinary team.

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**“Peer workers are so important. They just get it in a way that other staff can’t.”**

- Young person

## **Mature professional development and career pathways for peers**

Peer work is incredibly skilled and valuable work, delivered by committed health professionals. In many cases, development as a peer worker will be an ongoing focus and professional aspiration. For some, it may be a transition point in the careers of young people, families, and carers with lived experience. While supporting peer workers to succeed within the role, ICA mental health services need to support peer workers to plan and invest in their ongoing professional development and certification of skills. This needs to be broader than just undertaking a Certificate IV in Mental Health Peer Work and needs to include supporting peer workers who wish to 'specialise' in supporting children of particular backgrounds, in particular settings or with particular types of mental ill-health. It needs to also include professional development and training activities such as leadership development and pathways to higher education.

The development and 'specialisation' of the peer workforce requires clear planning and definition, and the establishment of 'pathways' for peer workers to undertake further professional development and training.

## Key action 5

Investing in the capability and wellbeing of the ICA mental health workforce

## Recommendation 20

Establish clear roles, capabilities, and career pathways for **Aboriginal mental health workers**

Aboriginal mental health workers perform a crucial role in ensuring that services are, and are perceived as being, culturally safe, appropriate, and trustworthy. Increasingly, Aboriginal mental health workers are relied upon, both formally and informally, to develop the capability and cultural competency in working with Aboriginal children, families, and communities, and helping those children, families and carers feel culturally safe and secure, providing direct support to those families and assisting in navigation. However, compared with other mental health professionals, there is a poor understanding of the role and capabilities of Aboriginal mental health workers; they are provided with more limited career opportunities and experience more professional isolation than other members of multi-disciplinary teams.

There is also an inconsistent deployment of Aboriginal mental health workers across the ICA mental health system. Although WACHS is drafting an Aboriginal mental health model of care (see Case Study 10), there are currently some WACHS CAMHS teams and CAHS Community CAMHS teams that do not include any Aboriginal mental health workers; despite serving a local population that includes a significant Aboriginal population.

The future system needs a significantly expanded, supported, and empowered Aboriginal mental health workforce. This needs significant investment to develop a more accessible pathway for Aboriginal people to become mental health workers, and clarity of roles and responsibilities to ensure that all members of the ICA mental health workforce understand the remit, and value that Aboriginal mental health workers bring to multi-disciplinary teams. Additionally, Aboriginal mental health workers need to be supported to 'specialise' in medical, nursing and allied health fields, rather encouraging their own professional development.

Aboriginal mental health workers should not have sole responsibility for ensuring that ICA mental health services are culturally safe. This is the responsibility of the entire ICA mental health workforce, who require ongoing professional development in culturally responsive practice.

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**“I think it’s important to clarify the roles of Aboriginal mental health workers. It can put a lot of pressure on them when the team has different expectations to what is within their scope of practice.”**

- Clinician or service provider

## Case Study 10 | WACHS Aboriginal Mental Health Model of Care

### WACHS ABORIGINAL MENTAL HEALTH MODEL OF CARE WESTERN AUSTRALIA

#### Description

The Aboriginal Mental Health Model of Care provides high-quality mental health services for Aboriginal people in regional and remote Western Australia through combining cultural and clinical expertise to deliver services supporting social and emotional well-being concepts. It aims to foster responsive and culturally sensitive service delivery, free from racial discrimination and ultimately empowering Aboriginal people with lived experiences of mental health illness.

The Model is built upon key themes of culture, people and respect with dignity. It is guided by the following set of principles:

- Build strength and resilience into the mental health workforce through an inclusive multidisciplinary approach to specialist patient care for Aboriginal people.
- Enhance knowledge and health literacy within regional and remote communities.
- Consult with communities and respond appropriately to local need and cultural nuances. Engage in internal and inter-agency partnerships and shared care arrangements that foster high-quality mental health care for Aboriginal people.
- Co-locate, collaborate and communicate effectively with community-controlled organisations and established health services to deliver mental health care to Aboriginal people.

Aboriginal mental health workers play a fundamental role in the implementation of the model, acting as a bridge to join the values, knowledge and practices of Aboriginal Communities, Mental Health Services and Primary Care & Support Services together to provide a client-centric integrated service.

## Key action 5

Investing in the capability and wellbeing of the ICA mental health workforce

## Recommendation 21

Increase the overall capability of the ICA mental health workforce to appropriately **support the diversity** of all children across WA

Many of WA's children, families and carers come from diverse ethnic and cultural backgrounds. The ICA mental health system needs to be equipped to support the diversity of children, families and carers across all of WA. This does not mean treating all children, families and carers the same, it means tailoring and adjusting the care that is provided, and how it is provided so that it is safe and appropriate for the unique background and context of each child and their family.

The **composition** of the workforce needs to reflect the diversity of children, families and carers they support. This means that the workforce needs to have staff that represent the diversity of the WA community. It also means that there needs to be a commitment to, and common practice of utilising cultural and language interpreters, where and when necessary to ensure children, families and carers are supported to make informed decisions about their own care.

Secondly, the workforce needs to have the **capability** to support the diversity of children that require mental health supports, in all settings where they may receive care. All ICA mental health staff in emergency departments, Community ICAMHS, statewide services, emergency telehealth services, and primary care

services, need to be able to adapt how they support and interact with all children, families and carers in a safe and appropriate way. This needs to include, but not be limited to:

- training in trauma-informed practice, to improve care for children with complex and intergenerational trauma
- training in culturally safe and appropriate practice in working with Aboriginal children, families and communities, and with cultural interpreters
- training in working with children, families and carers from ELD backgrounds, and with interpreters, including incorporating INSPIRE ELD training program as part of HSP Mandatory Training packages
- training in safely supporting and working with LGBTQIA+ children
- training in working with autistic children, and children with intellectual, neurodevelopmental and neuropsychiatric conditions.

It is imperative that all of these training programs are codesigned in partnership with lived experience children, families and carers from each unique group.

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**“It would be useful to have more resources to support ELD families with appropriate services. We provide services often only in English and then rely on them to work out what to do next with little or no information that they can rely on in the future.”**

- Clinician or service provider

## Key action 5

Investing in the capability and wellbeing of the ICA mental health workforce

## Recommendation 22

Ensure that staff feel **safe, valued and connected** across the ICA mental health system

WA's ICA mental health workforce has been on the front-line of a system in crisis. Staff working across ICA mental health services feel forgotten, underappreciated, and left behind; as investment in the broader health system has exceeded investment in the wider mental health system, which in turn has seen proportionally more investment in youth and adult services. As the system has continued to experience capacity constraints and rising demand, staff are reporting feeling burnt-out, vicariously traumatised, and are leaving the workforce. This potentially impacts risk to workplace health and safety, clinical quality and safety, as well as to the experiences of children, families and carers.

The future ICA mental health system must be better at supporting its workforce. Addressing the capacity constraints of the system (see Key Action 6) must be the first step in a long journey of earning back the trust of staff, and making staff feel safe, valued, and appreciated. The culture in ICA mental health services overall, needs to be a priority to create an environment that is able to reform. It also requires a cultural shift at a government, leadership and health system level so that working in mental health is seen as equal to physical health.

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**“Staff commitment keeps services going, but the workforce is exhausted. This has been the case since well before COVID.”**

- Clinician or service provider

Transforming the culture of the ICA mental health system is not a shift that can happen quickly. Increasing the capacity of the workforce is a critical first step, but must be complemented by initiatives that create a more caring and compassionate environment for staff, including:

- Establishing mechanisms that support collaboration and creating an ‘ICA mental health community’ across the system. This could include establishing interagency networks, and communities of practice, that bridge organisational divides to bring staff together.
- Establishing a flexible workforce model and working arrangements to help increase the attraction and retention of ICA mental health staff.
- Establishing mechanisms to create a unified CAMHS workforce that shares knowledge and capability, including creating arrangements for ‘secondments’ and staff exchanges to ensure that staff are exposed to different parts of the system, and empowered to continuously develop their skills and capability.

These initiatives are just an example of the types of things that are needed. A sustained effort is needed to create an environment where all people who choose to work in ICA mental health feel proud, valued and recognised for their work.

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**“There needs to be a parity of esteem. How can our staff feel valued if they are constantly treated as second class clinicians by others in the wider health system?”**

- Clinician or service provider

## Case Study 11 | Wellbeing Check Program

### WELLBEING CHECK PROGRAM

AUSTRALIA

#### Description

The Wellbeing Check (WBC) program was one of four elements of the Well at Work initiative to support staff and promote health and wellbeing during the Royal Commission into Institutional Responses to Child Sexual Abuse.

The centrepiece of the program was an individual, bi-monthly wellbeing check with a dedicated wellbeing counsellor assigned to each member of staff. Appointments were preceded by two online psychometric surveys measuring levels of wellbeing and stress.

The WBC program was delivered by an external provider, who submitted a bi-monthly report to the Human Resource team including de-identified information on emerging issues and trends.

The wellbeing checks adopted a person-centred, strengths-based approach. Counsellors focused on areas where staff felt positive about their work, reflecting on existing coping, problem solving and relationship management strategies, and discussing self-care practices.

## 13. Key Action 6: Growing and sustaining the capacity of the ICA mental health workforce to better meet needs

### What is it?

The ICA mental health workforce has been under immense pressure for several years. Whilst there has been little growth in the capacity of the workforce, demand for mental health services from children and adolescents has been rapidly rising. The result is a sizeable gap between the current capacity of the ICA mental health workforce and the capacity needed to meet the current needs of children and families across WA.

Key Action 6 focuses on addressing this shortage as an urgent priority, but recognises this may take many years. There is not a 'workforce in waiting' that can immediately fill the gaps in the workforce, even if additional funding was made available. Therefore, Key Action 6 resolves to address the current, and future shortage in a sustainable and pragmatic way.

In the short-term, this means targeting specific and critical gaps in the workforce, particularly in regional and remote WA, supporting mental health nurses in training to remain within the service, and increasing the numbers of peer workers and Aboriginal mental health workers.

In parallel, it is critical to build a 'pipeline' for the workforce of the future, especially in attracting and developing the psychiatry workforce, as well as shifting the structure, composition and skill mix of the workforce to increase multi-disciplinary capabilities and sustainably deliver the services needed in the future.

### Why is it important?

To inform the Strategy, Taskforce undertook comprehensive needs-based modelling that has estimated the 'quantum' of the gap between the current workforce capacity and that which is needed now, and in the future. The modelling identified a substantial shortage in the current ICA mental health workforce. It also identified that the workforce profile needs to look very different – with significantly more child and adolescent psychiatrists (especially psychiatrists in training), ICA mental health nurses, Aboriginal mental health workers, peer workers, and other allied health professionals. Currently psychologists are the only part of the workforce that are reasonably aligned to the workforce needed, albeit they are working within an overall workforce that is in a significant overall deficit.

Significant investment in the ICA mental health workforce, and a structural transformation in how the workforce is comprised, will ensure the workforce is able to meet future needs in a sustainable way.



## Recommendations for Key Action 6

Key action 6	Recommendation 23
Growing and sustaining the capacity of the ICA mental health workforce to better meet needs	Invest immediately in the <b>core capacity of the workforce</b> , especially for services in <b>regional and remote WA</b>

Whilst the entire ICA mental health system is in need of additional staff, there is a critical need to address urgent workforce shortages. Some of these investment priorities reflect the significant disparity in service capacity in regional and remote WA, relative to metropolitan WA, whilst others reflect areas that can be quickly addressed to provide the workforce with an immediate capacity uplift to address the urgent needs of children and families. These targeted investments complement the shift in the workforce mix that forms part of Recommendation 25.

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**“Staff care a lot, and they try their best, but there’s just too much demand.”**

– Young person

The immediate investments needed in the ICA mental health system are:

- Sustainably fund, recruit and embed the recent FTE uplift within CAHS. CAHS has started to recruit into these roles but only some of the positions are permanent positions beyond the current year. These positions need to be permanently established.
- An immediate increase to the ICA mental health workforce in WACHS, across all regions; with a particular focus on addressing gaps in psychiatry and nursing. This should be supported by a proportionate increase in administrative and support staff to ensure that clinical time can be focussed on clinical services.
- Alongside the establishment of structures to support and retain peer workers (see Recommendation 19) there should be an immediate increase in the permanent peer workforce working in Community ICAMHS teams; both in CAHS and WACHS.
- Alongside the establishment of structures to support Aboriginal Mental Health Workers (see Recommendation 20) there should be an immediate increase in the permanent Aboriginal mental health workforce working in Community ICAMHS teams; both in CAHS and WACHS.
- Ensure that there are established positions for front line workers in CAHS and WACHS that are in the final stages of training (notably graduate nurses).

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**“We all want reform, we all want it now – but we also fear what happens if we are asked to make changes without any additional staff. When will we have time to make these changes?”**

– Clinician

## Key action 6

Growing and sustaining the capacity of the ICA mental health workforce to better meet needs

## Recommendation 24

Grow and sustain the **pipeline** of the ICA workforce to meet needs

There is no ICA mental health 'workforce in waiting' and there is no pipeline that will help build the workforce into the future. In critical areas of the workforce, even with immediate investment, these shortages cannot be addressed in the short to medium term. This is most evident for child and adolescent psychiatrists, some allied health professions, and child and adolescent-trained mental health nurses.

Creating the ICA mental health workforce of the future, first needs significant effort and investment in the creation of a workforce 'pipeline', focused on building a sustainable workforce with the right skills-mix and qualifications.

### **Develop a workforce plan specific to ICA mental health that sets the objectives and actions required to grow and sustain the required workforce capacity and capability**

In response to Recommendation 26 of the Sustainable Health Review, the WA Government is currently developing a 10-year health and social care workforce strategy that will outline the skills and training needs to ensure an interdisciplinary and equitable approach to care across all acute and community health settings. Within this strategy, a targeted ICA mental health workforce plan is needed.

**"We have nurses ready to join the workforce, but they are leaving the workforce quicker than we have nurses joining."**

- Clinician

The workforce plan should be informed by the recommendations presented in this report and needs to define:

- The critical capabilities, roles, functions, diversity needs, and locations for the ICA mental health workforce, with an emphasis on roles in regional and remote WA
- The local, national and international supply chains, including universities, vocational education and training, re-skilling, and skilled migration, and the limitations of each supply chain
- Strategies to 'build' a local workforce, 'attract' workers from interstate and overseas, and identify temporary workforce solutions to address urgent gaps.
- Strategies to improve the 'recruitment' and 'retention' of the workforce, including a substantial streamlining and shortening of recruitment processes for all ICA mental health roles.

The workforce plan needs to be informed by the ongoing development of the needs-based modelling; in particular to align it with the forthcoming 2021/22 National Mental Health Service Planning Framework, and emerging evidence related to the ongoing impact of the COVID-19 pandemic on infants, children and adolescents.

The workforce plan also needs to leverage the work underway at the Commonwealth level (through the National Mental Health Workforce Strategy Taskforce) and build on frameworks developed locally; including the MHC's Workforce Strategic Framework.

## Identify initiatives within education settings to support growth in the pipeline of the ICA mental health workforce

The WA Government needs to work in partnership with the education and training sector to invest in and grow a local ICA mental health workforce. As shown through COVID-19, WA cannot rely too heavily on an interstate and international supply to meet local workforce needs. The existing formal partnerships between the WA Government, including the 'Chiefs of Professions'<sup>30</sup> need to be leveraged and strengthened to develop strategies, and invest in ways to attract, develop, and retain local ICA mental health workers. This needs to include a number of initiatives:

- **Promotion activities.** Partner with universities and TAFEs to promote education pathways and careers in ICA mental health, aligned with the skills and workforce mix identified in the workforce plan, including potential use of grant subsidies to encourage students into the profession. This could include establishing a greater number and diversity of 'Chairs' within WA's universities.
- **Curriculum and work experience alignment.** Ensure that University and VET programs align with the capability requirements of the ICA system. This needs partnerships between system leaders, the Chiefs of Professions, the Royal and Australian Colleges<sup>31</sup> and the secondary and higher education sector.
- **Increasing clinical rotations and training positions.** Increase the number of clinical rotations and training positions within ICA mental health, and specifically in child and adolescent psychiatry and nursing. This should include as a priority, an increase in the number of training psychiatric registrar positions in ICA mental health services.

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<sup>30</sup> WA's Chief's of Professions include the Chief Medical Officer, Chief Medical Officer (Mental Health), Chief Nursing and Midwifery Officer, Chief Allied Health Officer, and the Chief Psychiatrist.

<sup>31</sup> The Royal and Australian Colleges include the Royal Australian and New Zealand College of Psychiatrists (and Faculty of Child and Adolescent Psychiatry), and the Australian College of Mental Health Nurses.

## Key action 6

Growing and sustaining the capacity of the ICA mental health workforce to better meet needs

## Recommendation 25

Increase the **capacity, flexibility and diversity** of the ICA mental health workforce

Investing in a healthy and sustainable workforce pipeline is necessary, but not by itself sufficient to build the ICA mental health workforce of the future. The workforce also needs structural reform. This includes: thinking differently about how the workforce itself is structured; what workforce models are used to deliver the new models of care; exploring and investing in more innovative models of care that are responsive to the realities of a workforce constrained system; and creating capacity within the front line workforce through easing and streamlining administrative burden.

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**“A manageable workload is essential to prevent burnout and keep our staff. As a clinician, I find it difficult maintaining my current workload with all of the admin I need to do, including having to login to multiple system many times a day. There are so many things I have to do that add nothing to a child’s treatment outcomes.”**

– Clinician or service provider

Specific priorities in implementation need to include:

- **Review the ICA mental health workforce mix in line with national and international best practice.** WA’s ICA mental health workforce is structured differently to workforce models in other Australian and International jurisdictions and does not closely reflect the skills mix used by the National Mental Health Service Planning Framework. Specifically, WA has a substantially lower proportion of psychiatrists in training, peer workers and nurses.
- **Augment workforce models to deliver new models of care safely and sustainably.** The future ICA mental health workforce needs to be structured to deliver the care and treatment that children and families want. This requires more flexible and dynamic teams, that are enabled to work more collaboratively with other services. Future models of care cannot be overly-reliant on a medical workforce that we know will be hard to recruit; and needs to better leverage the expertise of the nursing and allied health workforce. To achieve this, services need to develop, trial, and implement new workforce models, including models of care that are nurse-led and allied health-led, with appropriate governance arrangements (see case study below for an example of this).
- **Reduce administrative burden through streamlining the non-child-facing requirements on clinicians.** Clinicians are overburdened with regulatory and administrative requirements that take away from time spent with children and families. This has seen clinicians spend less than half of their time with children and families, with the remainder spent on administration made further difficult by inefficient systems and processes. This needs to be addressed through a rapid process of identifying opportunities to reduce administrative ‘red-tape’, and investment in systems and technology to streamline processes for information collection, and information sharing.

## Case Study 12 | Mental Health Emergency Department Diversion: Nurse Practitioner-Led Mental Health Service Model

### MENTAL HEALTH EMERGENCY DEPARTMENT DIVERSION: NURSE PRACTITIONER-LED MENTAL HEALTH SERVICE MODEL AUSTRALIA

#### Description

The Nurse Practitioner (NP)-led Mental Health Service Model is a proposed alternative for people presenting to EDs experiencing episodes of mental-ill health. Based on a successfully evaluated model in NSW, the service is supported by a team of specialist mental health and emergency specialist nurses, who are available to see patients with undifferentiated mental health, drug and alcohol, and behavioural problems.

Co-located adjacent to a tertiary ED, patients are able to self-refer ('walk-in') or be referred from triage if presenting with a primary mental health condition). Patients can also be referred by GPs, primary health services, and non-government provided mental health services. A close working and complementary relationship with the ED team and psychiatry service ensure appropriate governance, safety and timely admission if clinically indicated.

## 14. Key Action 7: Enhancing ICA mental health services with contemporary infrastructure, technology, and research

### What is it?

Key Action 7 focused on the enhancements to infrastructure, technology, and research capability needed to underpin the function, experience, and continuous improvement of the ICA mental health system.

The increased efficiency of, and access to care within the future ICA mental health system depends on safe and accessible infrastructure – both physical infrastructures to provide safe and welcoming environments, and digital infrastructure, to enhance system efficiency and provide safer, better, more responsive, and more accessible care for children and families in the most remote parts of our State.

WA needs to continue its growth as a national leader in research and innovation in child and adolescent mental health. The capability and capacity of our staff to lead research and innovation is essential to building a system that continuously improves, with a focus on delivering care that meets the needs and expectations of children and families.

### Why is it important?

ICA mental health facilities are often unsuitable and sometimes unsafe for children, including those with experience of trauma, those from diverse backgrounds, and those who live with a disability. The future ICA mental health system has been designed to bring services closer together and closer to children and families. The recommended services, however, will require targeted investment in infrastructure. This aligns with the recently released WA State Infrastructure Strategy, which highlighted mental health infrastructure as a state priority; and takes into account that much of the infrastructure used to support ICA mental health services is not conducive to delivering high-quality care.

The future ICA mental health system has been designed to leverage the potential of digital health, especially in virtual care. The current system has made significant investments in virtual care in some places, particularly through WACHS, but it is still underutilised statewide. The future ICA mental health system requires investment in modernising its information systems to enable more innovative modes of service delivery, supporting clinicians to spend more time with children and families.

WA's unique geographic size and dispersed population means that contemporary and innovative solutions are continuously needed to improve the quality and accessibility of care for some of the State's most vulnerable and remote children and families. Investment in research, learning and innovation across the ICA mental health system can drive service improvement, and lead to better outcomes.

## Recommendations for Key Action 7

Key action 7	Recommendation 26
Enhancing ICA mental health services with contemporary infrastructure, technology and research	Expand the <b>function and availability of virtual care</b> across the ICA mental health system

The use of virtual care has increased in recent years as a way to make healthcare more accessible to people that would ordinarily experience significant barriers to accessing care.

In WA, WACHS has led innovation in virtual care through the development of its Command Centre and telehealth services. Through the Command Centre, WACHS is delivering digitally enabled, specialist clinical healthcare to its network of 80+ hospitals across the state; enabling more people to be supported in the local hospital and reducing the need to transfer to other larger facilities at great expense and inconvenience.

Investment in virtual care is a priority of the WA health system, one that has been emphasised in the context of the COVID-19 pandemic. The proposed future ICA mental health system has been designed to leverage the investment that has already been made in virtual care and encourage ongoing investment to create a system that integrates virtual technology into all models of care, including in the short term:

- Expanding and investing in CAMHS Crisis Connect and WACHS ETS to further enable their ability to support children leaving emergency departments, and whilst they wait for support from an ICA mental health service.
- Establishing ICA mental health expertise in the WACHS Command Centre to provide specialist access and support to child and adolescent mental health services for children in regional and remote WA.
- Establishing virtual care capability in all schools, headspace centres, GP clinics, and AMS' and ACCHO's in regional and remote WA to support consultation liaison and shared care with Community ICAMHS
- Establishing virtual care capability (and associated training) in all statewide services to support the provision of consultation liaison and shared care to regional Community ICAMHS teams

Ultimately, to realise the full extent and potential of virtual care, WA should move toward a single statewide ICA mental health virtual service jointly operated by WACHS and CAHS. This will achieve the greatest synergies between the statewide services and Community ICAMHS teams, as well as maximising utilisation of scarce resources.

In addition, telehealth is just one component of virtual care. It is anticipated that any future virtual care capability could include features such as:

- Digitised care planning and documentation to support multi-disciplinary teams
- Data collection forms and tools
- Consumer portals for children and family to access information about their care plans and upcoming appointments
- Remote monitoring devices
- Analytics that capture and manage outcomes of planned care and interactions with the child and their family.

As it develops, the single statewide ICA virtual mental health capability can support all specialist ICA mental health services and the integration with other services.

#### ***Definition of virtual care***

Virtual care is often used interchangeably with telehealth. It is also distinct from other forms of distance care that use 'telephones', in that virtual care is increasingly synonymous with care provided using 'videoconference' technology.

While telehealth is one aspect of virtual care, other forms include online counselling and treatment, group therapies and forums, remote monitoring and virtual 'waiting rooms'.



<b>Key action 7</b>	<b>Recommendation 27</b>
Enhancing ICA mental health services with contemporary infrastructure, technology and research	Establish new <b>integrated ICA mental health facilities</b> in all regions to support more flexible, responsive and expert care

Key Actions 2 and 3 describe a detailed vision for Community ICAMHS in each region across the State, with integrated 'Hubs' in the Perth South, Perth North and Perth East metropolitan regions, and across regional WA. These hubs need to be the 'engine-room' of the future ICA mental health system, delivering comprehensive, child-centred mental health services. The Community ICAMHS Hubs provide an opportunity to bring traditionally separate services together into a single community-based setting as part of a 'one-stop-shop' for all health and mental health supports for children, and their families and carers.

