GOVERNMENT OF
WESTERN AUSTRALIA

Emerging Directions: The Crucial Issues For Change

Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0–18 in Western Australia

Contents

Acknowledgement

Taskforce wishes to acknowledge the impact of mental health issues on the lives and wellbeing of Western Australia's children, families, carers and community. Further, we honour the diversity and resilience of all children, families, carers and communities.

Taskforce is grateful for the wisdom, courage and compassion of dozens of children, young people, family members, carers, staff, service providers, and other stakeholders that have supported the work of Taskforce and contributed to the insights and directions of this paper.

Message from the Chair

The Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents was established by the then Minister for Health in recognition that the tragic circumstances surrounding the death of Ms Kate Savage and the grief of her family was not acceptable to families, communities, staff providing the services nor the WA Government. In establishing the Taskforce, it has also been acknowledged that the problems faced by the Savage family were not uncommon, with many children and families struggling with mental health concerns, fearful of being unable to get help when they most need, some grieving the harm or loss of a child.

The scope of Taskforce is deliberately broad, long-sighted, ambitious and yet practical. The job of Taskforce is to develop a vision for WA public specialist mental services for infants, children and adolescents (0 to 18 years) across the entire state, and to deliver a fully costed plan to deliver that vision.

Our conclusions must be practical, implementable and affordable to government and the community recognising that enduring and sustainable change is equally reliant on accessing and retaining skilled and supported staff and a long-term commitment to delivering good practice.

Taskforce jointly reports to the Minister for Mental Health and the Minister for Health recognising the criticality of this interface. We have been extremely lucky to be guided by children and families with lived experience, staff providing services, and key government and non-government agencies that provide mental health related supports, and other equally important services such as housing and education.

What we have heard from these experts has been painfully consistent and clear, including:

- How hard it is to get help – not knowing who to go to, and how much harder this is when you are in crisis and less able to cope.
- Having to wait for long periods of time to access a service, more often than not to then be told that you are ‘not sick enough’ for their help.
- Being referred to someone who can help, but is too busy to see you for months, if ever, and may not be available nearby.
- Children not feeling safe, listened to or respected. Families and carers feeling the same, with the added challenge of being helpless to support their loved ones.
- A realisation that the difficulties appear to have gotten progressively worse over the past ten years with the challenges facing children and families becoming more complex, occurring more frequently and requiring solutions beyond the state health system.
- Short term funding of non-government services that are soon overwhelmed and unable to access timely referral to state services.
- The lack of government and non-government early intervention or prevention services, which pushes people to specialist services making

them harder to access when they are needed.

- A lack of supports for children, families and carers to avoid escalating into a crisis or to help children when discharged from emergency services or inpatient care.
- The profound impacts on a passionate workforce as they see the system focussing on minimising risk rather than supporting children and families.

Taskforce has gathered the view that the mental ill-health of 0 to 17-year-olds is becoming more complex, is occurring more frequently and requires support that the current range of services is unable to provide to all those in need.

Critical gaps exist in the services available, particularly in community-based services, in services designed to support children and families in regional and remote WA, and in services that are designed to support infants and children under the age of 12. Ensuring that these services work harmoniously to meet needs is an enduring challenge that must be overcome.

Taskforce acknowledges that many of these challenges are not unique to WA, and that all Australian governments are currently needing to increase their investment in mental health in the face of escalating demand. There is no single cause for this large increase in children requiring help for complex and severe mental ill health. Increased economic pressures on families, changes to society and relationships associated with rapid changes in technology, increased awareness of mental ill health; poor access to interventions early in childhood; and in some instances, a lack of services for children and their families may all play a part.

There is, however, a fear and an impatience in WA as demand for services for children and families has outstripped historical investment. Small gaps in services have grown to the point that for some services, fewer than one in five children who are referred to a service are accepted for treatment; compared to 2014 when it was one in three. Some referrers are stating they have simply stopped referring to public mental health services.

A sense of urgency has been present in our discussions. Everybody wants change to happen; and they all urge that change must start now to address the most significant and immediate opportunities to better support children and families.

Taskforce recognises this urgency, but at the same time has clearly heard that there is an imperative to build a truly connected and sustainable infant, child and adolescent mental health system, rather than focussing on a small number of specialist services and services for those at the greatest risk. Many of the foundations that are needed for this simply do not exist and will need to be established, including a range of services which start from pre-birth, and includes greater support for children and families through to late adolescence.