Each 'hub' across the network could be a **purpose-built integrated facility** that supports the co-location of Community ICAMHS, with enhanced primary mental health services, GPs, child development services, and a range of other social support services. These hubs need to be **easily accessible in a non-hospital setting**. These facilities should be child and family friendly and be designed with input from children and families to create therapeutic, low-stimulation, and recovery-oriented environments.

It is expected that these facilities will look different in regional WA, due to the availability of infrastructure, and geographically dispersed areas that 'Hubs' will need to support. Virtual care will play a crucial role in 'virtually' bringing services together to create Hubs that are both virtually and physically integrated.

## Case Study 13 | Peel Health Hub

### PEEL HEALTH HUB

#### WESTERN AUSTRALIA

##### Description

The Peel Health Hub is a one stop shop for the health needs of young people, adults, families and carers in the Peel region, offering a coordinated response to health issues. This includes mental health, alcohol, and other drugs, assault, sexual abuse and family violence. The hub provides a coordinated approach to improve the mental, social and physical health of clients and operates using a 'no wrong door' policy.

Services provided by the Peel Health Hub are:

- **Peel Youth Medical Service** – provides confidential health services with a focus on young people, aged 12-25
- **Youth Focus** – Provides youth counselling and peer support programs among other services
- **Allambee Counselling** – Provides sexual assault and family and domestic violence counselling
- **Palmerston** – Provides alcohol and other drug services
- **Jobs South West** – Provides individualised and group programs for young people with complex behaviours
- **CAMHS** – Provides assessment and treatment of moderate to severe mental health issues for infants, children and young people
- **Richmond Wellbeing** – Provides inclusive, community-based mental health and wellbeing support services

## Key action 7

Enhancing ICA mental health services with contemporary infrastructure, technology and research

## Recommendation 28

Update **digital systems, technology and data** to better support the delivery and quality of ICA mental health services

There is a need to update, improve and use digital systems, technology, and data to better support the delivery and quality of ICA mental health services. Currently, the ICA system is not leveraging contemporary information systems to underpin service delivery.

### *WA Health Digital Strategy (2020-2030)*

The WA Health Digital Strategy 2020–2030 (the WA Health Digital Strategy) articulates the digital technologies that will support transformation of the WA health system in the way that care is delivered, information is shared and how consumers can engage with their health. Many directions of the Digital Strategy will shape the current and future delivery of ICA mental health, including the establishment of an Electronic Medical Record (EMR) as a key enabler to fully realise the benefits of digital innovation and new ways of working.

Supporting digital systems, technology and data in ICA mental health needs to be developed as part of and aligned to the WA Health Digital Strategy. A critical part of this strategy, the WA Health EMR program is in the first stages of development. Investing in a digital health record for community care is part of Stage 1 of the EMR program.

Whilst mental health wasn't initially intended to be part of this, there is a small window of opportunity for the requirements for ICA mental health to be integrated into the 'Community Care' module. This will require:

- Undertaking a detailed mapping exercise of the maturity of virtual care capabilities and their application to ICA mental health
- Procuring and rolling out of solution that meets a range of community requirements, including enhanced data management systems to support system oversight, performance monitoring and the analysis of emerging population trends.

In addition to the EMR, the development of new digital tools and processes are needed to support the continuous improvement of service delivery, including the use of mobile tools to support a workforce predominantly operating in community settings.

There are also opportunities to work with children, families, service providers and others to design and establish an online platform to access educational resources and to connect with services, as the future ICA mental health system develops.

## Key action 7

Enhancing ICA mental health services with contemporary infrastructure, technology and research

## Recommendation 29

Establish **dedicated structures for research, learning and innovation** that translate to improved and sustain outcomes

The current capacity for research and innovation within the public ICA mental health system is minimal. Clinicians are inhibited from research due to the demands of their roles, access to data, funding and the pathways for research to lead to better outcomes are not established. Children, families, and carers want the evidence that the services they access are effective and world class, and clinicians and researchers need to be supported to continuously improve services.

A future program of research, learning and innovation will play a critical role in meeting the future needs of children and families. Investment in research will generate the evidence necessary to inform policies, programs and service delivery that translates to better outcomes while strengthening the efficiency of the system in the long-term. Further, the opportunity for clinicians to contribute to the development of innovative best practices will be an important enabler of workforce attraction and retention.

A future ICA mental health research and innovation program will ensure that models of care adapt to changing needs, practices and technologies, and that outcomes for children, families and carers are optimised. It needs to include:

- Active engagement and partnership with children and families with lived experience, including those from regional and diverse communities, to ensure research is directed toward the mental health challenges that are most important.
- Opportunities for ICA mental health clinicians to contribute to and/or lead research and innovation, including service evaluation. This can ensure that current and future models of care are subject to research and routine evaluation supported by a strong evidence base. It will also contribute to the retention and sustainability of the workforce, as they have improved opportunities to balance clinical and research responsibilities.
- Embed research capacity in all models of care to drive evaluation and continuous service improvement.
- Improved capabilities for data collection, management, and utilisation, including increasing the accessibility of data between services and systems, in order to address the needs of the most vulnerable children.
- Dynamic partnerships with policymakers, including mental health, health, education, child protection, and justice system leaders; and researchers from a range of disciplines, including mental health, child development, health economics and other fields.

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## 15. Key Action 8: Driving performance of the ICA mental health system through governance and leadership

### What is it?

Multiple reviews and inquiries undertaken in the last 10 years have recommended structural reform of mental health governance arrangements. The most notable of these reviews are the Stokes Review in 2012, and the more recent Clinical Governance Review in 2019, which each pushed for structural reform of governance arrangements in WA's mental health system. Some of the recommended changes have been made, including the establishment of a Chief Medical Officer for Mental Health within the Mental Health Commission and the establishment of the Mental Health Executive Committee (MHEC) and Community Mental Health Alcohol and Other Drugs Council (CMC), but there is still a need to enhance the role and remit of governance bodies within the ICA mental health system to strengthen leadership, reduce fragmentation and embed the voice of lived experience.

Key Action 8 focuses on enhancements to governance that should build on the direction that has been set, and the work already done. We need to leverage the authority and accountability of existing decision-making bodies in WA and Commonwealth health, mental health, and human services agencies, and reinforce the integral role of community-managed organisations, the Aboriginal-controlled sector and people with lived experience.

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**“Good governance is needed as high-risk scenarios can occur in ICA mental health.”**

– Service provider

## Why is it important?

Effective governance of WA's ICA mental health system is fundamental to realising the ambitions set out in this Strategy. It will help to strengthen the community's confidence in the system, and in the agencies and organisations which deliver and manage services. It will also be a key enabler of system reform.

The many children, families, carers, clinicians and service providers who have contributed to Taskforce processes, and the broader WA community, should be confident that the right mechanisms are in place to lead and oversee the system reforms which are needed urgently. To be effective, future governance arrangements need to serve the future ICA mental health system in seven ways, set out in Figure 19.

<p><b>1 ACCOUNTABILITY</b> The roles and responsibilities of all structures are clear and well-communicated</p>	<p><b>2 LEADERSHIP AND OVERSIGHT</b> Mechanisms are in place to provide strong leadership and independent oversight</p>	<p><b>3 STRATEGIC DIRECTION</b> A consistent and evidence-informed strategic direction guides investment, planning and policy decision-making</p>
<p><b>4 SYSTEM PLANNING</b> A comprehensive, data-driven plan for the ICA mental health system is in place to inform decision-making</p>	<p><b>5 COMMISSIONING AND FUNDING</b> Commissioning and funding is informed by the system plan, and undertaken collaboratively</p>	<p><b>6 PERFORMANCE MONITORING</b> Performance monitoring is outcomes-focused and drives continuous improvement</p>
<p><b>7 CLINICAL SAFETY AND QUALITY MONITORING</b> Clinical safety and quality monitoring is consistent, efficient and transparent</p>	<p><b>8 COMPLAINTS AND FEEDBACK</b> Complaints processes are more streamlined and accessible, and drive system improvement</p>	<p><b>9 CLINICAL AND LIVED EXPERIENCE VOICE</b> Clinicians and people with lived experience play an integral role in system governance</p>

Figure 19: Nine features of the governance of the future system

## Recommendations for Key Action 8

Key action 8	Recommendation 30
Driving performance of the ICA mental health system through governance and leadership	Establish <b>clear accountabilities and transparent governance arrangements</b> for the ICA mental health system

To establish the conditions for successful system reform, clear and transparent governance arrangements need to be established to reduce fragmentation, drive collaboration, promote accountability, and enhance the public's trust in ICA mental health services.

### Establish stronger leadership and independent oversight over the ICA mental health system reform

Successful reform of the ICA mental health system requires not only strong leadership from within the ICA mental health system and across government, but also robust independent oversight to provide assurance to the Minister and the public that the WA Government's commitments are being fulfilled. To strengthen leadership and independent oversight, there is a need to:

- Define and publish the roles and responsibilities of all agencies and organisations involved in ICA mental health: While the overall management of, and accountability for, the ICA mental health system rests with the Director General of the Department of Health as 'system manager', there are a range of other agencies and organisations which have a critical role in system planning and governance. The most critical of these is the role of the MHC, in collaboration with the Department of Health, in setting the strategic direction of the system and system planning. This will never be more important than in the implementation of the reforms recommended in this report.
- The roles and responsibilities of all agencies and organisations need to be clearly defined and published to provide clarity and transparency to children, families, carers, clinicians, service providers, and the broader WA community.
- Establish a Ministerial Oversight Committee: An independent Ministerial Oversight Committee needs

to be established to provide oversight over the implementation of Taskforce's recommendations, and recommendations from additional inquiries and reviews undertaken in relation to ICA mental health. It needs to include clinical and lived experience representation, and representation from the Department of Premier and Cabinet and the Department of Treasury. See Section 0 for greater detail.

- Establish an Implementation Steering Committee: An Implementation Steering Committee needs to be established to lead the implementation of Taskforce's recommendations. It would endure for the entirety of the system reform program, reporting on progress to the MHEC and CMC. The Committee should be chaired by the Mental Health Commissioner and comprise of senior executives from CAHS, WACHS, WAPHA, and the Department of Communities, Education and Justice. It needs to also include clinical and lived experience representation.
- Continue to strengthen the role of the MHEC and CMC: The MHEC and CMC have helped to improve cross-government and cross-sector collaboration, bringing together the leaders from across the public, community, and Aboriginal-controlled sectors. To continue driving integration, the MHEC and CMC should play a prominent role in leading the reform of the ICA mental health system.
- Establish links with the proposed Director Generals Health and Human Services Group (DGHHS): The proposed DGHHS brings together the leaders from all of WA's health, mental health and human services agencies, and central agencies. A standing item should be created on its agenda, dedicated to tracking the progress of ICA mental health system reforms.

## **Strengthen clinical and lived experience representation in the governance of the ICA mental health system**

All HSP boards and executive teams need to work towards having at least one member with demonstrated experience in a clinical leadership role in mental health, to promote the integration of physical and mental health services, and to support improvement in the clinical safety and quality, and overall performance of mental health services within the HSP.

In view of the significant reforms required in ICA mental health, CAHS and WACHS need to establish a joint leadership model for ICA mental health, that includes a dedicated Executive Director of Mental Health working in partnership with a senior child and adolescent psychiatrist.

There is also a need to grow mental health leadership more broadly across the ICA mental health system, in recognition of the importance of diversity in expertise in decision-making roles. New roles need to be developed with the authority to lead decision-making, including executive roles in mental health nursing and allied health.

Additionally, governance bodies in the ICA mental health system need to have lived experience representation, wherever feasible and appropriate. Where it is not feasible or appropriate, there need to be mechanisms in place for children, families, carers, and others with lived experience to input into decision-making.

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**“There is a need to strengthen the prioritisation of mental health within governance structures.”**

- Service provider



## Key action 8

Driving performance of the ICA mental health system through governance and leadership

## Recommendation 31

Establish a **data- and outcomes-driven approach** to system-wide **planning and commissioning** of the ICA mental health system

The Productivity Commission identified that the current approach taken across Australia to planning and commissioning is a structural challenge, and that changes are needed to how government agencies work together. Structural reform is hopefully underway, with State and Territory Governments and the Commonwealth Government in the midst of negotiating the first National Mental and Suicide Prevention Agreement (the Agreement). The Agreement should clarify and articulate the roles and responsibilities of all governments in reforming the mental health system, and the contributions of each government in addressing the gaps in the mental health system.

Concurrent with the Agreement, two changes need to support state government agencies work together, and with the Commonwealth Government, to drive collaboration and integration.

### Establish a joint, data-driven approach to system-wide planning for all ICA mental health services

The Department of Health, MHC and WAPHA need to work together to develop a consistent approach to planning in relation to ICA mental health services, including primary services, to ensure a more cohesive and integrated system. Developing this approach should include clearly defining each agency's roles and responsibilities in relation to system-wide planning.

To support system-wide planning, the needs-based modelling undertaken by Taskforce (see Section 125) needs to be refreshed periodically, to ensure that planning is informed by a contemporary understanding of needs. In the first instance, the modelling needs to be updated to reflect the publication of the *2021/22 National Mental Health Service Planning Framework*. It should also be refreshed as government and public health agencies learn more about the likely impacts of the COVID-19 Pandemic on ICA mental health. The data should be made available to all the agencies and

organisations involved in system-wide planning.

All planning activities need to be undertaken in partnership with existing representative bodies within the ICA mental health system, including the sub-networks of the WA Mental Health Network. They also need to meaningfully involve children, families, carers and others with lived experience.

### Establish a collaborative approach to commissioning ICA mental health services

The WA Government is in negotiations with the Commonwealth Government to agree on an approach to regional commissioning which brings together WA and Commonwealth Governments, community-based organisations, and those with lived experience. The Department of Health, MHC and WAPHA need to work together to agree on an ICA mental health-specific approach to commissioning which aligns with the agreed approach at the State and Commonwealth levels. It is critical that the ICA mental health-specific approach embeds innovations proposed in the Sustainable Health Review and the forthcoming State Commissioning Strategy. Innovations include co-commissioning between state government agencies, and between state government agencies and WAPHA; and the utilisation of flexible funding models for community mental health services.

## Key action 8

Driving performance of the ICA mental health system through governance and leadership

## Recommendation 32

Strengthen the **oversight and public reporting** of clinical quality and safety in ICA mental health

The future ICA mental health system needs to ensure that all services are safe, high-quality, and genuinely making a difference to children, families, and carers. To realise this, a more consistent and unified approach to monitoring clinical safety and quality is required. A new, outcomes focused approach to managing the performance of ICA mental health services, which drives greater accountability, continuous improvement, and collaboration, is also required.

### Streamline the monitoring of clinical safety and quality

Some of the other recommendations set out in this report go some way to improving the monitoring of clinical safety and quality in public specialist ICA mental health services. These include creating joint leadership teams in CAHS and WACHS with a senior child and adolescent psychiatrist, and exploring workforce models that create more authority and decision-making for mental health nurses and allied health workers. However, there is a pressing need to review and reset the way that the Department of Health, MHC and Chief Psychiatrist monitor the clinical safety and quality of public specialist ICA mental health services. This needs to include establishing a joint approach to monitoring clinical safety and quality that minimises the administrative burden on HSPs and ensures that relevant agencies and bodies and the community are able to see the 'full picture' of clinical safety and quality in the system.

Additionally, the complaints processes for public specialist ICA mental health services need to be reviewed. The purpose of this review should be to propose a more streamlined complaints process that is easier and more accessible for children, families, carers and others with lived experience that is aligned with the proposed service guarantee (See Recommendation 1).

## Review and update the indicators used to assess the performance of public ICA mental health service providers

The current approach to managing the performance of ICA mental health service providers is inadequate. It does not drive continuous improvement, nor incentivise services to collaborate and focus on improving the experience and outcomes of children, families, and carers. This is, in large part, due to the fact that the indicators used to assess provider performance (for HSPs and community-based organisations) focus too strongly on inputs and outputs, rather than on experiences of service and outcomes.

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**“Why do we focus on activity, when it’s outcomes that we care about?”**

– Young person

### *Indicators used to assess HSP performance in relation to ICA mental health services*

Currently, there are only two performance indicators used to assess HSP performance in relation to ICA mental health services:

- Readmissions to hospital within 28-days of discharge from acute specialised mental health inpatient units.
- Percentage of contacts with community-based public mental health non-admitted services within seven-days post discharge from public mental health inpatient units.
- The WA Auditor General, in her recent audit of state-managed mental health services, strongly criticised the use of these indicators, noting that:
  - “The 28-day readmission rate is at best a blunt indicator that does not take into account that effective care for some people can include planned readmissions.”
  - “The seven-day follow-up does not reliably capture whether or not a person is actually connected to a community service and in some circumstances does not involve a contact from a community mental health team at all.”

In relation to performance management, the Sustainable Health Review<sup>32</sup> stated that: “It has become obvious that WA does not have the right set of measures to really understand if the services provided in mental health are truly making a difference to improving people’s health outcomes and experience.”

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<sup>32</sup> Sustainable Health Review 2019, Sustainable Health Review: Final Report to the Western Australian Government. Department of Health, Western Australia

The indicators used to assess the performance of all ICA mental health services need to be reviewed and updated, with a view to driving greater accountability, continuous improvement, and collaboration. Future indicators need to:

- **Be more focused on the experience and outcomes of children, families and carers.** The experiences and outcomes of children, families and carers in the system will only be improved if services are held accountable for them.
- **Include a mix of provider-completed, consumer-completed, and family-and-carer-completed indicators.** This is key to ensuring that children, families and carers are treated as equal partners in the delivery and oversight of ICA mental health services. Consumer-completed and family-and-carer-completed indicators will also help to provide a deeper and more nuanced understanding of the experience and outcomes of children, families and carers.
- **Be collaboratively designed with children, families, carers and others with lived experience.** It is critical that the indicators used to monitor provider performance are developed in partnership with children, families, carers and others with lived experience, to ensure that they reflect what matters most to them.
- **Be publicly reported and updated to drive transparency.** The Mascie-Taylor Review<sup>33</sup> and Sustainable Health Review set a goal to drive transparency in the reporting of service performance and health outcomes. Currently, there are no publicly reported safety, quality and performance indicators related to mental health. A set of indicators needs to be collected and made publicly available, to increase transparency about the performance of the ICA mental health system.

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<sup>33</sup> Mascie-Taylor, H. & Hoddinott, J. 2017, Review of Safety and Quality in the WA health system: A strategy for continuous improvement. Available at: [https://ww2.health.wa.gov.au/~/\\_media/Files/Corporate/general-documents/Review-of-Safety-and-Quality/Review-of-safety-and-quality.pdf](https://ww2.health.wa.gov.au/~/_media/Files/Corporate/general-documents/Review-of-Safety-and-Quality/Review-of-safety-and-quality.pdf)

## 16. Implementation roadmap

### Implementation strategy

This report, which marks the completion of Taskforce, is a critical milestone. However, it is only the start of the ICA mental health system's reform journey in WA. Considerable work lies ahead to achieve the vision set out in the Strategy.

Implementation will be a complex and challenging task, particularly in the current context of increasing demand unmatched by resources. To be successful, implementation needs to be well-planned, effectively governed and appropriately resourced. It will also need to meaningfully involve children, families, carers and others with lived experience, and clinicians. A high-level Implementation Strategy, comprising of the three components in Figure 20, has been developed to provide a foundation for a more comprehensive, detailed Program Plan. Each of the components of the Implementation Strategy are detailed in turn below.

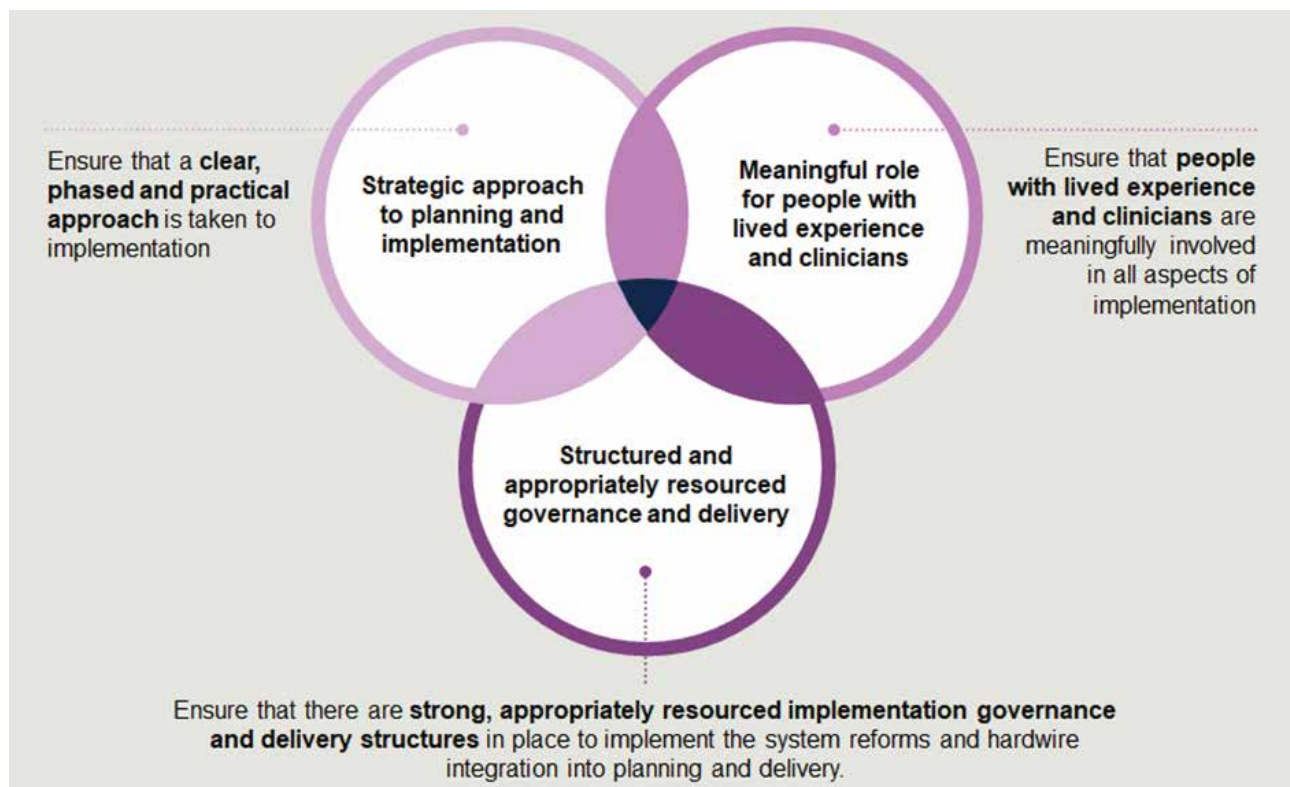


Figure 20: Three components of Taskforce's implementation strategy

## A strategic approach to planning

Given the scale and complexity of the ICA mental health system reforms, a clear, phased and practical approach to implementation will be required. Undertaking the system reforms in phases will allow a focus on a manageable subset of system reforms, reducing the risk of overwhelming the system. A phased approach will also allow improvements to be made to the implementation program over time, as new data and evidence is gathered.

The system reforms need to be phased over four horizons, as shown in Figure 21. The phasing has been guided by two principles:

- Immediate targeted support is required to address the most critical needs of children, families, and carers.
- Building the capability and growing the capacity needed to deliver some of the system reforms will take time, particularly given the challenges and shortages facing the workforce.

In the immediate-term, the focus should be on setting up the implementation program, including establishing implementation governance and delivery structures, and progressing any system reforms that are feasible in the short-term. A key example of this is Recommendation 24, which calls for the development of an ICA mental health workforce plan.

In the short-term horizon, the focus should be on implementing short-term priorities, which provide immediate targeted support to meet the most critical needs of children, families and carers. The focus should also be on making a start on the collaborative design of new and enhanced services.

In the medium-term, the focus should be on building the capability and growing the capacity of the system – in relation to research, infrastructure, and technology. This will establish the foundations for a high-performing, sustainable ICA mental health system.

In the long-term, the focus should be on embedding system reforms. It is in this horizon that we will truly begin to realise the vision set out in this Strategy.



Figure 21: Four time horizons

The phasing of the system reforms will need to be set out in a comprehensive and detailed Program Plan. At a minimum, the Program Plan should set out:

- the implementation approach
- the system reform activities to be implemented
- the responsibilities and timeframes associated with each system reform activity
- the implementation governance and delivery structures
- measures of implementation success to be used to monitor system reform progress.

Implementing the system reforms will require collective effort from a range of stakeholders, including government agencies, non-government organisations, health workers, children, families and carers, and the broader WA community. To ensure the success of the implementation program, it is critical that all these stakeholders are represented in the development of the Program Plan.

## Meaningful partnerships with children, families and carers

People with lived experience and clinicians played a key role in the design of the future system, which was shaped by their experiences, expertise and perspectives. Moving forward, people with lived experience and clinicians need to play a key role in all aspects of implementation. As shown in Figure 22, there are four aspects of system reform which people with lived experience and clinicians need to be involved in.

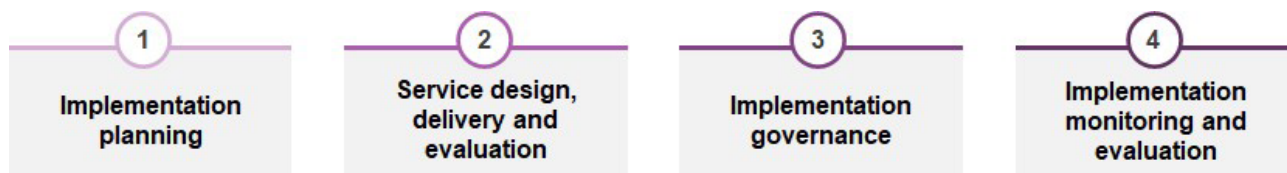


Figure 22: Four aspects of system reform

People with lived experience and clinicians need to have meaningful, rather than tokenistic, opportunities for involvement in system reform. Ideally, they should be provided with opportunities for co-production – they should be equal partners in the planning, design, delivery and evaluation of initiatives, programs, services and supports. This approach is consistent with the MHC’s Engagement Framework 2018-25 and recognised good practice. Where co-production is not feasible, people with lived experience and clinicians should be involved in as many phases as possible.

### Structured and appropriately resourced implementation governance and delivery

Strong governance and delivery structures will be critical to implementation success. They will ensure that the ICA

mental health system reforms are implemented effectively and efficiently, in an integrated manner. It will be critical for existing governance structures to be drawn on, wherever possible. It will also be critical for the implementation governance and delivery structures to align with the future system governance, to ensure continuity in system leadership and oversight. The structure identified in Figure 23 needs to be put in place to implement the ICA mental health system reforms. The roles of these structures are described in Table 1.

In addition to having strong governance and delivery structures in place, there needs to be investment in building the capability and capacity required to implement system reform. Services are not able to ‘absorb’ implementation; the skills are highly sought after and are core to sustainability and successful implementation; dedicated resources with appropriate skill sets need to be put in place.

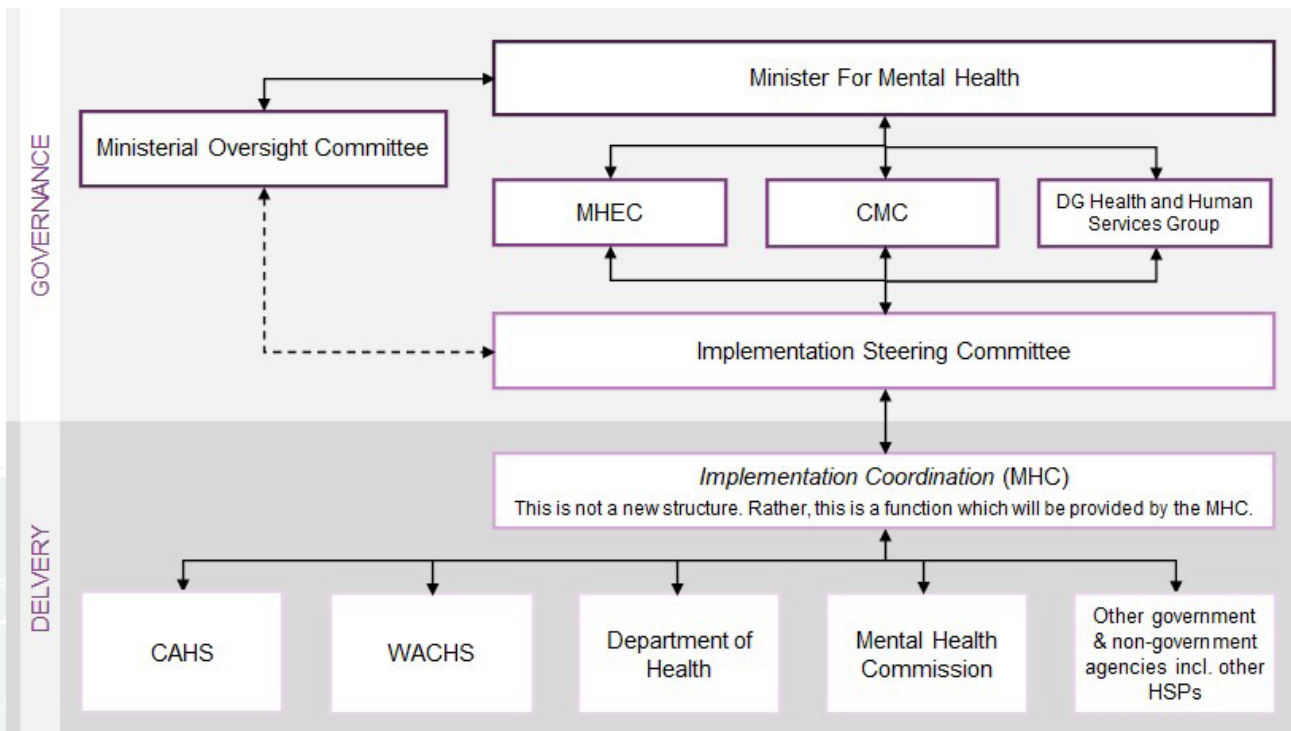


Figure 23: Implementation governance and delivery structures



**Table 1 : Roles of the implementation governance and delivery structures**

<b>Structure</b>	<b>Role</b>
<b>Ministerial Oversight Committee</b>	The Ministerial Oversight Committee will provide independent oversight over the implementation program. In doing so, it will provide assurance to both the Minister and the public that the WA Government's commitments to ICA mental health are being effectively met.
<b>MHEC, CMC and DG Health and Human Services group</b>	The MHEC, CMC and DG Health and Human Services Group will oversee the implementation program to ensure that it stays true to the original intent and vision, and it delivers the intended benefits.
<b>Implementation Steering Committee</b>	The Implementation Steering Committee will provide direction and leadership over the implementation program, and facilitate a coordinated, collaborative approach to system reform.
<b>Implementation Coordination (MHC)</b>	The MHC, in its commissioning role, will provide implementation coordination. Its role will involve sequencing, coordinating, and commissioning activities and resources to deliver the ICA mental health system reforms. It will ensure that all activities meet strategic objectives, meet co-design requirements, are allocated appropriately, and are delivered on time to a sufficient level of quality.
<b>CAHS, WACHS, DoH, MHC, and other government and non-government agencies</b>	The majority of system reform delivery resources will be based in government and non-government agencies – primarily CAHS, WACHS, the Department of Health and the Mental Health Commission. All HSPs need to appoint a senior representative that will be responsible for leading individual ICA mental-health related reforms in each organisation. These individuals will be the point of accountability in each HSP.

## Implementation roadmap

This implementation roadmap sets out how the eight Key Actions can be achieved across the four time horizons. Greater detail on immediate priorities and medium- to long-terms areas of focus follows.

	IMMEDIATE AND SHORT-TERM	MEDIUM-TERM	LONG-TERM
<b>CAPACITY</b> <i>Growing and sustaining the capacity of the workforce</i>	Provide <b>immediate targeted capacity support</b> ; and determine the <b>target profile</b> for the workforce	<b>Continue to grow the capacity</b> of the workforce to align with the target profile	Sustain the capacity of the workforce, with a focus on expanding in <b>specific areas of expertise</b>
<b>CAPABILITY</b> <i>Building and maintaining the capability and wellbeing of the workforce</i>	Provide <b>immediate targeted support to staff</b> ; and determine the <b>future capability needs</b> of the workforce	Develop and deliver programs and supports to meet the <b>future capability needs</b> of the workforce, and enhance <b>staff wellbeing</b>	Sustain the capability and wellbeing of the workforce, with a focus on maturing <b>career progression and professional development</b>
<b>SERVICES</b> <i>Transforming services across the full continuum of care</i>	Collaboratively design <b>new models</b> for ICA mental health services	<b>Fully implement</b> the models for ICA mental health services; and establish more clarity and consistency on <b>service transitions</b>	<b>Embed</b> the models of ICA mental health services
<b>COLLABORATION</b> <i>Working with government and community services from other systems</i>	Improve collaboration between <b>Community ICAMHS</b> and other services	Improve collaboration between the <b>broader ICA mental health system</b> and other systems	Develop and implement <b>whole of government</b> responses to the <b>social determinants</b> of mental health and wellbeing
<b>GOVERNANCE</b> <i>Strengthening leadership of and oversight over the system</i>	Establish system and implementation <b>governance structures</b> , and co-design <b>new system performance monitoring arrangements</b>	<b>Embed</b> governance structures and system performance monitoring arrangements	<b>Review</b> governance structures and system performance monitoring arrangements to ensure that they <b>remain fit-for-purpose</b>
<b>INFRASTRUCTURE</b> <i>Enhancing the infrastructure and technology underpinning the system</i>	Integrate ICA mental health into <b>existing infrastructure and technology-related projects</b> ; and prepare <b>business cases</b>	<b>Undertake work</b> to develop new and refurbish existing facilities	<b>Complete</b> the development of new and refurbishment of existing facilities

## Detailed implementation roadmap

The detailed implementation roadmap is the consolidated list of actions and initiatives across all eight Key Actions, structured across three time horizons. The time horizons reflect the urgency of each initiative, and the level of effort and investment required for implementation. The initiatives have been organised according to six broad categories: **Capacity, Capability, Services, Collaboration, Governance, and Infrastructure.**

### Capacity

Growing and sustaining the capacity of the workforce	
<b>Immediate- and short-term</b>	<p><b>To alleviate the immediate pressures on the services:</b></p> <ul style="list-style-type: none"><li>• Embed the recently announced increases to staff, which are in the process of being recruited by CAHS (see Key Action 6).</li><li>• Increase the WACHS workforce to address capacity gaps and geographical disparities, and better meet the needs of rural and remote children, families and carers (see Key Action 6).</li><li>• Undertake a rapid review to identify opportunities to improve efficiency across the workforce. This includes opportunities to reduce the administrative burden on staff and increase their time spent on core functions of their role (see Key Action 6).</li></ul> <p><b>To begin to address critical workforce gaps, establish:</b></p> <ul style="list-style-type: none"><li>• Peer workers within all public specialist ICA mental health services (see Key Action 6).</li><li>• Aboriginal mental health workers within all public specialist ICA mental health services (see Key Action 6).</li><li>• Cross-cultural experts within services that support communities with significant ethnocultural and linguistically diverse populations (see Key Action 6).</li><li>• Increase the Clinical Psychologist input to the CAHS Refugee Health Service.</li></ul> <p><b>To support the development of the future workforce pipeline:</b></p> <ul style="list-style-type: none"><li>• Develop an ICA mental health workforce plan, informed by the modelling (see Key Action 6).</li><li>• Foster and leverage partnerships with universities and TAFEs (see Key Action 6).</li></ul> <p><b>Other actions that need to be taken in the immediate-and short-term include:</b></p> <ul style="list-style-type: none"><li>• Establish workforce models that include executive-level mental health nursing roles, to provide oversight over, and ensure accountability for, nursing practice and standards in the ICA mental health system (see Key Action 6).</li><li>• Pilot the National Human Services Workforce Framework for the Aboriginal and Torres Strait Islander Community Controlled Sector, in the context of the ICA mental health system (see Key Action 2).</li></ul>

Growing and sustaining the capacity of the workforce	
<p><b>Medium-term</b></p>	<p>The capacity of the workforce needs to continue to be built, in line with the ICA mental health workforce plan. This may involve a focus on positions such as peer workers, Aboriginal mental health workers, and nurses (see Key Action 6).</p> <p>The number of <b>clinical rotations and training positions</b> within ICA mental health needs to be increased, and specifically in child and adolescent psychiatry and nursing. This should include as a priority, an increase in the number of <b>training psychiatric registrar</b> and graduate nurse positions in ICA mental health services (Key Action 6).</p> <p>The <b>needs-based modelling</b> needs to be reviewed to ensure that it reflects updates made to the National Mental Health Service Planning Framework, and any learnings regarding the impact of COVID-19 (see Key Action 6).</p> <p><b>Partnerships with universities and TAFEs</b> need to be embedded to further the development of the future workforce pipeline. This may involve increasing the number of Professional Chairs for ICA mental health across key professions (see Key Action 6).</p>
<p><b>Long-term</b></p>	<p>The capacity of the workforce needs to continue to build as the workforce pipeline established in the short-term starts to achieve an increase in graduates wanting to focus on ICA mental health (see Key Action 6).</p> <p>As the workforce capacity increases there is a greater focus on achieving the <b>ideal workforce mix</b> in line with the National Mental Health Service Planning Framework. (see Key Action 6).</p> <p>The <b>composition of teams</b> within Community ICAMHS teams also needs to better reflect the diversity of the local communities that they serve (see Key Action 6).</p> <p>The <b>needs-based modelling</b> needs to be re-visited to determine the extent of the gap between the capacity of the workforce and forecasted needs. The ICA mental health workforce plan then needs to be updated to reflect this (see Key Action 6).</p>

## Capability

Building and maintaining the capability and wellbeing of the workforce	
<p><b>Immediate- and short-term</b></p>	<p><b>To address immediate capability gaps of the workforce:</b></p> <ul style="list-style-type: none"> <li>• Bring dedicated ICA mental health expertise into the WACHS Command Centre to better manage rural and remote children presenting to emergency departments in crisis (see Key Action 7).</li> <li>• Establish dedicated consultation liaison positions within Community ICAMHS for ACCHOs and AMSs (see Key Action 2).</li> <li>• Ensure all HSPs include INSPIRE ELD training within their Mandatory Training packages (Key Action 5).</li> </ul> <p><b>To address immediate capability gaps of the workforce:</b></p> <ul style="list-style-type: none"> <li>• Bring dedicated ICA mental health expertise into the WACHS Command Centre to better manage rural and remote children presenting to emergency departments in crisis (see Key Action 7).</li> </ul>

## Building and maintaining the capability and wellbeing of the workforce

<p><b>Immediate- and short-term</b></p>	<ul style="list-style-type: none"> <li>Establish dedicated consultation liaison positions within Community ICAMHS for ACCHOs and AMSs (see Key Action 2).</li> <li>Ensure all HSPs include INSPIRE ELD training within their Mandatory Training packages (Key Action 5).</li> </ul> <p><b>To ensure that Aboriginal mental health workers and peer workers are safe, supported and empowered, collaboratively design and implement:</b></p> <ul style="list-style-type: none"> <li>A peer workforce model (see Key Action 5).</li> <li>An Aboriginal workforce model (see Key Action 5).</li> </ul> <p><b>To determine what actions are required to meet the workforce's future capability and support need:</b></p> <ul style="list-style-type: none"> <li>Establish a dedicated ICA mental health workforce development function, which can proactively identify the skill mix required of the workforce, and lead training, development, and deployment activities across the entire system (Key Action 5).</li> <li>Undertake a training needs analysis to determine current and future capability gaps (see Key Action 5).</li> <li>Undertake a literature review to identify actions, initiatives and models to support the wellbeing of the workforce (see Key Action 5).</li> </ul>
<p><b>Medium-term</b></p>	<p>Informed by the training needs analysis, develop and deliver a suite of <b>training programs</b> to build the capability of the ICA mental health, and the broader health, workforce. This should include pathways for professional development (see Key Action 5).</p> <p>Models of care need to be re-designed, with a focus on leveraging multi-disciplinary skills, enabling the workforce to use their full scope of practice. This should include consideration for nurse practitioner-led models (see Key Action 5).</p> <p>Informed by the literature review, new initiatives and models need to be put in place to improve staff wellbeing, informed by the literature review (see Key Action 5).</p> <p>Co-led with WAPHA, training programs need to be developed to build GPs' capability to provide low-intensity treatment to children (see Key Action 2).</p>
<p><b>Long-term</b></p>	<p>Clear pathways for career progression and professional development need to be embedded, with a particular focus on the peer workforce and Aboriginal mental health workforce (see Key Action 5).</p> <p>The training programs to build GPs' capability to provide low-intensity treatment to children need to be implemented (see Key Action 2).</p>

## Services

### Transforming services across the full continuum of care

#### Immediate- and short-term

##### To improve the experiences of children, families and carers:

- Collaboratively design a detailed 'service guarantee' for all services, building on the draft guarantee proposed by Taskforce (see Key Action 1).
- Undertake dedicated collaborative design processes with Aboriginal children, families, carers and communities to ensure that social and emotional wellbeing principles and practices are embedded in all models of care and service (see Key Action 2).

##### To address gaps identified in current services:

- Expand **CAMHS Crisis Connect** and **WACHS MH ETS** to support children, families and carers waiting to access public specialist ICA mental health services, as an interim measure (see Key Action 2).
- Establish a dedicated ICA mental health specialist virtual capability in the **WACHS Command Centre** to provide specialist access and support to ICA mental health services and children, families and carers (see Key Action 7).
- Identify opportunities to increase the capacity of mental health and **social and emotional wellbeing services** provided by ACCHOs and AMSs (see Key Action 2).

##### Collaboratively design and prepare for the implementation of:

- Co-led with WAPHA, **the Head-to-Health Kids** and **enhanced headspace** models of care to support integrated care (see Key Action 2).
- Specific stepped care models for **infants (0-4 years)**.
- A stepped care model for children with an **intellectual disability and/or neurodevelopmental or neuropsychiatric conditions** and co-occurring mental health issues, in partnership with the Child Development Service (see Key Action 3).
- A stepped care model for children with **early psychosis** and children with **complex trauma** (see Key Action 3).
- A model of care for **Acute Care and Response Teams** across Perth, and rural and remote WA (see Key Action 3).
- **'Child safe places'** for children in crisis, adjacent to the PCH and FSH emergency departments (see Key Action 3).

##### To redesign priority services in line with a stepped model of care, collaboratively design and prepare for the implementation of:

- A model of care for **Community ICAMHS**, including the detailed design of a 'hub-and-spoke' model across Perth, and rural and remote WA (see Key Action 3).
- A stepped care model to **re-configure EDS**, and an eating disorders model of care that supports children across WA in the community and, where required, in hospitals (see Key Action 3).
- A stepped care model to **re-configure Touchstone**, and a personality disorders model of care that supports children across WA in the community and, where required, in hospitals (see Key Action 3).

Transforming services across the full continuum of care	
<b>Immediate- and short-term</b>	<ul style="list-style-type: none"> <li>A stepped care model to <b>re-configure Pathways</b>, and a model of care for children aged 5-11 years (see Key Action 3).</li> </ul>
<b>Medium-term</b>	<p>The hub and spoke model for Community ICAMHS is <b>fully implemented</b> in all regions (see Key Action 2).</p> <p>Models of care needs to be collaboratively designed to re-configure other the remaining existing specialised services into the new stepped care model used by statewide services (see Key Action 3).</p> <p>The models of care and service which were collaboratively designed in the immediate- and short-term need to be implemented. These include:</p> <ul style="list-style-type: none"> <li>Head-to-Health Kids and enhanced headspace services (see Key Action 2).</li> <li>Model of care for <b>Community ICAMHS</b> across Perth, and rural and remote WA (see Key Action 3).</li> <li>Reconfigured stepped care models for <b>EDS, Pathways and Touchstone</b> (see Key Action 3).</li> <li>Stepped care models for <b>infants (0-4 years)</b> (see Key Action 3).</li> <li>Stepped care model for children with <b>intellectual disability and/or neurodevelopmental or neuropsychiatric conditions</b> and co-occurring mental health issues (see Key Action 3).</li> <li>Stepped care model for children with <b>early psychosis</b> and children with <b>complex trauma</b> (see Key Action 3).</li> <li>'Child safe places' for children in crisis through a pilot, followed by a full roll-out (see Key Action 3).</li> </ul> <p>To enable collaboration between GPs and public specialist ICA mental health services, a <b>review of MBS items</b> needs to be advocated for and undertaken (see Key Action 2).</p> <p>To improve transitions between ICA, youth and adult services, <b>age cohort definitions need to be agreed on</b>. Following this, clinical guidelines need to be established to govern transitions between services (see Key Action 2).</p>
<b>Long-term</b>	<p>Complete the implementation of all statewide services as new stepped models of care; working collaboratively with the increased capacity in Community ICAMHS teams (see Key Action 3).</p>

## Collaboration

Working with government and community services from other systems	
<b>Immediate- and short-term</b>	<p><b>To better address children's mental health needs, collaboratively design:</b></p> <ul style="list-style-type: none"> <li>A <b>collaboration model</b> to define how Community ICAMHS will <b>work with schools</b> to address children's mental health needs (see Key Action 4).</li> </ul>

## Working with government and community services from other systems

<p><b>Immediate- and short-term</b></p>	<ul style="list-style-type: none"> <li>• A <b>collaboration model</b> to define how Community ICAMHS will <b>work with child protection</b> services to address the mental health needs of children in care (see Key Action 4).</li> <li>• Develop and implement an <b>ICA forensic mental health model of care</b> including assertive wrap around care for children in the transition out of Banksia Hill Detention Centre (Key Action 4).</li> <li>• In collaboration with Department of Justice further develop the <b>model of care at Banksia Hill Detention Centre</b>, including an uplift to the Banksia Hill mental health workforce (Key Action 4).</li> </ul> <p><b>Other actions that need to be taken in the immediate- and short-term include:</b></p> <ul style="list-style-type: none"> <li>• Work with the <b>Graylands Reconfiguration and Forensics Taskforce</b> to identify need for adolescent forensic beds (Key Action 4).</li> <li>• Broaden the <b>eligibility criteria</b> of all public specialist ICA mental health services to ensure that they are not restrictive for children with higher levels of risk (see Key Action 4).</li> <li>• Increase the capacity of MHC funded programs and supports which provide <b>prevention and early intervention</b>, and <b>postvention support</b> to schools (see Key Action 4).</li> </ul>
<p><b>Medium-term</b></p>	<p>To improve <b>schools' capability</b> to address children's mental health needs, the capability of school leaders and teachers to identify the early signs of mental ill-health in children needs to be developed. School-based mental health service provision also needs to be expanded by introducing <b>other mental health professionals</b> to supplement school psychologists. This may include mental health nurses, peer support workers, social workers and youth workers.</p> <p>Further, a <b>service delivery model needs to be collaboratively designed</b> to define how ICA mental health and other services (broader than Community ICAMHS) will <b>work with schools</b> to meet children's mental health needs. This should include school-based and school-linked services (see Key Action 4).</p> <p>To improve child protection services' capability to address the mental health needs of children in care, the capability of child protection workers to identify the early signs of mental ill-health in children needs to be developed. <b>Child protection liaison</b> roles need to also be established within Community ICAMHS, and Community ICAMHS liaison roles in child protection teams (see Key Action 4).</p> <p>To better address the mental health needs of children in contact with the justice system, the <b>ICA forensic mental health model of care</b> needs to be implemented, in alignment with the Graylands Reconfiguration and Forensics Taskforce to identify need for adolescent forensic beds (see Key Action 4).</p>
<p><b>Long-term</b></p>	<p>Whole of <b>government collaborative responses</b> to better support the mental health of vulnerable children should be established (see Key Action 4).</p>



## Governance

Strengthening leadership of and oversight over the system	
<b>Immediate- and short-term</b>	<p><b>To enhance system leadership and oversight:</b></p> <ul style="list-style-type: none"> <li>Implement the recommended system and implementation <b>governance structures</b> (see Key Action 8, ensuring that people with lived experience are involved at all levels (see Key Action 1).</li> <li>Establish a joint <b>leadership approach</b> in CAHS and WACHS with the Executive Director Mental Health working alongside a lead child and adolescent psychiatrist (see Key Action 8).</li> <li>Ensure that the ICA mental health system reform is a standing item on the agenda for the proposed Directors <b>General Health and Human Services Group</b> (see Key Action 8).</li> <li>Clarify and articulate the <b>role of the System Manager</b> in child and adolescent mental health workforce, infrastructure, and technology planning (see Key Action 8).</li> </ul> <p><b>To improve commissioning:</b></p> <ul style="list-style-type: none"> <li>Align the <b>ICA mental health commissioning model</b> with the forthcoming National Mental Health and Suicide Prevention Agreement and the State Commissioning Strategy (see Key Action 8).</li> </ul> <p><b>To strengthen system performance monitoring:</b></p> <ul style="list-style-type: none"> <li>Collaboratively design outcomes and outcome measures for a <b>system performance monitoring framework</b> (see Key Actions 1 and 8), ensuring that they reflect the 'service guarantee' (see Key Action 1).</li> </ul>
<b>Medium-term</b>	<p>To continue to enhance system leadership, mental health expertise needs to be <b>embedded in HSP Boards and Executive Teams</b> (see Key Action 8).</p> <p>To continue to improve commissioning, the new <b>ICA mental health commissioning model</b> needs to be embedded across the system (see Key Action 8).</p> <p>To continue to strengthen system performance monitoring, the <b>new system performance monitoring framework</b> needs to be embedded across the system. Further, public reporting on ICA mental health system performance needs to be introduced (see Key Action 8).</p> <p>Establish the mechanisms to monitor performance against <b>the 'service guarantee'</b> including the development of associated tools to measure and report performance (see Key Action 1).</p>
<b>Long-term</b>	<p>The collaboratively designed 'service guarantee' needs to be <b>embedded into all service agreements</b> with agencies and organisations providing ICA mental health services (see Key Action 1).</p> <p><b>Periodic reviews</b> of the governance and performance monitoring arrangements need to be undertaken, to ensure that they remain fit-for-purpose (see Key Action 8).</p>

## Infrastructure

Enhancing the infrastructure and technology underpinning the system	
<p><b>Immediate- and short-term</b></p>	<p><b>To address the infrastructure needs of the future system:</b></p> <ul style="list-style-type: none"> <li>Prepare strategic asset plans and associated business cases for the development of new infrastructure, or refurbishment of existing infrastructure, with a focus on the new hubs (see Key Action 7).</li> </ul> <p><b>To improve information sharing:</b></p> <ul style="list-style-type: none"> <li>Prepare, publish and communicate guidance to increase the sharing of client information between services within the ICA mental health system (see Key Action 2).</li> <li>Integrate community mental health (prioritising ICA mental health services) into the scope of Stage 1 of the Electronic Medical Record through the implementation of the WA Health Digital Strategy (see Key Action 7).</li> </ul>
<p><b>Medium-term</b></p>	<p>To continue to address the infrastructure needs of the future system, work needs to be commenced and progressed on developing new, and refurbishing existing, infrastructure, with a <b>focus on the new hubs</b> (see Key Action 7).</p> <p>A business case also needs to be developed for a <b>statewide virtual care service</b>, aligned to the WA Health Digital Strategy (see Key Action 7).</p> <p>To continue to improve information sharing, public specialist ICA mental health community services need to prepare for, and transition to, the <b>Digital Record</b> (see Key Action 7).</p> <p><b>Mechanisms to enable data and information sharing</b> between ICA mental health services, as well as between ICA mental health and other services also need to be established (see Key Action 2).</p>
<p><b>Long-term</b></p>	<p>Once the work to develop new, and refurbish existing, infrastructure is complete, the integrated hubs for Community ICAMHS can be established across metropolitan, and regional and remote WA (see Key Action 7). CAHS and WACHS' separate telehealth services can also be transitioned into the statewide virtual care service (see Key Action 7).</p> <ul style="list-style-type: none"> <li><b>Establish the integrated hubs for Community ICAMHS</b> across metropolitan Perth, and rural and remote WA (see Key Action 7).</li> <li>Embed <b>research and innovation processes</b> and structures (see Key Action 7).</li> </ul>

# 17. Future sustainability

## Immediate and long-term investment

Addressing the critical gaps within current services and meeting the needs of children, families and carers requires significant investment. The future ICA mental health system will require an expanded and enhanced workforce, resources, and infrastructure to effectively address needs.