There is an opportunity to invest wisely in services to improve child mental health which will have enormous benefits and cost savings across life and development. These include less adult mental illness, less drug use and incarceration, better education and employment outcomes, better support for parents and a reduction

in intergenerational trauma, fewer children in out of home care, better health outcomes and a greater capacity for children to become contributing citizens. This Emerging Directions paper is intended to provide an early 'snapshot' of what Taskforce has learned to date, from reviewing key data and documents, and listening to children, families, clinicians and others. It sets out a draft vision and purpose for the future of services, and a set of principles to guide and inform how this vision and purpose should be achieved. We have no doubt that each of these can be improved by your feedback, to ensure that it is both visionary and practical.

The Emerging Directions paper also set out 10 overarching and emerging directions that Taskforce believe are critical in securing better mental health outcomes for children and strengthening support for families. These emerging directions include a short-term focus on addressing immediate issues, whilst at the same time establishing the long-term foundations for a contemporary, equitable, high-performing, and sustainable mental health system which meets the needs of children and families across WA.

Our vision, principles and emerging directions are summarised on the next page. These emerging directions:

- Recognise the importance of providing appropriate interventions early in a child's life rather than allowing crisis situations to escalate.
- Acknowledge the importance of filling critical service gaps, leveraging expertise, infrastructure, digital capabilities and revised service models to extend access to children, families and communities that cannot access the support they need.
- Reaffirm the criticality of a supported and appropriately skilled workforce and its obvious role in achieving the mental health outcomes for every child.
- Emphasise the importance of effective partnerships with the Commonwealth government and other government and community services, to ensure that children and families can simply access the appropriate support at the right time and not be handballed between agencies and departments.

Over the next four weeks we will seek your views about what we have missed, how these directions should be prioritised and sequenced, and how we can make sure that they are properly implemented, so that children and families see real results quickly and into the future.

On behalf of all Taskforce members, I would like to pay a special thanks to the members of our Expert Advisory Groups and the many clinicians, staff and other stakeholders that have given their time to support our work to date. It is very much appreciated.

Robyn Kruk AO

July 2021

A summary of Taskforce's vision and the emerging directions we have identified

Taskforce propose the following vision, purpose and principles for the future.