Taskforce undertook various modelling and supporting analyses to understand the scale of future investment required, and the potential return on investment. This included:

- **Needs-based modelling** which estimates the population needs for ICA mental health services based on best-available evidence on prevalence and resources required to address needs.

- **Cost modelling** which estimates the costs associated with the additional resources required – effectively the scale of investment needed.
- **Benefits analysis** which estimates the benefits to children (due to improved access to more effective care) and cost offsets for government associated with investment that is more sustainable.

The needs-based modelling informed the cost modelling and the benefits analysis. For example, it estimated the additional frontline staff required to address population need which informed the cost modelling. In addition, it provided estimates of the additional number of children who would receive mental health care which informed the benefits analysis.

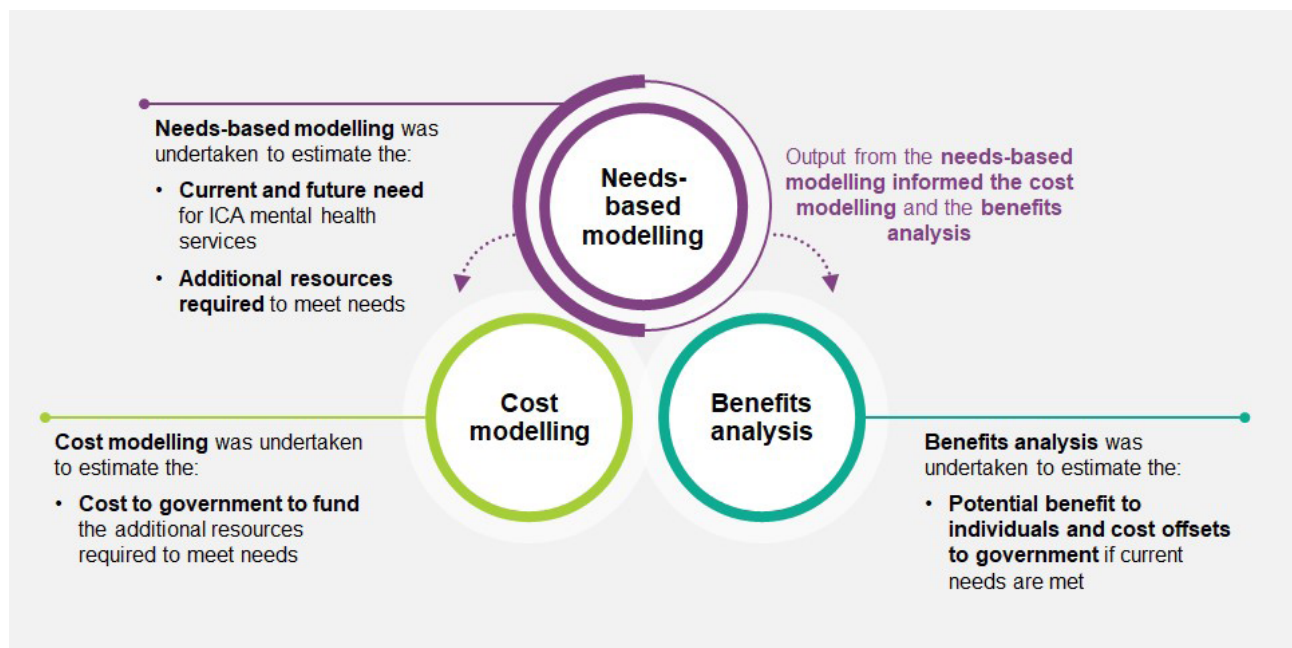


Figure 24: Different modelling and analysis was undertaken to estimate the scale of future investment required and the potential return on investment

## The scale of investment required

### A needs-based approach helps to understand the future requirements for ICA mental health services

Taskforce has analysed current and future projections of population need and compared these against the current capacity of services to meet that needed. This gap analysis has helped to understand the scale of investment needed to implement a sustainable whole of system plan for ICA mental health. The needs-based modelling was conducted by the Mental Health Commission and the Department of Health, supported by Taskforce's project team and has sought to estimate both the current and future needs for ICA mental health services, consistent with the approach recommended by the SHR to focus on modelling needs rather than modelling demand. By estimating need rather than demand, Taskforce modelling identifies the resources required to address this need over time and addresses the shortfalls of demand-based modelling that does not capture unmet need for services (particularly where there are access barriers, such as insufficient workforce, or infrastructure constraints).

A robust approach to the needs-based modelling was undertaken and informed by:

- evidence and service profiles from the National Mental Health Service Planning Framework (NMHSPF)
- insights from a review of research into ICA mental health
- historic and service activity data for ICA mental health services, including trends
- a clinical Validation Panel.<sup>34</sup>

The needs-based modelling which underpins this report has considered a range of evidence sources including existing frameworks, published literature and clinical, carer and lived experience input and validation. The modelling has been done on a best endeavour basis and has tried to bring a range of data sources together to estimate the need. Unfortunately, there are gaps in the evidence base, which should improve over time.

Therefore, the modelling will continue to be refined and updated over time.

### A significant increase in the ICA mental health workforce is needed to address the needs of WA children now and into the future

The needs-based modelling identified that the current level of unmet need among children in WA is substantial and the current capacity of the ICA mental health workforce is manifestly inadequate to meet these needs.

The modelling process identified that the ICA mental health system currently requires:

- **A significantly larger future workforce** – modelling indicates that a significant uplift from the current ICA health workforce is required to meet need.
- **A different profile for the future workforce** – to transition towards a more contemporary and sustainable workforce model more closely aligned with the needs based modelling estimates (a lower proportion of psychologists, and a higher proportion of occupational therapists, counsellors, social workers and peer workers).

As the evidence base improves over time, further refinement, and updating of the needs-based modelling (and the cost modelling) is needed. While a robust process based on available evidence was undertaken by Taskforce, some gaps in the evidence base have been identified, and assumptions (informed by clinical validation) had to be made.<sup>35</sup> As an initial priority, the modelling should be updated upon the release of the new NMHSPF. An updated analysis will ensure that future estimates are based on the most up-to-date evidence and data.

<sup>34</sup> The Validation Panel was established to support the needs-based modelling and consisted of a dozen ICA clinicians, chosen and chaired by Taskforce Clinical Expert Advisory Group co-chairs.

<sup>35</sup> For example, evidence regarding the prevalence of mental illness (and service needs) among Aboriginal children nationally and in WA remains limited. In addition, the needs-based modelling was undertaken using the 2016 version of the NMHSPF which does not incorporate more recent prevalence data.

## **Taskforce has estimated the scale of investment required to address the workforce need**

Cost modelling was undertaken to estimate the scale of investment required should government fully address the identified needs of children for ICA mental health services. This cost modelling is not comprehensive, as it excludes costs relating to expansion of existing infrastructure if applicable, establishing contemporary service delivery model infrastructure requirements, digital infrastructure to provide more effective and efficient work practices, workforce strategies and cost of implementing and governing reform. The cost modelling does not include costs associated with:

- Developing contemporary infrastructure, technology, and research capability, which underpins the future ICA mental health system (see Section 14). For example, building new, or enhancing current physical and digital infrastructure will require additional funding.
- Implementing system reform, which needs to be appropriately resourced, well-planned, and effectively governed (see Section 16). For example, building the capability for change management and delivery within CAHS, WACHS and other key government and non-government bodies will require additional resources.

It should be recognised that while the expenditure needed for reform will be substantial, the costs of not reforming will be higher and are summarised in the following section.

## **Understanding the potential benefits of this investment**

### **Mental ill-health costs families and costs governments**

It is widely recognised that mental ill-health imposes large costs (both financial and non-financial) to individuals and communities.<sup>36</sup> Mental ill-health can affect a person's quality of life and health outcomes, as well as their economic and social outcomes. Families and carers providing informal care are also affected, in terms of their own mental health, economic and social outcomes. The life path for children and adolescents can be changed dramatically if mental ill-health onsets during their formative years. It can disrupt their education and training, and lead to missed opportunities to develop skills while at school or vocational training. This in turn affects their lifelong employment outcomes and social outcomes.

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<sup>36</sup> Productivity Commission 2020, Mental Health, Report no. 95, Canberra.

## The economics of mental ill-health – an annual cost snapshot for young people in WA

Mental ill-health and substance use issues caused the largest disease burden (of all ill-health) for young people in Western Australia. The cost of mental ill-health for this age group is substantial. In the most recent data available, young Western Australians lost just under 9,850 years of healthy life every year due to living with, and dying early from, mental ill-health and substance use issues. Mental ill-health and substance use issues accounted for about 22 per cent of total burden of disease; and 41 per cent of non-fatal burden of disease (that is, years of healthy life lost due to disability). In WA, the cost of diminished health and reduced life expectancy was estimated to be over \$2.2 billion in 2015.<sup>37</sup>

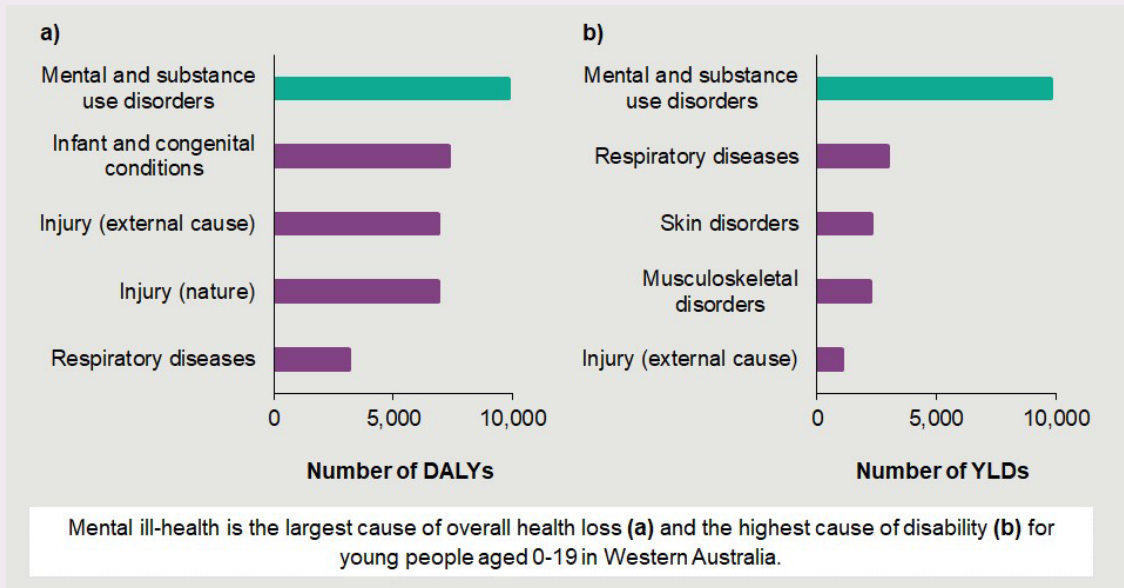


Figure 25: The largest disease burden for those aged 0-19 in Western Australia<sup>38</sup>

### Investing in ICA mental health can lead to life-long benefits for individuals, families and carers

There are a range of benefits identified in the literature that support investment in ICA mental health. Key benefits include:

- **Reduction in the progression of ill-health.** Mental ill-health often starts in childhood, adolescence, or

youth, with 50 per cent of all mental issues starting by 14 years of age.<sup>39</sup> Studies have found that almost 80 per cent of all adult mental ill-health can be reframed as extensions of ill-health that onset prior to the age of 18 years.<sup>40</sup> Intervening during childhood and adolescence is effective in limiting the severity and progression of ill-health.<sup>41,42</sup> If early and appropriate treatment is provided, medium-

<sup>37</sup> Taskforce analysis – multiplying the number of life years lost due to disability and premature death with the value of a statistical life year. Life years have not been discounted.

<sup>38</sup> A disability-adjusted life year (DALY) is a measure of the effect of a disease. One DALY corresponds to a loss of one year of healthy life. In cases where people experience illnesses and recover — the time spent living with the illness can be thought of as years lived with disability (YLD). Analysis based on Australian Institute of Health and Welfare 2019, Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Australian Burden of Disease series no. 19. Cat. no. BOD 22. Canberra.

<sup>39</sup> Colizzi et al 2020, Prevention and early intervention in youth mental health: is it time for a multidisciplinary and trans-diagnostic model for care?, International Journal of Mental Health Systems, vol. 14, no. 23

<sup>40</sup> Furber et al. 2015, Preventing mental illness: closing the evidence-practice gap through workforce and services planning, BMC Health Services Research, vol. 15, no. 283, pp. 1–14.

<sup>41</sup> RANZCP 2010, Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand.

<sup>42</sup> Institute of Medicine 2009. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Washington, DC: The National Academies Press

and long-term outcomes can improve significantly, including less admissions to hospital, shorter periods of inpatient care, more rapid and complete recovery, decreased risk of relapse over the following few years, and less treatment resistance.<sup>43</sup> Because the majority of mental ill-health onsets before adulthood, investing in ICA mental health is the most effective form of prevention and early intervention.

- **Improved health outcomes.** Effective treatment of ICA mental ill-health can improve physical and mental health outcomes into adulthood. One study estimated that 25–50 per cent of adult mental ill-health could be prevented if effective ICA mental health interventions were provided.<sup>44</sup> Research also suggests that effective interventions that address mental health problems early in life may reduce long-term risks of substance use, abuse, and dependence, as well as general health outcomes in adulthood.<sup>45,46</sup>
- **Improved educational outcomes.** Children with mental ill-health are less connected and engaged with their schooling, attend school less often and have poorer academic outcomes than their peers. Analysis of linked data from WA's Social Investment Data Resource (SIDR) shows that 32 per cent of children accessing a mental health service had at least one school suspension; and 31 per cent had an attendance rate of less than 60 per cent, between 2015 and 2019. This compares with six per cent of their peers who did not access a mental health service. Evidence shows that access to mental health support can prevent students with mental ill-

health from falling further behind relative to students with mental ill-health who do not access care.<sup>47</sup>

- **Improved employment and economic outcomes.** Mental ill-health in children is a significant risk factor for poor employment outcomes in adulthood. Children with mental ill-health had a five-fold increased risk of not being in education, employment, or training at age 24.<sup>49</sup> Studies also show that children with mental ill-health are more likely to have financial issues in adulthood.<sup>50</sup> Early intervention to re-engage young people in training and employment is crucial for their longer-term outcomes; and some programs that integrate employment and vocational services with clinical mental health support can improve employment rates.<sup>51</sup>
- **Improved social outcomes.** Appropriate mental health care for children can lead to improved social outcomes, including reduced contact with the justice system and improved housing outcomes. Children with mental ill-health are overrepresented in the youth justice system<sup>52</sup>, and are more likely to be associated with criminal activity in adulthood. For example, 80 per cent of all criminal activity is attributable to adults who had conduct problems during their childhood.<sup>53</sup> Mental ill-health in adolescence is also closely linked with poor housing outcomes in adulthood.<sup>54</sup> Mental health interventions have been shown to improve social outcomes, including reducing offending by 35–50 percent<sup>55,56</sup> and reducing the risk of homelessness.<sup>57</sup>

<sup>43</sup> NSW Health 2001, Getting in Early – A framework for early intervention and prevention in mental health for young people in NSW.

<sup>44</sup> Kim-Cohen, J. et al. 2003, Prior Juvenile Diagnoses in Adults With Mental Disorder, *Arch Gen Psychiatry*, vol. 60, pp. 709–717.

<sup>45</sup> U.S. Department of Health and Human Services & Office of the Surgeon General, 2016, Facing Addiction in America: The Surgeon general's Report on Alcohol, Drugs, and Health. Washington, DC: HHS.

<sup>46</sup> Naicker, K., Galambos, N. L., Zeng, Y., Senthilselvan, A., & Colman, I. 2013, Social, demographic, and health outcomes in the 10 years following adolescent depression. *Journal of Adolescent Health*, vol. 52, no. 5, pp. 533–538.

<sup>47</sup> Goodsell, B et al., 2017, Child and Adolescent Mental Health and Educational Outcomes: An analysis of educational outcomes from Young Minds Matter: the second Australian Child and Adolescent Survey of Mental Health and Wellbeing.

<sup>48</sup> Goodsell, B et al., 2017, Child and Adolescent Mental Health and Educational Outcomes: An analysis of educational outcomes from Young Minds Matter: the second Australian Child and Adolescent Survey of Mental Health and Wellbeing.

<sup>49</sup> Clarke A. and Lovewell, K. 2021, Adolescent mental health evidence brief 2: The relationship between emotional and behavioural problems in adolescence and adult outcomes, Early Intervention Foundation.

<sup>50</sup> Veldman, K., Reijneveld, S. A., Ortiz, J. A., Verhulst, F. C., & Bültmann, U., 2015. Mental health trajectories from childhood to young adulthood affect the educational and employment status of young adults: results from the TRAILS study. *Journal of Epidemiology and Community Health*, vol. 69, no. 6, pp. 588–593.

<sup>51</sup> The National Centre of Excellence in Youth Mental Health, 2019, Research Bulletin: Vocational Interventions for young people with mental ill-health.

<sup>52</sup> WA MHC 2020, Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020–2025.

<sup>53</sup> Sainsbury Centre for Mental Health 2009, The chance of a lifetime: Preventing early conduct problems and reducing crime.

<sup>54</sup> Productivity Commission 2020, Mental health, report no. 95, Canberra.

<sup>55</sup> Sexton, T and Turner CW 2010, The Effectiveness of Functional Family Therapy for Youth with Behavioral Problems in a Community Practice Setting, *J Fam Psychol*, vol. 24, no. 3, pp. 339–348.

<sup>56</sup> Sainsbury Centre for Mental Health 2009, Chance of a lifetime, Policy Paper, London.

<sup>57</sup> Wang, J.Z., et al, 2019, The impact of interventions for youth experiencing homelessness on housing, mental health, substance use, and family cohesion: a systematic review, *MHC Public Health*, 19, 1528.

- **Improved benefits for families and carers.** Families and carers can accumulate physical, emotional and mental costs associated with caregiving. For example, one study found that carers can experience rates of depression that are 1.8 times higher than the general population; and poorer physical health outcomes too.<sup>58</sup> Time spent caring for loved ones also means less time available for employment. In 2018, nationally, 14 per cent of working-aged primary mental health carers had to leave work for at least three months to provide care, 23 per cent needed time off work at least once a week, and 25 per cent had to take time off work (but not as often as once a week).<sup>59</sup> The benefits for families and carers could be substantial. It was estimated that the total replacement cost for informal mental health carers was \$14.3 billion per year, nationally<sup>60</sup> — this is about \$1.5 billion in Western Australia, based on population share. While this provides an indication of the economic value of informal care, it also illustrates the potential economic benefit for carers from improved mental health in their children.

### **There are substantial cost offsets for government in the short- and long-term**

While improved outcomes for children builds a strong case for investment on its own, an enhanced ICA mental health system would also generate longer-term cost savings and offsets to government. Studies have estimated the longer-term cost savings from effective child and adolescent mental health programs, finding that savings arise from reduced use of health services, education support, social care, voluntary agencies and from reduced criminal behaviour over time.<sup>61</sup>

- **Cost offsets for the health system:** investing into the ICA mental health system could lead to reduced health service costs in the short- and long-term. In the short-term, timely access to appropriate mental health support will lead to less emergency department presentations<sup>62,63</sup> and fewer hospital admissions and bed-days.<sup>64,65</sup> In the long-term, it can lead to reduced health service use as adults. Improved mental health care can lead to improved physical health outcomes, and reduced risk of substance use as adults – generating substantial cost savings for the health system over time.<sup>66,67</sup>
- **Cost offsets for other government services:** investing into the ICA mental health system could improve a young person's education, economic and social outcomes in the short- and long-term. In relation to the criminal justice system, effective mental health interventions for conduct disorder can reduce offending behaviour by 50 per cent and reduce a young person's involvement in criminal behaviour as adults too.<sup>68</sup> Reduced contact with the criminal justice system over time would lead to significant cost offsets for government now and overtime. In relation to homelessness services, appropriate mental health care and other social supports can improve future housing outcomes for individuals and lead to cost offsets for homelessness services – of the 25,000 individuals who accessed homelessness services in the state, 13 per cent of them reported their mental health issues as being a reason for seeking assistance.<sup>69</sup> The WA Government spent \$83 million on homelessness services in 2019-20.

<sup>58</sup> Productivity Commission 2020, Mental health, report no. 95, Canberra.

<sup>59</sup> Productivity Commission 2020, Mental health, report no. 95, Canberra.

<sup>60</sup> Diminic et al. 2017, The Economic Value of Informal Mental Health Care in Australia: Summary Report, Commissioned by Mind Australia, University of Queensland, Brisbane.

<sup>61</sup> Bonin et al. 2011, Costs and longer-term savings of parenting programmes for the prevention of persistent conduct disorder: a modelling study, BMC Public Health, vol. 11, no. 803.

<sup>62</sup> PriceWaterhouseCoopers Consulting 2018, Economic impact of the Safe Haven Café Melbourne, report for St Vincent Hospital Melbourne.

<sup>63</sup> Calvo, A., Moreno, M., Ruiz-Sancho, A., Rapado-Castro, M., Moreno, C., Sánchez-Gutiérrez, T., Arango, C. and Mayoral, M. 2014, 'Intervention for adolescents with early-onset psychosis and their families: a randomized controlled trial', Journal of the American Academy of Child and Adolescent Psychiatry, vol. 53, no. 6, pp. 688–696.

<sup>64</sup> Pharoah, F., Mari, J.J., Rathbone, J. and Wong, W. 2010, 'Family intervention for schizophrenia', Cochrane Database of Systematic Reviews, no. 12, Art. CD000088.

<sup>65</sup> Bird, V., Premkumar, P., Kendall, T., Whittington, C., Mitchell, J. and Kuipers, E. 2010, 'Early intervention services, cognitive-behavioural therapy and family intervention in early psychosis: systematic review', The British Journal of Psychiatry: The Journal of Mental Science, vol. 197, no. 5, pp. 350–356.

<sup>66</sup> Productivity Commission 2020, Mental health, report no. 95, Canberra.

<sup>67</sup> Naylor C. et al. 2012, Long-term conditions and mental health: The cost of co-morbidities, Centre for Mental Health.

<sup>68</sup> Sainsbury Centre for Mental Health 2009, The chance of a lifetime: Preventing early conduct problems and reducing crime.

<sup>69</sup> Australian Institute of Health and Welfare 2021, Specialist Homelessness Services.



### Other return on investment analyses of ICA mental health

Past economic analyses of ICA mental health interventions show that the return on investment is high.

- The Productivity Commission's Inquiry into Mental Health examined the cost-effectiveness of various recommendations and found that mental health interventions in early childhood and school was the most cost effective relative to other areas of reform.<sup>70</sup>
- The National Mental Health Commission assessed the benefits of several interventions and found an average return on investment of 2.34 meaning, for every \$1 invested, \$2.34 is returned to the economy.<sup>71</sup>
- A cost benefit analysis of a Nurse-Family Partnership program which focuses on perinatal mental health found a \$2.88 return for every \$1 invested.<sup>72</sup>
- Research within the UK which assessed the benefits of early intervention in conduct disorder found a return on investment of \$7.89 for every \$1 spent.<sup>73</sup>
- A longitudinal study of a parenting program that aims to reduce poor emotional development in children realised a return of \$4.57 for every \$1 spent over 30-years, accounting for impacts on health, welfare, education, and criminal justice services.<sup>74</sup>

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<sup>70</sup> Productivity Commission 2020Mental Health, Report no. 95, Canberra.

<sup>71</sup> National Mental Health Commission, 2019, The economic case for investing in mental health prevention.

<sup>72</sup> Social Policy Research Centre UNSW 2007, Cost Effectiveness of Ealy Intervention Programs for Queensland, Queensland Council of Social Services.

<sup>73</sup> Knapp, M., McDaid, D., & Parsonage, M., 2011, Mental Health Promotion and Prevention: The Economic Case, Department of Health, London.

<sup>74</sup> McDaid et al 2019, The Economic Case for the Prevention of Mental Illness, Annual Review of Public Health.

## Estimating the return on investment – benefits and offsetting costs

To illustrate the potential size of benefits in monetary terms, quantitative analysis was undertaken to understand the potential benefits and cost offsets in the short-term, at a 'macro level'.<sup>75</sup> This was applied to the benefits and cost offsets associated with enhancing, and expanding the coverage of Community ICAMHS to address current need (see Section 10).<sup>76</sup>

Estimating the benefits of system-wide reform involved: quantifying and monetising the potential improvement in quality of life for children receiving care; and quantifying the potential offsetting costs for government.<sup>77</sup>

## Needs based modelling and analysis of costs and benefits.

Benefits and offsetting cost savings	Low scenario (\$ million)	High scenario (\$ million)
<b>Benefits from improved quality of life</b>		
In year 1	\$110.4	\$195.0
In subsequent years	\$92.2	\$162.9
<b>Total benefits</b>	<b>\$202.6</b>	<b>\$358.0</b>
<b>Offsetting cost savings</b>		
Reduced emergency departments presentations	\$1.1	\$3.5
Reduced inpatient bed-days	\$17.1	\$32.2
Reduced contact with the justice system	\$7.3	\$10.5
<b>Total cost offsets</b>	<b>\$25.6</b>	<b>\$46.2</b>
<b>Total benefits and cost offsets</b>	<b>\$228.1</b>	<b>\$404.1</b>

<sup>75</sup> This quantitative analysis does not fully convey the potential return on investment as it does not capture the longer-term health, social and economic outcomes that improve because of accessing appropriate mental health care.

<sup>76</sup> Ideally, quantifying the benefits associated with each recommendation would help decision making over individual elements, but given the appetite for system-wide reform, plus time and data constraints, this was deemed to be the most suitable approach to inform the decision at hand.

<sup>77</sup> The cost offsets are unlikely to yield cash that can be "harvested" to improve the fiscal balance, as hospitals usually have waiting lists, plus they need to accommodate underlying population growth, which means that the resources freed up from reform are most likely to be used to service other individuals, rather than generate a cash saving for government.

## 18. Monitoring, reporting and evaluation

To ensure that the ambitions set out in this Strategy are realised, monitoring, reporting and evaluation arrangements need to be improved. Currently, monitoring and reporting arrangements are sub-optimal, focussing too strongly on inputs and outputs rather than outcomes, and providing too little information on the state of ICA mental health in WA. Similarly, current evaluation arrangements do not align with best practice. Evaluations are conducted infrequently, and when they are undertaken, they do not necessarily provide valuable insights to inform future decision-making. Unless monitoring, reporting and evaluation arrangements are improved, there will be no way of ensuring that ICA mental health services are delivering improved experiences and outcomes for children, families and carers, or that the ICA mental health system is operating in an efficient, sustainable manner.

The approach to monitoring, reporting and evaluation set out in Figure 26 needs to be adopted in WA's ICA mental health system. It involves three pillars: outcomes-focused system performance monitoring; consistent, regular, and high-quality evaluations; and strong public accountability. Each of the pillars are detailed in turn below.

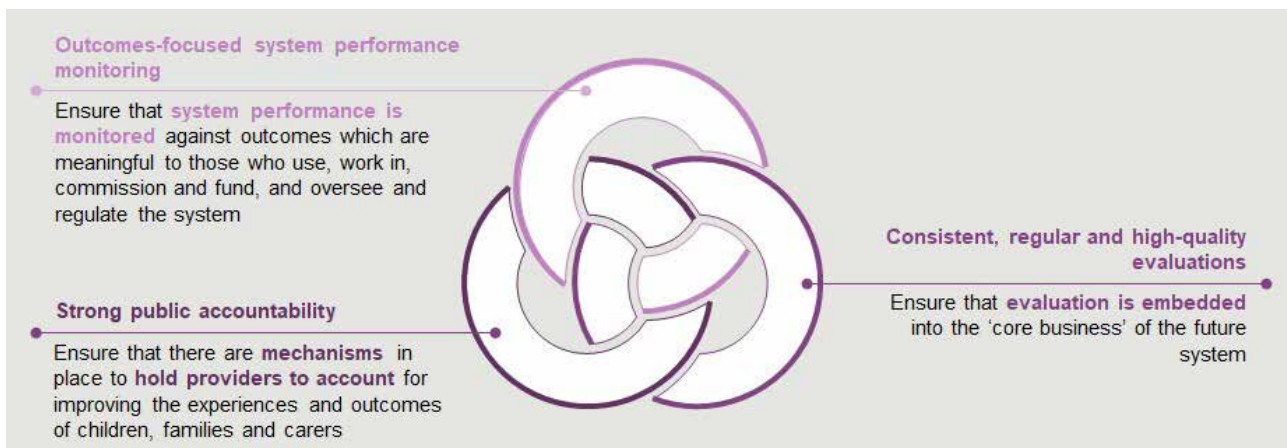


Figure 26: Three components of an effective monitoring and evaluation approach

## Outcomes-focused system performance monitoring

System performance monitoring is key to ensuring that progress is being made towards improving the experiences and outcomes of children, families and carers, and that the system is sustainable. There are four requirements of effective system performance monitoring.



Figure 27: Four requirements of effective system performance monitoring

- **Focus on outcomes rather than outputs:** Currently, system performance monitoring focuses more heavily on inputs and outputs, including activity and expenditure, than outcomes. Though measuring inputs and outputs is essential, it does not provide insight into what changes need to be made to improve the experiences and outcomes of children, families and carers. The focus needs to shift from what has been delivered to children, families and carers (inputs and outputs), to what has been achieved for and with them (outcomes).
- **Develop outcomes in partnership with stakeholders:** Outcomes used to monitor system performance need to be reflective of what matters most to the people who use, work in, commission and fund, oversee and regulate the system. This is critical to understanding what value the system delivers to stakeholders. To ensure that the outcomes are meaningful, they must be developed in partnership with stakeholders, including children, families and carers.
- **Take a broad view to mental health and wellbeing:** 'Mental health and wellbeing' is a broad, multi-faceted concept, which goes beyond the absence of mental ill-health. The concept refers to success across all parts of the lives of children, families and carers, including the cognitive and educational, emotional, physical, psychological, and social. To understand whether the mental health and wellbeing of children, families and carers is improving, we need to monitor outcomes across all these domains.
- **Reflect culturally diverse concepts of mental health and wellbeing:** The concept of 'mental health' can differ between Aboriginal and non-Aboriginal communities. Aboriginal communities tend to prefer the more holistic concept of 'social and emotional wellbeing' to 'mental health'. Similarly, many ethnoculturally and linguistically diverse communities view mental health differently. To ensure that the system meets the needs of all children, families and carers, culturally diverse concepts of mental health need to be recognised and reflected in how system performance is monitored.

A **System Performance Monitoring Framework**, which meets these four requirements, needs to be developed in partnership with those with lived experience and clinicians. It should be used to monitor outcomes, to inform investment, planning and policy decisions.

The [WA Outcomes Measurement Framework's](#) domains (see Figure 28) should be used as a 'starting point' for the System Performance Monitoring Framework.



Figure 28: Six domains of the WA Outcomes Measurement Framework

It will be important for the System Performance Monitoring Framework to align with other outcome measurement-related initiatives and projects being undertaken in WA and across Australia. This includes the development of the Outcomes Measurement Framework to support the WA State Priorities Mental Health, Alcohol and Other Drugs 2020-2024, and the development of the State Commissioning Strategy for community services in WA.

It will also be important for the System Performance Monitoring Framework to align with existing outcomes frameworks and targets, including the Closing the Gap targets, the Contributing Life Framework, and the National Mental Health Performance Framework, among others.

## Consistent, regular, and high-quality evaluations

Evaluation must be embedded into the 'core business' of the future system. The importance of building a 'learning system' which meets the needs of consumers is a priority across many government portfolios, beyond health and mental health. For example, the State Commissioning Strategy for community services emphasises the important role that evaluation plays in supporting services and systems to meet the needs of those that use them.

Moving forward, a consistent and system wide approach to evaluation that is grounded in best practice – based on the approach outlined in – is required.

Three enablers will need to be put in place to embed this approach to evaluation into the 'core business' of the future system. These are:

- Develop an **Evaluation Framework** outlining a system wide approach to evaluation, to ensure that evaluations and reviews are consistent, regular and high-quality. The Evaluation Framework should build on the high-level approach set out in Figure 29.
- Set an expectation that evaluation is a **condition for funding** for all new initiatives, programs and services. This should apply to government and non-government providers.
- Support the workforce to build evaluation mindsets and skillsets.

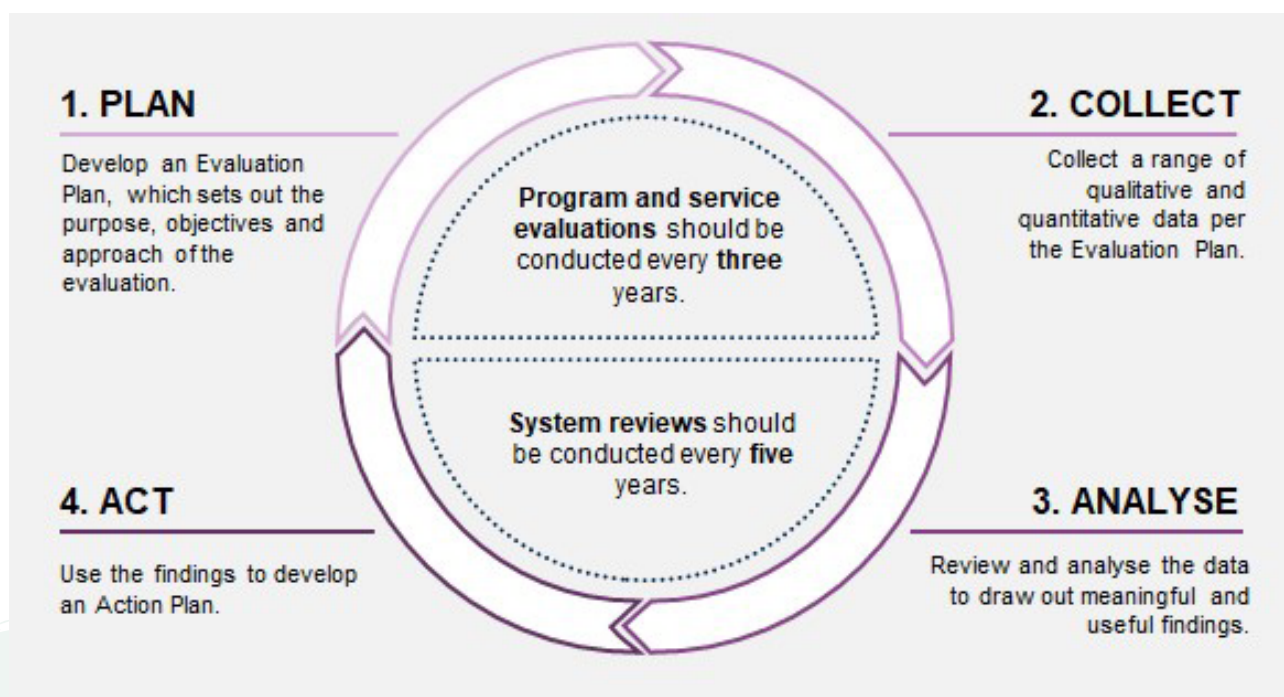


Figure 29: System wide approach to evaluation

## Strong public accountability

To improve the experiences and outcomes of children, families and carers, providers need to be publicly held to account for doing so. There is evidence to show that public reporting at a service level leads to improvements in the quality and safety of services.<sup>78</sup> Despite this, there is no public reporting in relation to ICA mental health services in WA, impeding self-improvement among providers.

Introducing public reporting in relation to ICA mental health services in WA will encourage providers to deliver improved experiences and outcomes for children, families and carers. Progress against a selection of outcome measures from the System Performance Monitoring Framework need to be publicly reported at both a service and system level. These outcomes and measures could be reported via a dashboard or website, or via periodic reports.

<sup>78</sup> Productivity Commission, Inquiry Report into Mental Health, p.1220.

## Appendix A: Glossary

<b>ACCHO</b>	Aboriginal Community Controlled Health Organisation
<b>ACCO</b>	Aboriginal Community Controlled Organisation
<b>AMS</b>	Aboriginal Medical Service
<b>AOD</b>	Alcohol and Other Drugs
<b>ASD</b>	Autism spectrum disorder
<b>CAHDS</b>	Complex Attention and Hyperactivity Disorder Service
<b>CAHS</b>	Child and Adolescent Health Service
<b>CAMHS</b>	Child and Adolescent Mental Health Service
<b>Children</b>	5-11 years of age
<b>CMC</b>	Community Mental Health and Alcohol and Other Drug Council
<b>Community ICAMHS</b>	Community Infant, Child and Adolescent Mental Health Services
<b>CYMHS</b>	Child and Youth Mental Health Service
<b>CYPRESS</b>	Children and Young People Bereaved by Suicide Program
<b>DGHHS</b>	Director Generals Health and Human Services Group
<b>DGIG</b>	Directors General Implementation Group
<b>EAGs</b>	Expert advisory groups
<b>ED</b>	Emergency Department
<b>EDS</b>	Eating Disorder Service
<b>ELD</b>	Ethnographically and Linguistically Diverse
<b>EMHSS</b>	Enhancing Mental Health Support in Schools
<b>EMR</b>	Electronic Medical Record
<b>EPPIC</b>	Early Psychosis Prevention and Intervention Centre
<b>ETS</b>	Emergency Telehealth Service
<b>FSH</b>	Fiona Stanley Hospital
<b>GDS</b>	Gender Diversity Service
<b>GP</b>	General Practitioner
<b>HaDSCO</b>	Health and Disability Services Complaints Office
<b>HSPs</b>	Health Service Providers
<b>ICA</b>	Infants, children and adolescents

<b>Infants</b>	0-4 years of age
<b>LGBQIA+</b>	Lesbian, gay, bisexual, transgender, queer, questioning, intersex, pansexual, two-spirit, asexual and ally
<b>MBS</b>	Medicare Benefit Schedule
<b>MHC</b>	WA Mental Health Commission
<b>MHEC</b>	Mental Health Executive Committee
<b>MHID</b>	Mental Health Intellectual Disability
<b>MOU</b>	Memorandums of Understanding
<b>MST</b>	Multisystemic Therapy
<b>NDIA</b>	National Disability Insurance Agency
<b>NDIS</b>	National Mental Health Service Planning Framework
<b>NMHSPP</b>	National Mental Health Service Planning Framework
<b>NP</b>	Nurse Practitioner
<b>NQAFMHS</b>	North Queensland Adolescent Forensic Mental Health Service
<b>PCH</b>	Perth Children's Hospital
<b>PHN</b>	Primary Health Network
<b>Schools Response</b>	Response to Suicide and Self Harm in Schools Program
<b>SHR</b>	Sustainable Health Review
<b>SIDR</b>	Social Investment Data Resource
<b>Taskforce</b>	Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in Western Australia
<b>the Agreement</b>	National Mental and Suicide Prevention Agreement
<b>The Strategy</b>	ICA Mental Health Strategy
<b>The WA Health Digital Strategy</b>	WA Health Digital Strategy 2020–2030
<b>WA</b>	Western Australia
<b>WACHS</b>	WA Country Health Service
<b>WAPHA</b>	Western Australian Primary Health Alliance
<b>WBC</b>	Wellbeing Check
<b>YCATT</b>	Youth Community Assessment and Treatment Team



# Appendix B: Terms of Reference

## Background

For the purpose of this project the term **public specialist infant, child and adolescent mental health services** will be used to describe the services within scope.

As mental ill-health is the leading cause of disability and poor life outcomes for children and young people<sup>79</sup>, the mental health of young Western Australians has been identified as a priority issue since at least 2015. Three in four people with a mental ill-health develop symptoms before they are 25. Both the Western Australian Mental Health and Alcohol and Other Drug Services Plan 2015 – 2025 (the Plan) and the Commissioner for Children and Young People's 'Our Children Can't Wait' report from 2015, highlighted the need to improve services available to support children and young people with mental health and/or alcohol and other drug (AOD) issues.

In March 2020, the then Minister for Health; Mental Health released the WA State Priorities Mental Health, Alcohol and Other Drugs 2020 – 2024, in which infants, children and young people were confirmed as an immediate priority. In addition, the Ombudsman Western Australia has made a number of recommendations in relation to improving mental health services for young people in the report Preventing Suicide by Children and Young People 2020.

Over recent years, there has been an ever-increasing demand on the mental health services provided by the Child and Adolescent Health Service (CAHS) and WA Country Health Services (WACHS), with the COVID-19 pandemic creating a further surge in demand for CAHS and WACHS child and adolescent mental health services (CAMHS). In addition, the demand for inpatient services exceeds the number of beds available. In WACHS, children are often cared for in general medical wards.

## Key Data to support the increasing demand on CAMHS across WA:

- There has been a decline in the average age (now around 14.5 years or less) of Perth Children's Hospital (PCH) emergency department (ED) attendances associated with suicide risk/attempt.
- Referrals to the CAHS Eating Disorders Service (EDS) in August 2020 were at their highest levels in the services' history.
- CAHS community CAMHS clinics have reported a large increase in demand and complexity over a five-year period, ranging from 4,313 referrals in 2016 to 5,794 referrals in 2019; resulting in additional clinician workload and stress as there has not been a proportionate increase in FTE.
- There has been a 26 per cent increase in ED self-harm presentations for 0-15 year old children and adolescents from 2015/16 to 2019/20.
- There has also been a 34 per cent increase in mental health ED presentations for this cohort from 2015/16 to 2019/20.
- There has been a 22 per cent increase in ED self-harm presentations for 0-18 year old children and adolescents from 2015/16 to 2019/20. There has also been a 26 per cent increase in mental health ED presentations for this cohort from 2015/16 to 2019/20.<sup>80, 81</sup>

<sup>79</sup> Orygen (2020). A Global Framework for Youth Mental Health: Investing in Future Mental Capital for Individuals, Communities and Economies. World Economic Forum. Retrieved from: <https://www.orygen.org.au/About/Orygen-Global/Files/Orygen-WEF-global-framework-for-youth-mental-health.aspx>.

<sup>80</sup> Mental Health Commission (MHC) data verified by the Department of Health indicates.

<sup>81</sup> Note that there have been changes to population, service, capacity and an increase in coding in WACHS that have contributed to this increase.

## Key Data to support the increasing demand on CAMHS across WA:

- WACHS community CAMHS services have experienced a 41 per cent increase in demand over the last five years with 4,163 referrals in 2016 to 5,866 referrals in 2020.
- Activated referrals to WACHS CAMHS increased 67 per cent from 2016 to 2020. Clinician workload has increased as there has not been a proportionate growth in FTE.<sup>82</sup>
- Eating disorder presentations to WACHS EDs has risen from four in 2017 to 12 in 2020. There has been a steady increase in eating disorder admissions to WACHS community CAMHS services for 0 to 17 year-olds; nine in 2016 increasing to 29 in 2020.
- Admissions to WACHS general hospitals for eating disorders for 0-17 year-olds indicated there were 10 admissions in 2019/20 which was a 100 per cent increase from the five admissions in 2018/19. The majority of the admissions in the last five years (56 per cent) were for 16 year-old females.
- There has been a seven per cent increase in the number of self-harm presentations to WACHS EDs from 2017/18 to 2018/19, however there was a nine per cent decrease in 2019/20 for 0 – 15 year-olds.
- There has been a 16 per cent increase in the number of mental health presentations to WACHS EDs from 2017/18 to 2019/20 for 0 to 15 year-olds. There has been a 47 per cent increase in the number of self-harm presentations to WACHS Emergency Departments from 2017/18 for 0 to 17 year-olds.
- There has been a 17 per cent increase in the number of mental health presentations to WACHS Emergency Departments from 2017/18 to 2019/20 for 0 to 17 year-olds.

## Feedback from people with lived experience

Feedback from young people and their families and carers as part of the consultation for the Young Peoples Priorities for Action 2020-2025, indicate significant gaps across the mental health and AOD sector with young people and their families experiencing difficulty accessing timely and effective help, including from the services provided by CAHS.

### Chief Psychiatrist's Review

Kate Savage was a 13-year-old girl who tragically died in July 2020 while under the care of the CAHS CAMHS. The Chief Psychiatrist (CP) undertook a targeted review into her care at the request of the then Minister for Health; Mental Health under s.517 of the Mental Health Act 2014. The Chief Psychiatrist's Review into the Treatment of Ms Kate Savage by Child and Adolescent Mental Health Services (the Review) made seven recommendations to close critical service gaps in CAMHS and to rebuild the CAMHS system; including Recommendation Seven – that a Child and Adolescent Mental Health Ministerial Taskforce be appointed immediately to develop a whole of system plan for Perth metropolitan and WA country specialist public child and adolescent mental health services.

The Review found:

- Families often feel they don't have a voice in the management and treatment of their child.
- The increasing rates of young people presenting with self-harm and the decreasing age of those presenting with complex high-risk problems is placing serious demands on the system leading to families having trouble accessing CAMHS, especially those between ages 0 to 12.
- There are gaps in service between hospital (inpatient and ED) treatment and the service currently provided by community CAMHS. Services are not set up to respond to crises effectively.
- There is significant pressure on inpatient beds at PCH.

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<sup>82</sup> Data provided by WACHS February 2021.

## Purpose

The purpose of the project is to develop a whole of system plan for Perth metropolitan and Western Australian (WA) country state government funded specialist infant, child and adolescent mental health services provided by WA health service providers (HSPs) and make recommendations to the Minister for Mental Health and the Minister for Health with actions and a costed implementation plan aimed at achieving better mental health outcomes for infants, children and young people; paying particular attention to the adequacy and equity of service provision across all ages from 0 to 18 years.

For the purpose of this project the term **public specialist infant, child and adolescent mental health services** will be used to describe the services within scope. This is in line with the wording of the Chief Psychiatrist's recommendation arising from his review into the treatment of Ms Kate Savage by CAHS CAMHS. The term 'specialist' is used to indicate that this does not refer to publicly funded primary care services. The mental health services in scope are those Western Australian (WA) state government funded services currently provided by health service providers (HSPs), including CAHS and WACHS. In the Plan and the Plan update 2018 these types of service are referred to as community treatment services, hospital-based services and specialised state-wide services. Community mental health psychosocial support services are not within scope, except at the interface and transition with the public specialist mental health services.

Taskforce will be led by an independent chair and actively engage children, young people, families, clinicians, support providers, and other key stakeholders in the design of public specialist infant, child and adolescent mental health services for infants, children and adolescents aged 0 – 18 years that fit the unique metropolitan, regional, rural and remote circumstances of WA.

## Taskforce will consider

- patterns of demand for CAHS, WACHS and other HSPs providing mental health services for children from 0 to 18 years, including ED presentations
- the current model of care and service, including its fitness for purpose
- interface and transition between services, including youth services and alcohol and other drug (AOD) services
- WACHS CAMHS transition between and access to CAHS CAMHS Perth based State-wide services including PCH mental health inpatient unit Ward 5A, Pathways, Eating Disorders Service, Gender Diversity Service and Touchstone
- gaps in services and pathways for infants, children, adolescents and their families; and - demand and pressure on the workforce supporting these services.

Taskforce will investigate in the first instance how current public specialist infant, child and adolescent mental health services can be optimised, enhanced, reconfigured or expanded; as well as identifying where new services may be required.

## In scope

- All mental health services provided by CAHS, WACHS and other HSPs for infants, children and adolescents aged between 0 and 18 years old.

## Out of scope

- CAHS and WACHS services that do not provide mental health care.
- Private mental health services.
- Commonwealth funded primary care mental health services, except in their interface and transition with mental health treatment services that are in scope.
- Community mental health support services, except in their interface and transition with mental health treatment services that are in scope.

## Objectives

A report that includes costings and an implementation plan will be prepared which will clearly articulate a vision for public specialist mental health services for infants, children and adolescents across WA by examining three broad aspects of current service provision:

### Models of care including:

- documenting the current services and referral pathways for intervention, general and sub-specialist mental health services identifying gaps in services for infants, children and adolescents and their families; and
- exploring current models against other contemporary models and benchmark provision.

### Service demand including:

- current and future patterns and projections, and mapping these to current services enabling a gap analysis.

### Sustainability including:

- costs, efficiency and improved outcomes.

The report will provide clear guidance and evidence supporting a contemporary, evidence informed model of service and models of care for services including infant mental health, mental health intervention, inpatient, community treatment and community support services that:

- meet the needs of infants, children, adolescents and their families in WA
- provide person and family centred care; - are well integrated with other services
- provide smooth pathways and supported transitions between services and agencies
- provides the best outcomes for infants, children, adolescents and their families.

### Which will be achieved by:

- identifying how current services can be optimised, enhanced, reconfigured or expanded; as well as identifying where new services may be required
- identifying the investment required to implement a sustainable whole of system treatment and care plan to meet demand, and improve mental health outcomes

- outline an implementation strategy including timeframes and responsibilities
- establish a governance mechanism for evaluation.

A paper outlining the emerging directions will be due by 31 July 2021 to inform the second stage of consultation and engagement and address any immediate actions. The final report, implementation plan and costings are due to be completed 30 November 2021 ready to be submitted in the 2022 budget submission process.

## Governance

Taskforce will report to both the Minister for Mental Health and the Minister for Health, and will be supported by three Expert Advisory Groups (EAGs) to ensure that Taskforce engages people with lived experience, clinicians, families, carers, young people and other key stakeholders, in the design of the public mental health services for children that fit WA's unique circumstance.

The Mental Health Executive Committee (MHEC) and Community Mental Health and Other Drug Council (CMC) will require updates and the opportunity to input on Taskforce's work as the subsequent implementation of the recommendations of Taskforce will be the responsibility of these groups. The MHEC and CMC are integral to keeping their HSPs and networks updated on the progress of the Taskforce.

## Membership

- Independent Chair
- Mental Health Commissioner
- Expert nominated by the Minister for Health – (Professor Helen Milroy)
- Chief Medical Officer – Mental Health (CMO-MH)
- Chief Nursing and Midwifery Officer
- CAHS Chief Executive (CE)
- WACHS CE
- Family / Carer lived experience representative
- Consumer lived experience representative
- Senior clinical representative

**Total number of members: 10**

The Taskforce, or its Chair, may invite non-members to participate as required. This will be undertaken when it is considered they are directly involved with the matter at hand or they have some expertise to assist on advising on matters, as required. The attendee will not have voting rights.

## Proxies

Proxies will not be allowed except under exceptional circumstances and with prior agreement from the Chair. Requests for proxies should be forwarded in writing to the Chair via the taskforce secretariat. All those attending as proxies should be provided with sufficient authorisation to speak on behalf of the member they are representing.

## Meetings

Taskforce will meet monthly.

## Conduct and operating principles

Members will abide by the agreed conduct and operating principles outlined in the taskforce charter. All members are equal and will work towards consensus wherever possible, will treat each other with respect and maintain confidentiality. Taskforce will operate in a trauma informed manner.

Members will be required to declare any potential, perceived and actual conflicts of interest. These conflicts, and the way in which they will be addressed, will be maintained in a register by the secretariat.

In the course of Taskforce operations, members may have access to information that constitutes sensitive personal information or sensitive Government information. Members must treat this material as strictly confidential and will be required to sign an agreement to this effect.

## Chair

Ms Robyn Kruk – independent Chair.

The Chair will try to seek consensus in relation to decisions. Where consensus is not reached the decision of the Chair is final.

## Secretariat

Secretariat support for Taskforce will be provided by the MHC. Minutes of meetings and other records are developed and maintained by this secretariat unit.

Additional support in researching, consulting and report writing will be provided by an external consultancy.

It is the responsibility of members to provide feedback to and from their respective Agency, organisation or network as required.

## Minutes

Minutes of each panel meeting shall be recorded and distributed within one week to each member.

## Reporting and engagement

A paper outlining emerging directions will be due on 31 July 2021. The final report with costed recommendations and an implementation plan will be due for submission to the Minister for Mental Health and Minister for Health by 30 November 2021.

Taskforce is supported by three EAGs. The EAGs will provide expert input and critical comment on Taskforce findings as they evolve, advise on matters raised by Taskforce and assist in facilitating consultation. Each EAG is required to report on their progress to each Taskforce meeting.

Taskforce, supported by the three EAGs, will undertake stakeholder consultation with children, adolescents, families, carers, clinicians, health service providers (HSPs), support providers and other key community stakeholders. Taskforce will also engage with key agencies across Government to promote a whole of Government approach in the articulation of recommendations.

## Interdependencies

The Chief Psychiatrist's Review into the Treatment of Ms Kate Savage by Child and Adolescent Mental Health Services made seven recommendations in relation to child and adolescent mental health services. Some are already being implemented, while the others require additional resources to implement. The Chief Psychiatrist's review will inform the work and direction of the Taskforce. The costed implementation plan prepared by Taskforce will assist in making business cases for the resources required to address all of the Chief Psychiatrist's recommendations. Taskforce will receive regular updates on the implementation of recommendations.

- The MHC is working on a Roadmap for Community Mental Health Treatment Services including Emergency Response Services (the Roadmap). The Roadmap project will include the findings and recommendations of this Ministerial Taskforce in relation to community treatment and emergency responses for infants, children and adolescents into the systemwide Roadmap.
- The MHC is preparing a Children's Priorities for Action in 2021 which will examine the priorities for action to support infants and children aged 0-12 years mental health across agencies and across the spectrum of severity of mental health. Taskforce will inform the priorities for action in mental health treatment services.

## Term

Unless otherwise agreed in writing by the MHC, Taskforce will finish on 30 November 2021.

## Supporting documents to inform Taskforce

The project will be informed by key documents, including but not limited to:

- The Chief Psychiatrist's Review into the Treatment of Ms Kate Savage by Child and Adolescent Mental Health Services
- The Ombudsman's Report Preventing Suicide by Children and Young People 2020
- The Commissioner for Children and Young People Report Our Children Can't Wait
- The Plan and Plan update 2018
- The Young People's Priorities for Action (YPPA) 2020-2025 and consultation reports from the YPPA.

## Related documents

- ICA Taskforce Charter - MHC21/25857
- Project Plan - MHC21/529
- Lived Experience Expert Advisory Group Terms of Reference (ToR)
- Clinical Expert Advisory Group ToR

## Appendix C: An overview of the public specialist ICA mental health system

Children, families and carers in WA who require formal support with their mental health can be assisted by a wide range of services from multiple service systems. The provision of services related to ICA mental health and wellbeing can be understood as existing at three levels including:

- the broader ICA wellbeing ecosystem
- the overall ICA mental health system
- the public specialist ICA mental health system.

While the focus of Taskforce relates to improving public specialist mental health services, it is important to understand the context in which these services are provide.

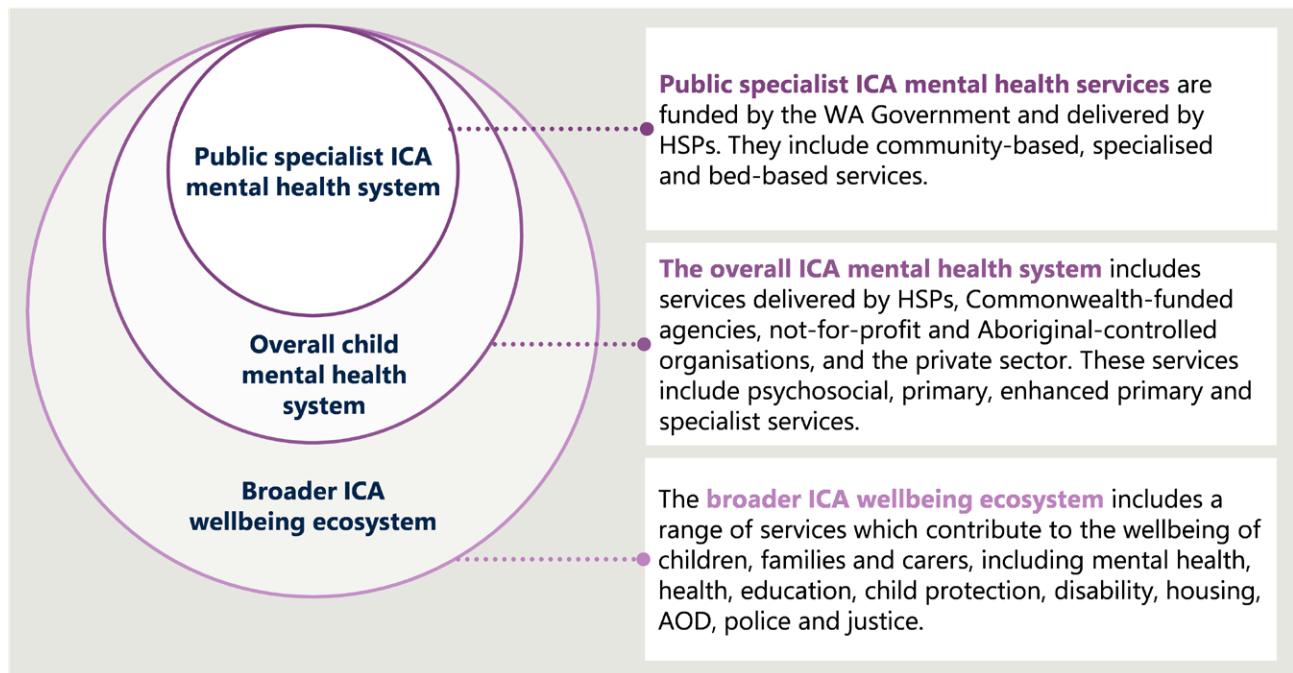


Figure 30: ICA mental health and wellbeing ecosystem

## The public specialist ICA mental health system

There are approximately 40 public specialist ICA mental health services available across WA, delivered by CAHS, WACHS, NMHS, EMHS and SMHS. Many of these ICA mental health services are commissioned by the MHC, which is responsible for planning and purchasing mental health and AOD services across WA.

The public specialist ICA mental health system is complex, comprising of a broad range of services which provide different types of treatment and supports; target different age cohorts; and are subject to different eligibility criteria. Table 2 provides a brief description of each service, organised by HSP, and Table 3 maps the services by age cohort, to show how the system is currently configured.

**Table 2:** Descriptions of all public specialist ICA mental health services in WA

HSP	Service	Description
CAHS	<b>Community CAMHS</b>	Community CAHMS clinics provide assessment, case coordination and multidisciplinary treatment services to children aged 0-17 with severe, complex and persistent emotional, psychological, behavioural and/or mental health problems. There are 10 clinics across the Perth metropolitan area in Armadale, Bentley, Clarkson, Fremantle, Hillarys, Midland, Peel, Rockingham, Shenton and Warwick.
	<b>Ward 5A at Perth Children's Hospital (PCH)</b>	The Mental Health Inpatient Unit on Ward 5A at PCH is the statewide assessment and treatment facility for children aged 15 or under with complex and acute mental health issues. Ward 5A is a recovery-focussed, child-and-family-centred service which offers a seven-day multidisciplinary program.
	<b>CAMHS Crisis Connect</b>	CAMHS Crisis Connect provides 24-7 phone and videocall support for children aged 0-17 who are experiencing a mental health crisis, as well as support and advice to families and professionals. The service provides specialist mental health consultation and liaison, crisis management, mental health and risk assessment, and follow up within 24 hours of being assessed at or discharged from PCH. Note: Children aged 16 and over cannot access CAMHS Crisis Connect at the PCH emergency department.
	<b>CAMHS Eating Disorders Service (EDS)</b>	CAMHS EDS is a statewide service for children aged 0-17 with severe eating disorders. It offers multidisciplinary assessment (for children aged up to 17 years and nine months) and treatment (for children aged 17 years and 11 months).
	<b>Paediatric Consultation Liaison Service (PCLS)</b>	PCLS is a statewide service, providing mental health and wellbeing support for children aged 0-17 who are receiving inpatient or outpatient treatment for physical health issues. The PCLS team works with other teams within PCH to ensure that children receive timely, comprehensive, responsive and effective mental health assessment and treatment.
	<b>Gender Diversity Service (GDS)</b>	GDS is a statewide service for children aged 0-17 experiencing gender diversity issues. It provides multidisciplinary assessment, treatment and support in an outpatient setting.
	<b>Multi-Systemic Therapy (MST)</b>	MST is a metropolitan service, providing an intensive intervention for families with children aged 11-16 who are experiencing severe behavioural and mental health difficulties. MST is a multi-modal form of family therapy which aims to provide families with the skills that they require to address their difficulties independently.
	<b>CAMHS Touchstone</b>	Touchstone is a metropolitan service, providing a structured day program for children aged 12-17 with emerging Borderline Personality Disorder, who have struggled with complex mental health issues for an extended period of time. The service offers an evidence-based intervention called Mentalisation Based Therapy (MBT).



CAHS	<b>Complex Attention and Hyperactivity Disorder Service (CAHDS)</b>	CAHDS is a statewide service for children aged 0-17 who have persistent attention and behavioural difficulties. Children must have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), and must be receiving treatment for their ADHD. The service provides multidisciplinary assessment, diagnosis (of other mental health disorders that can occur with ADHD), and recommendations to other services which can work in partnership with the referrer. It does not provide ongoing treatment.
	<b>Pathways</b>	Pathways is a statewide service, providing assessment, treatment and support to children aged 6-12 with complex and long-standing mental health difficulties. These children may also present with emotional, social, behavioural and educational difficulties. Pathways is a family focussed, recovery-based program, which aims to be flexible and adaptable to best meet the needs of the child.
WACHS	<b>WACHS CAMHS</b>	WACHS operates seven CAMHS in the South-West, Great Southern, Goldfields, Midwest, Wheatbelt, Pilbara and Kimberley. WACHS CAMHS provide assessment, treatment and support to children aged 0-17 with mental health issues, and their families and carers.
	<b>WACHS Mental Health Emergency Telehealth Service (ETS)</b>	WACHS Mental Health ETS provides rural and remote clinicians with access to specialist mental health nurses and psychiatrists, to assist with caring for people presenting to rural and remote hospitals in crisis. Currently, it is available at 86 hospitals, health services and nursing posts across rural and remote WA.
NMHS	<b>Neurosciences Unit (NSU) Paediatric General Diagnostic Program</b>	The NSU Paediatric General Diagnostic Program provides neuropsychological and speech pathology assessments to children aged 6-18 who require an assessment to assist with the diagnosis and management of cognitive and/or behavioural disturbance in the context of a known or suspected neurological condition, or a condition known to affect brain development.
	<b>Gender Pathways Service (GPS)</b>	GPS, within YouthLink, is a statewide service which provides gender diversity consultation, training, community development, and referral information and assessment for suitability and readiness for gender affirming medical treatment. It supports young people aged 17-24 experiencing gender diversity issues. Young people are eligible if they have complex mental health and/or neurodevelopmental disorders, and/or face significant barriers to access gender affirming treatment.
	<b>Centre for Clinical Interventions (CCI)</b>	CCI is a state-wide psychology service which provides evidence-based treatment for anxiety, depression, bipolar disorder and eating disorders to adults aged 18 and over. Treatment for eating disorders is provided to young people aged 16 and over.
	<b>YouthLink</b>	YouthLink provides counselling, therapy and case management to young people aged 13-24 years in the north and central metropolitan area with significant mental health problems and barriers to accessing mainstream services. It adopts a flexible and trauma-informed approach, using assertive case management and community outreach to support the engagement and retention of young people in the assessment and treatment of their mental health problems. An integrated triage and entry process exists between YouthLink, YouthReach South and Youth Axis.
	<b>Youth Axis</b>	Youth Axis is an early intervention service for young people aged 16-24 presenting with ultra-high risk psychosis and/or features of an emotionally unstable personality disorder in the metropolitan area. It targets young people who have not had extensive treatment by a specialist mental health service for these presenting problems. Treatment is informed by a variety of evidence-based practices including Dialectical Behaviour Therapy, Acceptance and Commitment Therapy and Cognitive Behaviour Therapy. Treatment is provided for up to six months in a location that is convenient and safe for the young person.

NMHS	<b>Youth Home in the Hospital (Youth-HITH)</b>	Youth-HITH is an eight-bed service for young people aged 16-24, providing short term intensive management for up to 14 days in the young person's home or usual place of residence that would otherwise be delivered within a hospital as an admitted patient. Youth-HITH clinicians work with the young person and their family or carers to provide intensive support, education, and guidance to all parties. It operates seven days a week.
	<b>YouthReach South</b>	YouthReach South provides counselling, therapy and case management to young people aged 13-24 in the south metropolitan area with significant mental health problems and barriers to accessing mainstream services. The service provides a trauma-informed, flexible approach, using assertive outreach to support engagement. An integrated triage and entry process exists between YouthLink, YouthReach South and Youth Axis.
EMHS	<b>East Metropolitan Youth Unit (EMyU)</b>	EMyU is a 12-bed inpatient service which provides mental health inpatient care for young people aged 16-24 presenting with complex and acute mental health issues who live in the EMHS, NMHS and WACHS catchment areas. It provides 24-hour, seven days per week inpatient multidisciplinary assessment, treatment and community care planning.
	<b>Mental Health Emergency Response Line (MHERL) and Rural Link</b>	Clinicians at MHERL and RuralLink provide assessments and support for young people experiencing a mental health emergency, and if required, referral to other mental health services. MHERL provides rapid response to health emergencies across the metropolitan area from Two Rocks to Peel and Waroona, and is operational 24-hours a day, seven days a week. RuralLink helpline is a service for people in rural communities and is operational 4.30pm-8.30am from Monday to Friday and 24-hours on Saturday and Sunday.
SMHS	<b>Fiona Stanley Hospital Youth Mental Health Service</b>	The services provided by the Fiona Stanley Hospital Mental Health Service include the 14-bed Fiona Stanley Youth Unit for young people aged 16-24 state-wide, and a Youth Community Assessment and Treatment Team (YCATT) for young people aged 16-24 in the south metropolitan area. YCATT is an outreach service, providing assessment, case management and treatment for a six-week period. It then works to link young people with community mental health services that can support their long-term recovery.
Other	<b>Mental Health Co-Response (MHCR)</b>	MHCR is a joint initiative between the WA Police Force, the MHC and HSPs which allows police officers and mental health clinicians to jointly attend crisis situations, where mental ill-health is identified as a likely factor. The initiative aims to divert people experiencing mental ill-health away from EDs and the justice system to a mental health service that can provide them with the support that they need.

**Table 3:** Mapping of all public specialist ICA mental health services in WA

Age cohort		Service
From age 0	All ages (0+)	EDs (non-PCH) WACHS ETS MHERL and Rural Link Mental Health Co-Response
	0-17	WACHS CAMHS Community CAMHS CAMHS Crisis Connect <sup>83</sup> EDS GDS CAHDS
	0-15	PCH ED Ward 5A at PCH Paediatric Consultation Liaison Service
Children only, and children and adolescents	4-12	Pathways <sup>84</sup>
	6-18	Paediatric General Diagnostic Program
Adolescents only, and adolescents and youth	11-16	MST
	12-17	Touchstone
	13-24	YouthLink Youth Reach South
16 and over	16-24	Youth-HITH YCATT Youth Axis
	17-24	EMyU Fiona Stanley Youth Unit

<sup>83</sup> Children aged 16 and over cannot access CAMHS Crisis Connect at the PCH ED.

<sup>84</sup> Pathways only accepts children aged 4-6 on a 'case-by-case' basis.

# Appendix D: Activity data

This appendix presents data that supports findings in Section 6: Why things have to change, in the Final Report.

## Service activity data

Between 2014 and 2020 the population of children aged 0-17 in WA has grown by 5.5 per cent, however, attendances to emergency departments for a mental health condition have grown by 64.9 per cent, inpatient separations with a principal diagnosis of mental health have grown by 79.5 per cent and referrals to community mental health treatment services have grown by 70.1 per cent. This is shown on Figure 31.

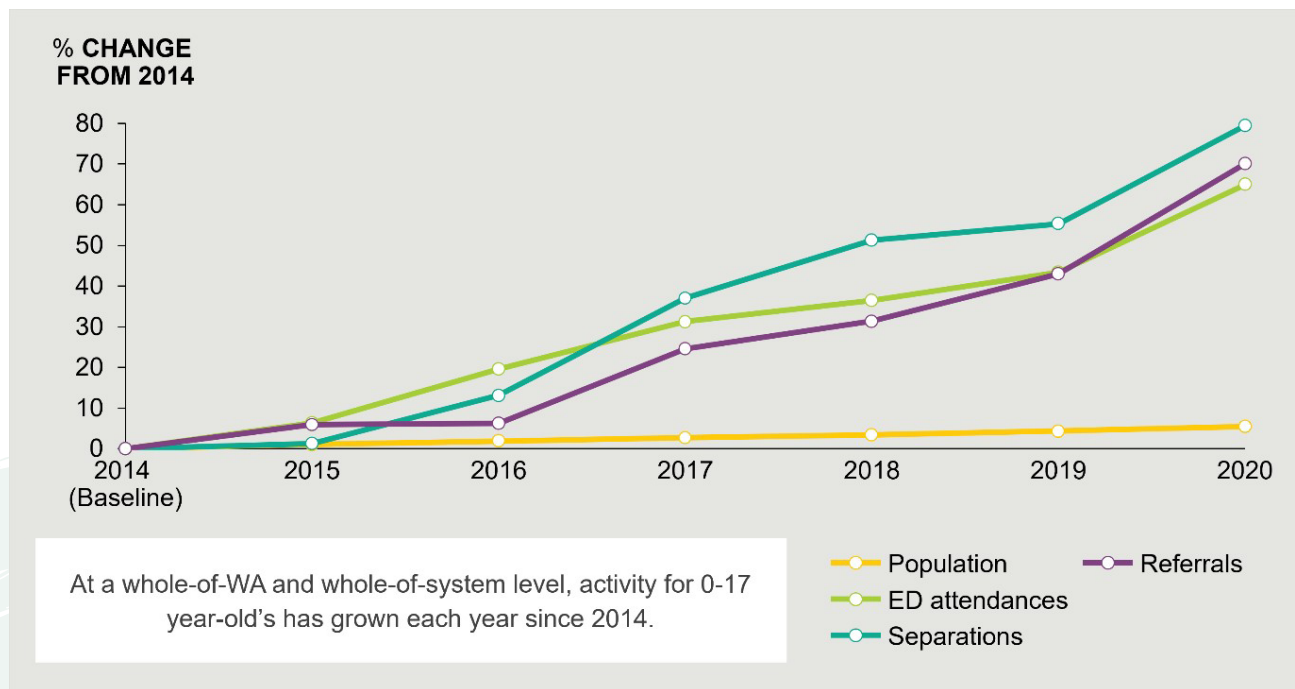


Figure 31: Population, ED attendances, separations and referrals percentage change from 2014 to 2020

## Community mental health treatment services

In 2020, **14,081** Western Australians aged between 0-18-years-old had at least one contact with a specialist ICA community mental health service (approximately 2.3 per cent of all 0-18-year-olds in WA).

- Since 2014, the number of children referred to specialist community treatment services has nearly doubled.
- Since 2014, the acceptance rate – the proportion of children that are referred that receive services – slightly increased across WA (see Figure 31), but decreased in the Perth metropolitan area.
- In 2014 about one in three referrals to a metropolitan CAMHS service was accepted, but this has reduced to only one in five in 2020 (see Figure 32).

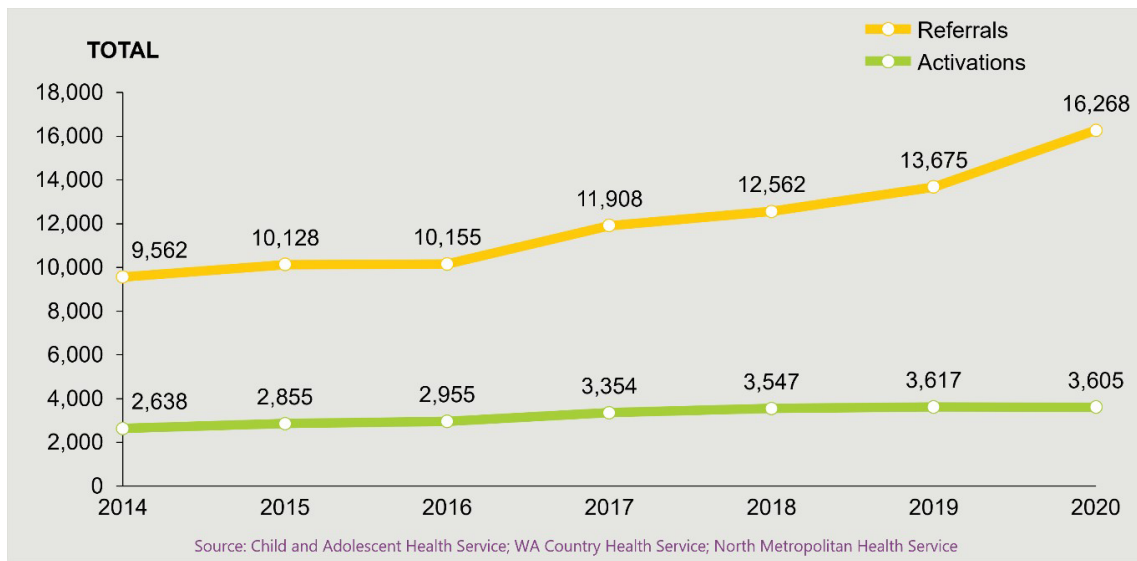


Figure 32: The number of referrals and activations at community treatment services between 2014 and 2020<sup>85</sup>

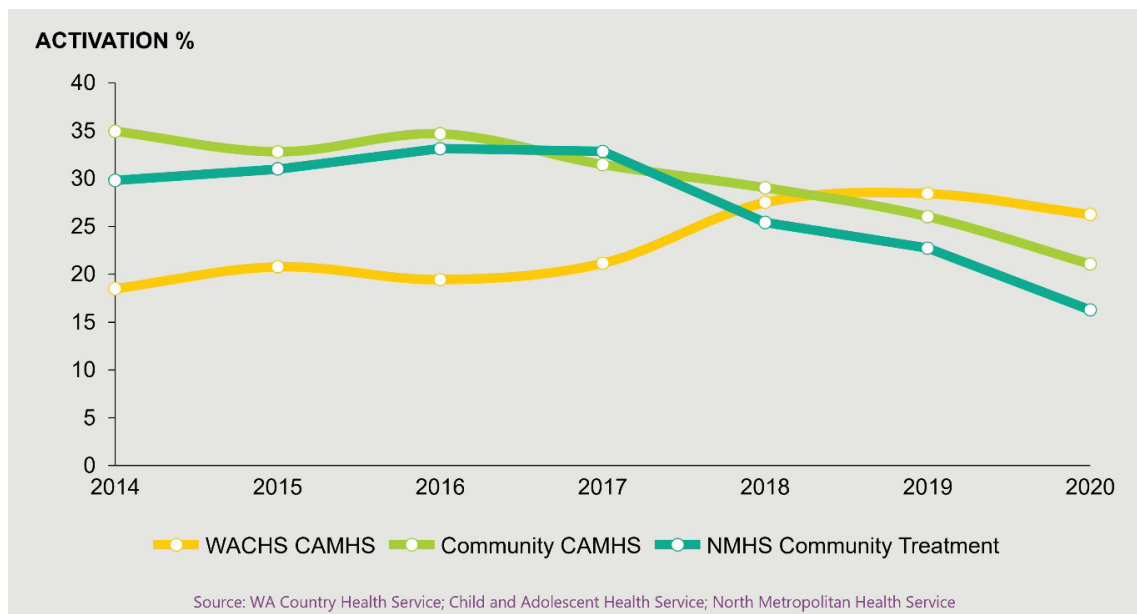


Figure 33: The activation rate at community treatment services between 2014 and 2020

<sup>85</sup> Note that WACHS referrals includes 'referrals by source' data.

## Emergency department presentations and hospital separations

The number of children that have attended an emergency department for a mental health reason has increased by almost 50 per cent since 2014, an annual growth rate of 6.6 per cent (see Figure 34).

- WACHS, which serves regional and remote children, has seen similar increases in mental health-related emergency department attendances, growing by 42 per cent.
- The number of times that a child attends an emergency department in WA each year has increased by 12 per cent, rising from approximately 1.4 attendances per child in 2014 to over 1.5 attendances per child in 2020.
- The number of times in which a child has presented to an emergency department regarding a suicide attempt and suicide risk has increased by 50 per cent during the past four years, rising from 2,736 attendances in 2017-18 to 4,103 attendances in 2020-21 (Figure 35).
- In 2020, on average, every day there are 24.5 presentations by 0-18-year-olds to an Emergency Department across WA for a mental health reason
- In 2020, on average, every day there are 6.9 admissions of 0-18-year-olds to hospitals across WA with a principal diagnosis of mental health.

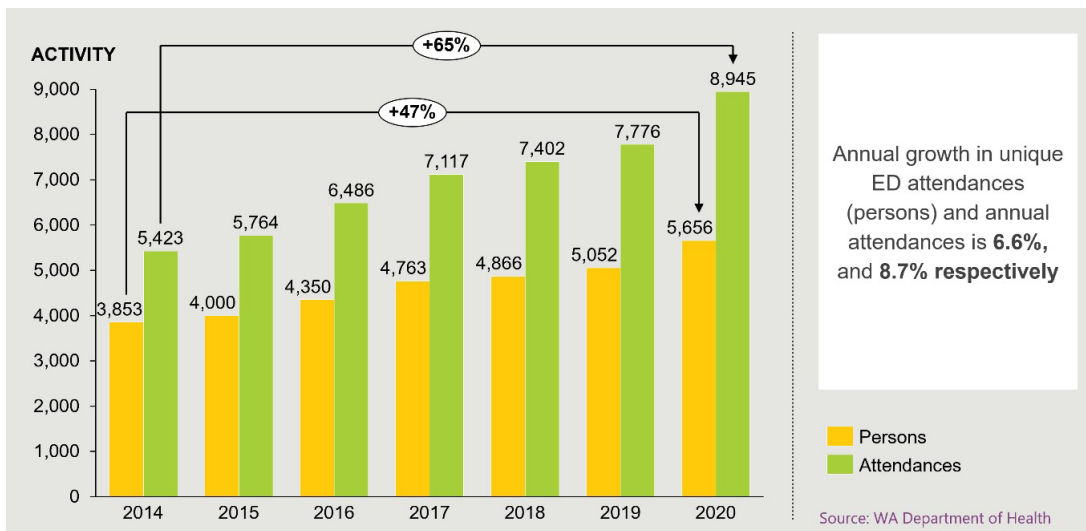


Figure 34: The number of Emergency Department attendances for mental health-conditions for 0-18-year-olds between 2014 and 2020

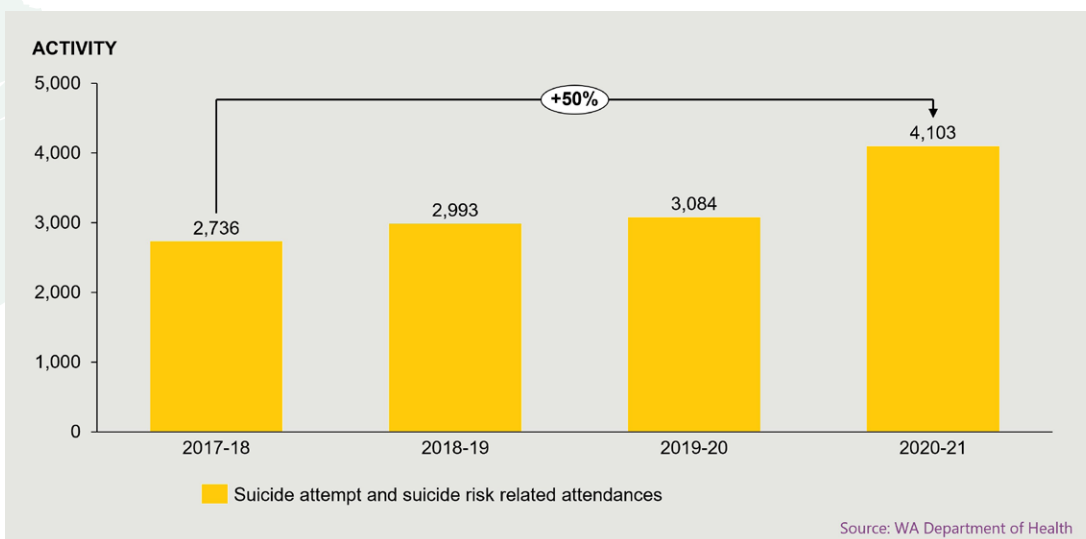


Figure 35: Total suicide attempt and suicide risk related ED attendances for persons under 18-years of age in WA from 2017-18 to 2020-21

## Eating disorder services

The Eating Disorder Service – the state-wide service for children with eating disorders – has experienced sustained growth in demand for services.

- Referrals to the service grew 42 per cent between 2014 and 2019; with a 47.9 per cent single year increase in 2020.
- Between 2017 and 2020 there has been a 168 per cent increase in eating disorders admissions to Child and Adolescent Health Service inpatient units.
- Eating disorder admissions from WACHS hospitals has increased over 200 per cent between 2017-18 and 2020-21.<sup>86</sup> And the number of eating disorder separations from metropolitan wards for WACHS residents has increased by over 400 per cent during the same time period.<sup>87</sup>

## Service use by age

Infants (aged 0-3-years of age) and children aged 4-12-years of age have been less likely to have access to treatment.

- During 2014 and 2020, the majority (75 per cent) of activations for community mental health services in metropolitan Perth were for those aged 12–17-years.<sup>88</sup>
- During 2014 and 2020, 66 per cent of activations for specialised services were for those aged 12–17-years.<sup>89</sup>

## Service use by location

Service use data shows differences between metropolitan Perth and regional WA.

- A higher proportion of 0-17-year-olds present to an emergency department in regional WA (1.1 per cent), as compared with the same cohort in metropolitan WA (0.9 per cent).
- Although country and remote children represent 21 per cent of all children in WA, in 2020, 28 per cent of all referrals to a community treatment service were to a WACHS CAMHS service.
- Despite representing 21 per cent of the 0-17-year-old population across WA, only 10 per cent of referrals to statewide specialised services are for children based in regional and remote WA. (All statewide specialised services – such as eating disorder, gender diversity or other services – are based in Perth and require travel to Perth to access).

## Service use by Aboriginal and non-Aboriginal children

In WA, Aboriginal children account for a disproportionately high number of service activities relative to non-Aboriginal children.

- During 2014 and 2020, despite only representing 6.7 per cent of the child population of WA, Aboriginal children made up 13.4 per cent of mental health-related emergency department attendances; 9.3 per cent of inpatient admissions; and 11.6 per cent of community treatment contacts.
- The acceptance rate for Aboriginal children for services to which they are referred is lower than that of non-Aboriginal children for all specialised services. That is a non-Aboriginal child that is referred to an ICA mental health services is more likely to access and engage with care than an Aboriginal child.
- Emergency department attendances for Aboriginal children have increased 73 per cent during 2014 and 2020, rising at a faster rate than non-Aboriginal children.
- Aboriginal children, who represent only 13 per cent of all regional children, made up 30 per cent of all regional emergency departments attendances.

<sup>86</sup> Taskforce analysis using unpublished data provided by WACHS; although note that this data includes hospital admissions for those under 20 year-olds.

<sup>87</sup> Taskforce analysis using unpublished data provided by WACHS.

<sup>88</sup> Taskforce analysis based on unpublished CAHS data.

<sup>89</sup> Taskforce analysis based on unpublished CAHS data.

## Service use projections

Given the data that has been collected around current and historic activity levels, Taskforce has extrapolated and quantified the impact of doing nothing in four critical activity measures using respective compound annual growth rates between 2014 and 2020:

- Increased presentations of children in crisis to emergency departments: emergency department presentations could increase from ~9,000 per year in 2020 to ~14,700 in 2026.
- Increased admissions of children to hospital meaning new beds will be required: Admissions will increase from ~2,500 a year in 2020 to ~4,500 a year in 2026.
- More children experiencing suicidal ideation and self-harming: Presentations to emergency departments associated with a risk of suicide will increase from ~3,000 in 2020 to 8,000 in 2026.
- Less likely that children referred for community treatment will be accepted for treatment: Referrals will increase from ~16,000 a year in 2020 to ~27,700 a year in 2026, of which only around one in seven will be accepted (currently this is one in five).

## Linked data on interactions with other government services

To support analysis, the Mental Health Commission, on behalf of Taskforce, requested de-identified data from the State's Social Investment Data Resource (SIDR). SIDR is an enduring, linked, administrative database which contains de-identified information on individuals who have had contact with key government agencies.

Insights from the SIDR data were collated to understand a child's interactions with mental health services, police, child protection and disabilities and education services.

## Police and mental health insights

There is a considerable cross-over between the mental health and police dataset.

- Between 2015 and 2019:
  - » One in five (19 per cent) 0-17-year-olds who accessed a mental health service also had contact with the police.<sup>90</sup>
  - » 21 per cent of 0-17-year-olds who had contact with the police accessed a mental health service.
  - » 51 per cent of 0-17-year-olds who accessed a mental health service and had contact with the police were prosecuted.
  - » 35 per cent of 0-17-year-olds who accessed a mental health service and had contact with the police received a caution.
  - » Nine per cent of 0-17-year-olds who accessed a mental health service had been prosecuted.

## Disability, Child Protection and mental health insights

Though the proportion of all children who have accessed a mental health service, have accessed a disability service or have had contact with Child Protection is low, a relationship between those factors exists for the population of children who have accessed a mental health service.

### General population insights:

- Four per cent of 0-17-year-olds<sup>91</sup> in WA accessed mental health services
- Two per cent of 0-17-year-olds in WA had accessed disability services<sup>92</sup>

### Between 2015 and 2019:

- Eight per cent of 0-17-year-olds who had accessed a mental health service also have disability.
- Two in five (39 per cent) 0-17-year-olds who had accessed a mental health service had contact with Child Protection

<sup>90</sup> The definition of 'Contact with Police' includes an arrest, caution, drug diversion, offence, prosecution, and referral to Juvenile Justice Teams.

<sup>91</sup> 0-17 years are defined as all WA Children who were aged between 0 and 18, and accessed a government service, at any time between 2015 and 2019

<sup>92</sup> Disability is defined as a person who was a client, who had applied to be a client of DSC; or, a person who has accessed services funded or provided by government.



- Six per cent of 0-17-year-olds who had accessed a mental health service received an order which is where a young person is taken into the care and responsibility of the Chief Executive Officer
- 16 per cent of 0-17-year-olds who had accessed a mental health service and child protection received an order
- 14 per cent of 0-17-year-olds who did have disability accessed a mental health service
- The number of 0-17-year-olds who did have disability and who had accessed a mental health service has been declining. In contrast, the number of 0-17-year-olds who did have disability and who had not accessed a mental health service is increasing.

#### **General population insights:**

- Four per cent of 0-17-year-olds<sup>93</sup> in WA accessed mental health services
- 11 per cent of 0-17-year-olds in WA had contact with Child Protection<sup>94</sup>

#### **Between 2015 and 2019:**

- 14 per cent of 0-17-year-olds who had contact with Child Protection accessed a mental health service
- 0-17-year-olds in contact with Child Protection, on average, used 35 per cent more mental health community treatment, inpatient and ED services than 0-17-year-olds who did not have contact with Child Protection.

## **Education and mental health insights**

Children with low attendance rates and a suspension are more likely to have accessed a mental health service in comparison to children with high attendance rates and no suspension.

#### **Between 2015 and 2019:**

- On average, 0–17-year-olds who accessed a mental health service and had a zero per cent – 50 per cent attendance rate used 22 per cent more mental health community treatment, inpatient and ED services than 0–17-year-olds with higher attendance rates.
- 0–17-year-olds in metropolitan Perth use 34 per cent more mental health community treatment, inpatient and ED services than those in regional WA.
- 0–17-year-olds in metropolitan Perth with a zero per cent – 50 per cent attendance rate used 50 per cent more mental health community treatment, inpatient and ED services than those in regional WA.
- 32 per cent of 0–17-year-olds who accessed a mental health service had at least one suspension. In comparison, six per cent of 0-17-year-olds who did not access a mental health service had at least one suspension.
- 31 per cent of 0-17-year-olds who accessed mental health services had an attendance rate of less than 60 per cent. In comparison, six per cent of 0-17-year-olds who did not access a mental health service had an attendance rate of less than 60 per cent.

<sup>93</sup> 0-17 years are defined as all WA Children who were aged between 0 and 18, and accessed a government service, at any time between 2015 and 2019.

<sup>94</sup> The definition of 'contact with Child Protection' is broad and encompasses the full spectrum of child protection outcomes from notifications received by the Department of Communities regarding concerns for a child's wellbeing, including where it is assessed that the information provided does not warrant a child safety investigation through to proceeding with intervention actions and the seeking of an order from the Children's Court, which may include a protection order where the child is taken into the Chief Executive Officer's care.



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## Appendix E: Relevant national and state strategies and reforms

The increasing scale and complexity of ICA mental ill-health impacting children, families and carers in WA reflects a national issue. The increasing prevalence of mental ill-health and challenges accessing care is a global and national trend, to which many governments are responding to proactively and significantly. Governments across Australia have made investments in youth and adult mental health over the last few years, but these developments have had a negligible impact on the mental health of children. Increasingly, the Commonwealth and state governments are recognising the significant underinvestment in ICA mental health and are taking action.

With over 50 per cent of mental health challenges emerging before the age of 18, improving ICA mental health is a national challenge. In October 2021, the National Mental Health Commission released the National Children's Mental Health and Wellbeing Strategy (The Children's Mental Health Strategy). This strategy seeks to help ensure that Australia has a nationally consistent mental health and wellbeing system in place to support all children, families, carers and communities to thrive. The Children's Mental Health Strategy is the first Commonwealth directive specific to the 0-12-age cohort, and articulates a rights-based approach to child mental health and wellbeing. It has four focus areas: family and community, the service system, education settings, and evidence and evaluation. Critically, it looks at a continuum of wellbeing, and promotes strategies to improve outcomes for those that are 'well', 'coping', 'struggling' and 'unwell'.

Table 13 sets out a number of other Commonwealth initiatives and strategies which are relevant to ICA mental health.

Additionally, the Commonwealth Government committed \$2.3 billion over four years to mental health across Australia in response to the Productivity Commission's Inquiry into Mental Health. Of that \$2.3 billion:

- \$278.6 million has been committed to expand and enhance the national headspace network. Within WA, this will directly impact headspace in Albany with the centre being upgraded from a satellite to a full headspace centre
- \$47.4 million to achieve universal perinatal mental health screening across public antenatal and postnatal care settings
- \$46.6 million for parenting education and support to parents and carers with children aged under 12-years and to develop national guidelines to assist with early identification of emerging emotional difficulties
- \$54.2 million over four years from 2021-22 to work with the states and territories to establish child mental health and wellbeing hubs to provide multidisciplinary care and preventive services.

**Table 13:** Commonwealth initiatives and strategies which are relevant to ICA mental health

## The National Mental Health Strategy

Commonwealth mental health settings and reform direction is articulated through the National Mental Health Strategy. This includes a set of documentation that forms the policy framework for the Commonwealth. It includes:

- The National Mental Health Policy (2008) – setting the strategic intent and long-term intentions for the development of state and territory mental health planning across all cohorts.
- The National Mental Health Statement of Rights and Responsibilities (2012) – this sets out the rights and responsibilities for all those involved in mental health. It articulates how all involved, from consumers through to service providers, can exercise their rights under the statement.
- The Fifth National Mental Health and Suicide Prevention Plan (2017-2022) (The Fifth Plan) – The Fifth Plan established a national approach for collaborative government effort across eight targeted priority areas, including developing coordinated treatment and supports for people with severe and complex mental health issues, and improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Under the Fifth Plan, state and territory governments are required to support regional integrated planning and service delivery.

*In May 2021, a further \$2.3 billion was announced by the Commonwealth to support the National Mental Health and Suicide Prevention Plan. Bi-lateral negotiations are currently underway between WA and the Commonwealth. Decisions through this process will update the direction for the Fifth Plan. Outcomes from the National Partnership Agreement negotiations were not available prior to the release of Taskforce's report.*

## National Children's Mental Health and Wellbeing Strategy

The National Children's Mental Health and Wellbeing Strategy (The Children's Mental Health Strategy) (2021) articulates a rights-based approach to child mental health and wellbeing, focused on early intervention and prevention across four areas:

- Family and Community
- Service system
- Education settings
- Evidence and evaluation.

The strategy provides a framework to guide critical investment in the mental health and wellbeing of children, families and carers and sets out clear pathways for proactively promoting child wellbeing and helping those who are struggling as early as possible to reduce long-term impacts of poor mental health.

*The Children's Mental Health Strategy is the first Commonwealth directive specific to the 0-12 cohort, their families and carers that nurture them. It reflects a growing importance on understanding and supporting mental health and wellbeing earlier in life, a policy response to the phenomenon that half of all mental health challenges emerge before the age of 14.*

## **National Mental Health Workforce Strategy Taskforce**

The Commonwealth has established the National Mental Health Workforce Strategy Taskforce (Workforce Strategy Taskforce) that is considering the quality, supply, distribution, and structure of Australia's mental health workforce. The Workforce Strategy Taskforce to date has identified and tested objectives through consultation, focused on:

- attracting and retaining appropriately skilled staff across the mental health workforce
- ensuring the workforce is utilised
- distribution of the workforce and capabilities where consumers need it
- using data to underpin workforce planning

*The Workforce Strategy Taskforce will deliver a ten-year plan to support the system to meet future demand, at the end of 2021. There will be opportunities to consider these actions in line with the capacity and capability requirements of the WA ICA mental health system.*

## **Australia's Disability Strategy 2021-31**

The development of Australia's Disability Strategy 2021-2031 (Australia's Disability Strategy) is currently underway and due for endorsement in late 2021. Australia's Disability Strategy will build on the previous strategy (National Disability Strategy 2010-20) that built a plan for improving the lives of people with disability, their families, and carers.

Australia's Disability Strategy also covers people with a psychosocial disability, a term used to describe a disability that may arise from a mental health issue.

## **National Agreement on Closing the Gap and WA Implementation Plan<sup>95</sup>**

The National Agreement on Closing the Gap (the National Agreement) (July 2020) was developed in partnership with Aboriginal and Torres Strait Islander people and government to overcome the inequality experienced by Aboriginal and Torres Strait Islander people. The agreement commits all signatories towards a future where policymaking and programs that impact their lives are carried out in genuine partnership. The National Agreement is focused around four Priority Reforms:

- formal partnerships and shared decision-making
- building the community-controlled sector
- transforming government organisations
- shared access to data and information at a regional level.

*WA has developed its first Closing the Gap Jurisdictional Implementation Plan that identifies the system level actions for the WA Government to undertake to address the priority reforms and socioeconomic targets, and specific activities, programs and services that are relevant to these. Phase one of the plan will be updated in mid-2022 to reflect progress, development and learning from the first 12-months of implementation.*

<sup>95</sup> WA Government, Closing the Gap Jurisdictional Implementation Plan: Western Australia, 2021.

Other state and territory governments have been proactive and made significant progress. The Royal Commission into Victoria's Mental Health System was established in February 2019 and published its final report in March 2021. The Royal Commission concluded that "Victoria needs a new infant, child and youth mental health and wellbeing system to meet the needs of its future generations." It outlined numerous recommendations, spanning prevention, school programs, postvention, forensic services, Aboriginal services and more. The Victorian Government demonstrated its commitment to the Royal Commission's recommendations by allocating \$842 million of the 2021-22 Victorian state budget to ICA mental health. More information on the Royal Commission is set out in Table 14.

Similarly, the NSW Government has made significant commitments to ICA mental health in recent months. Mental health services for children have recently been expanded as part of the NSW Government 10-year mental health reform agenda, NSW Mental Health Reform 2014-2024. In the 2021-22 NSW State Budget, \$109.5 million was committed to the establishment of 25 Safeguards Child and Adolescent Mental Health Response Teams. The Safeguards Teams will provide innovative and best practice care to children aged 0-17 experiencing acute mental health distress. In October, a further \$130 million was committed to training staff in primary care and schools to tackle rises in self-harm and suicidal ideation among children.

**Table 14:** Royal Commission into Victoria's Mental Health

### Royal Commission into Victoria's Mental Health System<sup>96</sup>

The Royal Commission into Victoria's Mental Health System was formally established in February 2019 on advice from the Victorian Government. Throughout the inquiry, people living with mental health disorders or psychological distress, families and carers, mental health workers, service providers and researchers were extensively consulted to understand the existing strengths and challenges of the system. Major themes that emerged from the inquiry's engagement and research included:

- demand has overtaken capacity
- community-based services are undersupplied
- access to services is not equitable
- the system is driven by crisis
- services are poorly integrated.

The Commission's 65 recommendations (and nine in the interim report) are centered on transformational reform, with a vision for a balanced system where mental health and wellbeing treatment, care and support are provided in the community, hospital and other residential settings. These reforms aim to rebalance the system so that more services will be delivered in community settings and extend beyond a health response to a more holistic approach to good mental health and wellbeing across the community.

The WA Government has released a wide range of plans and strategies relating to mental health in recent years, set out in Table 15. These plans and strategies shaped the WA Government's recent commitments to addressing mental ill-health in WA. Many of these commitments will benefit young people in WA aged 16-24; however, their impact will be negligible for children aged 15 and below. Current commitments that relate to the mental health and wellbeing of children and young people include:

- \$11 million towards a Metro Youth Step Up/Step Down community mental health service – ten beds, 24/7 psychosocial and clinical supports, based on existing step up/step down model.
- \$17.6 million investment in Social and Emotional Wellbeing services at five ACCHOs to deliver culturally situated brief intervention support, outreach and group work with young people and community members.
- \$7.3 million to pilot a multi-service facility which will provide services relating to child mental health, child health, child development, school health, Aboriginal health and immunisations.
- \$12.6 million in funding to implement a forensic outreach service for young people aged 10-24.

<sup>96</sup> Royal Commission into Victoria's Mental Health System, Final Report: Summary and recommendations, 2021.

**Table 15:** State initiatives and strategies which are relevant to ICA mental health

## WA State Priorities – Mental Health and AOD

In March 2020, the state government launched the WA State Priorities 2020-2024, that outlines the government's immediate priorities to reform and improve the mental health and AOD sector over four years from 2020. The priorities support the government's focus of providing a consumer-focused, holistic, integrated, and sustainable approach to mental health and AOD across:

- prevention
- community support
- community accommodation
- treatment services
- sector development
- system supports and processes.

The 29 focus areas identified within each of the six priorities identify those areas most likely to have the most impact on the mental health and AOD system.

*The priorities are a whole-of-government initiative, and reflect WA's direction, consistent with other state and national frameworks. The priorities will form the basis of the Mental Health Outcomes Measurement Framework, currently under development.*

## MHC reform settings

There are a range of significant strategy and policy documents that guide system design and decision-making by the MHC:

### **The Plan (incl. 2018 modelling update)<sup>97</sup>**

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan) sets out the approach to rebalance mental health services across the full spectrum of settings. The Plan articulates the need and the direction for the broader mental health and AOD service system across WA, to move from a focus on higher cost activities (such as hospital beds) to a greater focus on prevention and community-based supports. The Plan is not prescriptive about how programs and services will be delivered, but rather provides a guide for investment decisions and priority setting for all levels of government and non-government stakeholders to act on the optimal mix of mental health and AOD services required in WA based on extensive modelling.

### **The Prevention Plan<sup>98</sup>**

The WA Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 (the Prevention Plan) sets out the case for investment in promotion and prevention activities across mental health and AOD. It emphasizes the importance of health promotion and primary prevention in preventing ill-health by maintaining and/or enhancing the wellbeing of the general population. The Prevention Plan highlights the importance of primary prevention in perinatal and early years, as well as in children and young people, with specific strategies allocated to these life domains.

<sup>97</sup> WA Mental Health Commission, Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Plan Update 2018, 2019.

<sup>98</sup> WA Mental Health Commission, Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025, 2018.

### **Young People’s Mental Health and Alcohol and Other Drug Use: Priorities for Action<sup>99</sup>**

The Young People’s Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025, (YPPA) was co-developed with children, families and carers to provide guidance to government on the actions that will make a difference to the mental health and wellbeing of young people from 12 to 24. The YPPA identifies six strategies, and underpinning initiatives to guide investment and decision-making centered around:

- helping us to stay well
- supported by our family and community
- making it easier to find and access services that are right for us
- valuing that we are all unique
- services working together
- experiencing positive and trusting relationships and best practice care.

### **Workforce Strategic Framework<sup>100</sup>**

The state-wide Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025 (Workforce Strategic Framework, 2020), articulates a set of principles, priority areas, corresponding strategies and actions to achieving the overall aim to guide the growth and development of the mental health and AOD workforce in WA. It places a focus on:

- development of a more diverse workforce
- increased roles and support for peer workers
- a focus on the Aboriginal workforce as an integral component of the mental health and AOD workforce
- provision of culturally secure services by appropriately trained staff.

### **Alcohol and Drug Interagency Strategy<sup>101</sup>**

The WA Alcohol and Drug Interagency Strategy 2018-2022 (Interagency Strategy) outlines strategies to prevent and reduce the adverse impacts of AOD. The Interagency Strategy is underpinned by two core elements: a focus on prevention and early intervention; and secondly, on providing support for those who need it. Children are identified in the Interagency Strategy as a population group that experiences greater impacts from AOD use. Key focuses for this cohort, includes prevention, intervention before problems become entrenched and effective treatment and support services.

## **Sustainable Health Review<sup>102</sup>**

The Sustainable Health Review (SHR, 2019) was established with the intent to identify the changes needed in how health care is delivered in WA, and to facilitate a healthier and more sustainable future for the system. The SHR 2019 identified eight enduring strategies and thirty recommendations to drive a cultural and behavioural shift across the WA Health system.

<sup>99</sup> WA Mental Health Commission, Young People’s Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025, 2020.

<sup>100</sup> WA Mental Health Commission, Mental Health, Alcohol and Other Drug Workforce Strategic Framework: 2020-2025, 2020.

<sup>101</sup> WA Mental Health Commission, The Western Australian Alcohol and Drug Interagency Strategy 2018-2022, 2018.

<sup>102</sup> WA Department of Health, Sustainable Health Review: Final Report to the Western Australian Government, 2019.

*Improvement to mental health outcomes (Strategy 2) was recognised as a critical issue to be addressed, from a health and wellbeing perspective as well as a sustainability perspective. The SHR recognised that while the complexity of mental health service delivery and funding is not unique to WA, there were specific priority areas:*

- *Prioritise and invest in capacity to balance early intervention, community, step-up/ step-down, acute and recovery mental health, alcohol and other drug services*
- *Immediate transparent public reporting of patient outcomes and experience*
- *Ensure clear accountabilities for joint planning, commissioning, and service delivery for more integrated services*
- *Implement models of care for people to access responsive and connected mental health, alcohol and other drugs services in the most appropriate settings.*

## WA Digital Health Strategy<sup>103</sup>

The WA Health Digital Strategy 2020–2030 (the Digital Strategy) articulates the underpinning digital technologies and corresponding horizons of activity that will support transformation of the WA health system in the way that care is delivered, information is shared and how consumers can engage with their health. The Digital Strategy has a focus on the initiatives and the functionality most likely to achieve the desired digital future, to support:

- empowerment of consumers through equity of access
- informed clinicians through advanced information to support quality and safety
- support for the workforce.

*Many directions of the Digital Strategy will shape the current and future delivery of ICA mental health, including the establishment of an Electronic Medical Record (EMR) as a key enabler to fully realise the benefits of digital innovation and new ways of working.*

**Table 16:** Initiatives and strategies which are complementary to ICA mental health

## Closing the Gap – Jurisdictional Implementation Plan

The Closing the Gap Jurisdictional Implementation Plan was developed through collaboration across Government department and agencies, with critical input from the Aboriginal Advisory Council of WA and the Aboriginal Health Council of WA. The Plan articulates how the WA government will meet its obligations under the National Agreement on Closing the Gap.

The WA Government will pursue a phased approach to implementation. The first phase of the Implementation Plan details the actions that the WA Government is currently undertaking or developing. This first step provides a baseline to build from and enables Aboriginal people and the broader public to clearly see what the WA Government has said it will do to deliver on its commitments.

The Implementation Plan consists of two parts:

- **Part A** – provides an overview of the system level actions the WA Government intends to progress to address the Priority Reforms, and summaries of actions underway or to be undertaken, to address the socioeconomic targets.
- **Part B** – provides information on specific activities, programs and services relevant to each of the Priority Reforms and socioeconomic targets.

<sup>103</sup> WA Department of Health, WA Health Digital Strategy 2020–2030, 2019.



*The plan will lay the foundations and establish structures needed for the WA government, including the Department of Health and Mental Health Commission, to embark on whole of system reform. Ways of working with Aboriginal people will be challenged and the plan will help overcome longstanding barriers to program and service delivery.*

## WA Outcomes Measurement Framework

Development of an Outcomes Measurement Framework (the Framework) for community services was led by the WA Council of Social Service through the Supporting Communities Forum. Work to date has established a set of high-level outcomes:

- Healthy – we are healthy and well.
- Empowered – we choose how to live our lives.
- Connected – we are connected to culture, our communities, and our environment and to each other.
- Equipped – we have the skills, experiences, and resources to contribute to our community and economy.
- Stable – we are financially secure and have suitable housing.
- Safe – we are, and we feel safe and free from harm.
- Sustainable – our built and natural environments are livable and sustainable.

*Work is underway between government and the community services sector to further develop and implement the Framework, through the System-Wide Data Working Group, in alignment to the WA State priorities Mental Health, Alcohol and Other Drugs 2020-2024. The Framework will form the basis for a common set of outcomes that cut across multiple service sectors.*

## State Commissioning Strategy for Community Services<sup>104</sup>

A State Commissioning Strategy for Community Services (the Commissioning Strategy) is currently under development to determine how community services will be commissioned over the next five years, in order to:

- provide targeted and higher-quality services that deliver improved outcomes to service users, particularly those who are most vulnerable
- promote efficient delivery of services and get better outcomes from investment.

The Commissioning Strategy will articulate how the system can better invest in evidence based early intervention and prevention, plan and design of place-based supports, prioritise genuine partnerships with Aboriginal people and strength evidence-based practices across all government funded community services.

*The development of the Strategy provides an opportunity for a more coordinated and system wide approach to the delivery of services, in both mental health, and across adjacent service systems.*

## Foundations for a Stronger Tomorrow – State Infrastructure Strategy<sup>105</sup>

Foundations for a Stronger Tomorrow – State Infrastructure Strategy 2021 (draft Infrastructure Strategy) outlines the State's significant infrastructure needs and priorities over the next 20-years and addresses a broad range of sectors and cross-cutting themes to identify both build and non-build solutions such as policy reforms and priority projects and programs.

The draft Infrastructure Strategy identifies mental health services and infrastructure as a pressure point in WA, identifying its complex needs and services running at capacity. Provision of appropriate, contemporary health and forensic mental health services also translates to an infrastructure pressure point for the State.

<sup>104</sup> WA Government, State Commissioning Strategy for Community Services: Discussion Paper, 2021.

<sup>105</sup> Infrastructure Western Australia, State Infrastructure Strategy, <https://www.infrastructure.wa.gov.au/state-infrastructure-strategy>.

# Appendix F: Consultation Summary

Taskforce conducted a series of consultation and engagement activities with children, families, carers, clinicians and service providers, and system leaders and policymakers. The primary objective of these consultations was to validate and build upon the directions for the future service system set out in the Emerging Directions Paper. Consultations fell into the 6 categories outlined in Table 17 below.

**Table 17:** Six categories of consultation

Consultation	Scope	Purpose
<b>COMMUNITY &amp; SERVICE WORKSHOPS</b>	Workshops conducted in all regions across WA, including sessions with people with lived experience and service providers	To identify key issues impacting children and understand the potential solutions to address these issues.
<b>CHILD &amp; FAMILY TARGETED CONSULTATIONS</b>	Focus group discussions and interviews with specific groups of young people and families, with unique needs and experiences.	To identify key issues that need to be addressed to improve the experiences and outcomes of children and families with unique needs and experiences.
<b>SUBJECT MATTER EXPERT FOCUS GROUPS</b>	Roundtable discussions with subject matter experts regarding specific system issues and/or needs of unique groups.	To understand opportunities to improve services and outcomes, including across multiple systems.
<b>SYSTEM LEADER INTERVIEWS</b>	Interviews and meetings with formal and informal system leaders, including community members, service executives and other key voices	To identify priority actions for future reform and understand key considerations for implementation of future services and evaluation.
<b>HSP CLINICIAN ENGAGEMENT</b>	Series of forums, workshops and focus groups with clinicians and other staff across all Health Service Providers	To draw on the expertise of clinical teams across WACHS and CAHS to help develop the recommended system and service model
<b>STATEWIDE SUBMISSIONS</b>	Written submissions from people with lived experience, clinicians, organisations, peak bodies and others.	To refine the conclusions of the Emerging Directions Report and understand good practices.

In addition to the above, Taskforce notes with gratitude that informal consultation and other engagement activities were conducted by EAG members, including lived experience, clinical and interagency members, who engaged with their respective peers, as an input into the work of the Taskforce.

### Community and Service Workshops

Taskforce conducted 23 workshops across all regions of WA with approximately 200 young people, families, clinicians and service providers. Workshops were conducted in every region of WA, as shown below. Invited participants included individuals from some of the below organisations, communities and groups:

Organisations, communities and groups
Aboriginal-community controlled organisations
Children and adolescents with lived experience
Families and carers with lived experience
Community members and leaders
Private clinicians
Adjacent service providers
HSP clinicians
School teachers and principals
Peak bodies
Not-for-profit organisations
State and Local Government representatives
Youth leaders

## Child & Family Targeted Consultations

Taskforce Project Team conducted targeted consultations with over 50 individuals from nine specific groups of young people and families, listed in Figure 41.

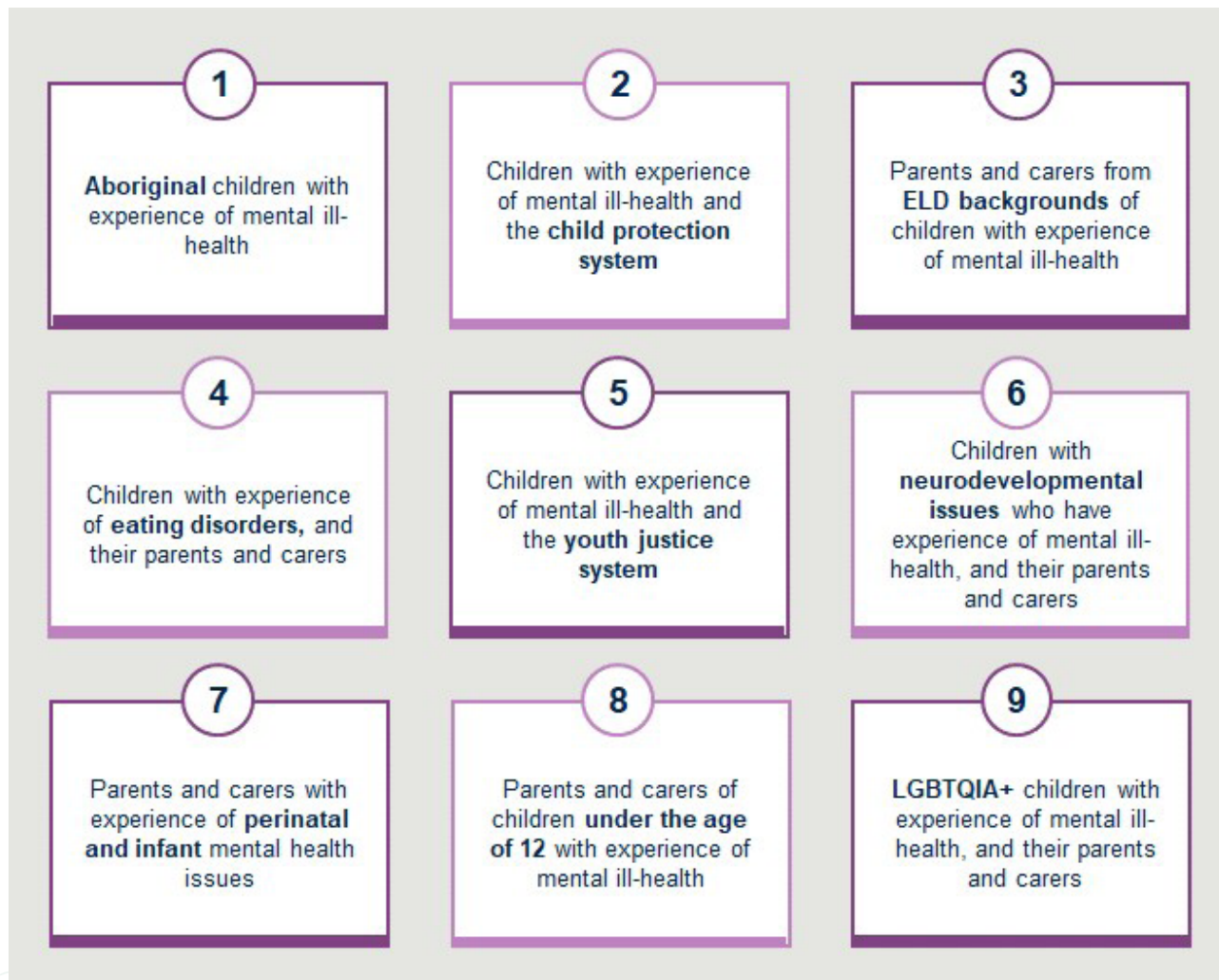


Figure 41: Specific cohorts of children and families

Taskforce acknowledge the support of the following organisations in identifying children and families from each of the above groups:

Support organisations	
AHCWA	Multicultural Futures
Department of Communities	Ngala
ED Sub network	Outcare
Freedom Centre	Pathways
Mental Health Subnetworks	Transfolk

## Child & Family Targeted Consultations

Taskforce conduct four roundtable sessions with people with lived experience and expert service providers regarding four priority groups:

- Children and families from ELD backgrounds
- Children with complex education and mental health needs
- Children with experience of youth justice services
- Children with experience of child protection services

Organisations and individuals that participated in these interviews included but were not limited to the following<sup>106</sup>:

Organisations and group	
ASeTTS	MHAS
CCYP	Multicultural Futures
CEWA	OMI
Department of Communities	Social Reinvestment WA
Department of Health	WA Police Force
Department of Education	WAPPA
Department of Justice	WASSEA
EDAC	YACWA
Individuals with lived experience	Yorgum
Life Without Borders	

<sup>106</sup> Note, some individuals participated in private discussion and have been de-identified

## System Leader Interviews

Taskforce conducted interviews with over 60 service system leaders across WA and Australia. Organisations that participated in these interviews included but were not limited to the following<sup>107</sup>:

Organisation	
Australian College of Nurse Practitioners	Health Services Union
Australian Department of Health	Mental Health Advocacy Service
Australian Medical Association	NMHS
Australian Mental Health Commission	Office of the Chief Psychiatrist, WA
Australian Nurses Union	Representatives from Mental Health Sub-Networks
CAHS	SMHS
CCYP	Telethon Kids Institute
Department of Education	WA Faculty of Child and Adolescent Psychiatrists
Department of Health	WAAMH
Department of Treasury	WACHS
EMHS	WACOSS

<sup>107</sup> Note, some individuals participated in private discussion and have been de-identified

## HSP Clinician Engagement

Taskforce conducted dozens of sessions with each of the HSPs, including CAHS, WACHS, EMHS, SMHS and NMHS. This included a series of forums and workshops with more than 320 HSP personnel regarding the recommendations in this report.

## Statewide Submissions

Taskforce invited submissions from key organisations and individuals, in addition to the general public, seeking feedback on the emerging directions report and guidance regarding future services. A total of 68 submissions were received from organisations, including:

Organisations, communities and groups
Aboriginal community-controlled organisations
Advocacy and advisory groups
Individuals with lived experienced
Government departments
HSPs
Not-for profit organisations
Peak Bodies
Private clinicians
Professional bodies
School leaders and teachers
WA Health statutory bodies

# Appendix G: Expert Advisory Group Members

## Overview of the expert advisory group's involvement

Taskforce has been supported by over 100 members across three Expert Advisory Groups (EAGs) - clinical, lived experience and interagency. Each EAG has been involved in five meetings and all EAGs came together for meetings 3-5. The knowledge and expertise of all EAG members has been critical to every stage of the Taskforce's work.

Members of the Clinical EAG	
Andrew Leech	Karla Cloke
Antonia Momber	Katie Browning
Brad Jongeling	Lisa Kickett
Chelsea Catchpole	Lisa Miller
Chinar Goel	Lynn Jones
Chris Gostelow	Mark Porter
Christina Foo	Mathew Coleman
Claire Guild	Mathew Reichard
Corinne Hoebert	Michael Verheggen
Daniela Vecchio	Nadine Caunt
David Lawrence	Nathan Gibson
Geoffrey Smith	Neal Ruane
Hayden Wilson	Roisin Maguire
Ilona Law	Sally Green
Jacques Claassen	Shannon McNear
Jennifer Brown	Vernon Dann
Jennifer Griffiths	Vineet Padmanabhan
Josie Ford	Zamia Pedro



### Members of the Interagency EAG

Andrew Beck	Kylie Maj
Arthur Papakotsias	Laura Allison
Astrid Kalders	Linda Richardson
Carrie Clark	Lucy Ledger
Deborah Roberts	Mark Burgess
Eamon Ryan	Mark Slattery
Ellie Carr	Mary Butterworth
Emma Crampin	Mason Rothwell
Ethan James	Merissa Van Der Linden
Helen Jackson	Paul Bailey
Hunter Gurevich	Peta Hart
Ian Anstee	Pushpa Siroley
Jacques Claassen	Rowan Brooker
Jaide Lancaster	Ruth Noonan
Jared Collins	Sandra Miller
Jennie Burns	Sarah Pollock
Jill Rundle	Sue Budalich
Jim Bell	Tarryn Harvey
Jo McCabe	Toni Tomlin
Joan McKenna Kerr	Tony Fotios
Jon Pfaff	Tony Pietropiccolo
Kate Taylor	Tracey Young
Kristen Orazi	Wai Chen

Members of the Lived Experience EAG	
Alyssa Sutton	Kristie Hardbottle
Amelia Graves	Lucca Leddin
Annie Hall	Lucy Kealley
Ari Rahim	Melissa Gibson
Chelsey Jackson	Natalia Moorin
Daniel Pierce	Oscar Devellerez
Donald Irvine	Ozais Day
Finlaey Hewlett	Renee Darbyshir
Grace Sanson	Sandra Della
Gracie Mizen-Lewis	Sharon Duffy
Grayson Goodacre	Shaunagh Pepper
Jacinta Wandel	Tanya Sim
Kara Nell	Vee (Vicki) Wilson
Kevin Gray	One member wishes to remain unnamed

## Appendix H: Recent government developments

Although not exhaustive, the below list is indicative of some of the recent commitments of the WA Government to meet the needs of infants, children, adolescents, young people, and their families and carers.

### Commitments for infants, children and adolescents ages 0-15 years

- The Government has committed to an investment of \$8 million over 2 years for an uplift of 25FTE to the CAMHS frontline workforce in the Perth metropolitan area.
- The WA Government has committed to providing \$12.6 million in funding to implement a forensic outreach service for young people aged 10-24, as part of their election commitments.
- Additional resource is also being invested in Emergency Telehealth Services to enhance the level of services and access. This commitment was made with immediate effect.

### WA Government election commitments for young people aged 16 to 24 years

- The WA Government has committed to \$35.3 million to fund the expansion of youth mental health community treatment services provided by South Metropolitan Health Service and new services for the North Metropolitan Health Service and East Metropolitan Health Service for 16-24 year olds.
- The Youth Long-Term Housing and Support Program has been provided with \$18.2 million, which includes both capital and operational funding, for 20 additional packages for young people ages 16-24.
- A metropolitan Youth Step Up/Step Down community mental health service for children aged 16 and over has been committed with an \$10.6 million investment . It will provide a 10 bed facility with 24/7 psychosocial and clinical supports.

- The WA Government has committed \$10 million to increasing access to appropriate specialist mental health assessment treatment and case management for vulnerable youth throughout the Perth metropolitan area.
- \$9.5 million has been invested for 30 psychosocial support packages for young people aged 16-24 in the metro area to assist them to live in the community.
- \$9.2 million has been committed for the expansion of the Strong Spirit Strong Mind Public Education Campaign to the regions.
- To address the disproportionate rate of mental health challenges and alcohol and other drug related issues experienced by LGBTQIA+ youth in Western Australia, \$0.4 million has been committed in grant funding to expand peer-based initiatives provided through the Western Australian AIDS Council.



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