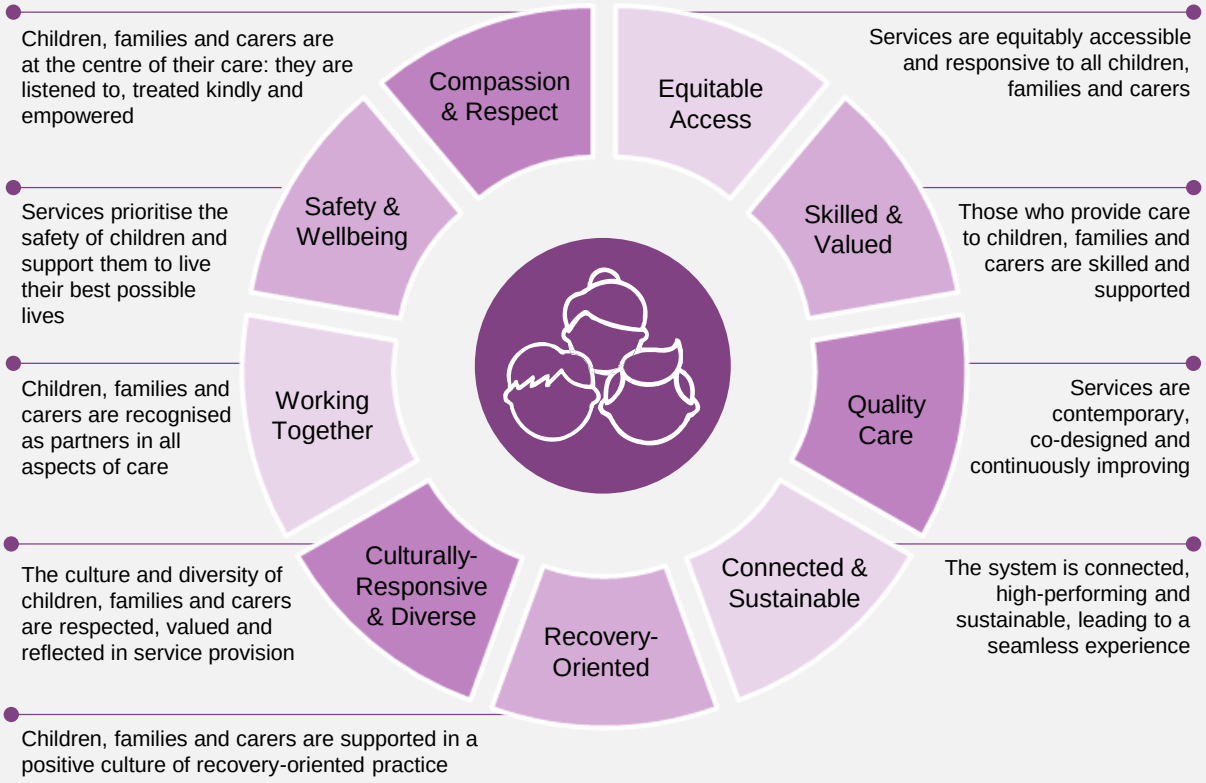
VISION FOR THE FUTURE

All infants, children, adolescents, families and carers are empowered to achieve and maintain their best possible mental health and wellbeing.

PURPOSE OF THE FUTURE SYSTEM

To ensure that all infants, children, adolescents, families and carers in Western Australia have timely, enduring and equal access to holistic, integrated and high-quality public mental health care.

UNDERPINNING PRINCIPLES



Taskforce have developed 10 emerging directions to guide the realisation of this vision.

1. **Address immediate service and capacity shortages** to meet the critical treatment, support and crisis needs of children, families and carers
2. **Transform community-based services** to ensure children, families and carers are supported in their own communities; when, where and how they need it
3. Design and implement flexible services that deliver the **best outcomes for rural, regional and remote communities**, including Aboriginal communities
4. Improve and extend **services for children with specific, complex and co-occurring needs** across all communities
5. Ensure that all services are **culturally-responsive and inclusive** for all children, families and carers, and their communities
6. **Integrate mental health services** so that all children, families and carers are supported to access services that holistically meet their needs
7. Utilise **multi-sector partnerships** with other national, state and non-government services to better support children, families and carers
8. Invest in a **skilled, diverse and supported workforce**
9. Strengthen the **planning, infrastructure, leadership, governance and accountability** to achieve sustainable and ongoing improvement
10. Establish dedicated structures for **research, learning and innovation** that translate to improved outcomes

1. About Taskforce and the emerging directions

Why was Taskforce established?

The mental health and wellbeing of 0-to-17-year-olds is a critical issue impacting all Western Australians.[1] 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).[2] The review recommended that a taskforce be formed to focus on rebuilding specialist public child and adolescent mental health services across the whole State. .

In early 2021, the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents in Western Australia ('Taskforce') was launched by the then Minister for Health and Mental Health.[3] Taskforce has a broader role which required it to develop a vision for the **public specialist mental health services for 0-to-17-year-olds across Western Australian** (WA) **and a fully costed plan to deliver that vision.**

The work of Taskforce comes at a time when public health and mental health services across WA are in the midst of significant change to deliver the objectives set out in the *Sustainable Health Review* (2019). That Review identified investment and reform of mental health and the health of children from the start of life as two of the eight most vital strategies for WA.

Recent government commitments for mental health services targeted at 16-to-24-year-olds have shown a commitment to progressively addressing gaps in services for young adults. It is essential and timely that Taskforce focusses on the mental health of those younger than this; infants, children and adolescents, and their families and carers; to ensure their needs are given the urgent attention needed.

Who are Taskforce members and its advisory groups?

Taskforce comprises senior leaders and clinicians from the WA public health and mental health systems, and members with lived experience. The 10-member group is being led by an independent Chair (see Appendix 1). Taskforce reports to the WA Ministers for Mental Health and Health.

Taskforce is being supported by over 100 members across three Expert Advisory Groups (EAGs) – clinical, lived experience and interagency. The ideas and insights of these members play an integral role in

[1] Whilst the title of Taskforce references 0-to-18 years, the scope of Taskforce is to look at the needs of Western Australians from birth to their 18th birthday. This paper will make reference 0-to-17 year-olds to avoid any misunderstanding that 18-year-olds are included.

[2] Taskforce is being careful in the use of the term 'CAMHS'. Whilst CAMHS is the name of the specialist mental health division within CAHS that was the focus of the Chief Psychiatrist's review, it is also the name of the community treatment services provided by the WA Country Health Service (WACHS). When this paper refers to CAMHS, it is referring to community treatment services provided by CAHS and WACHS, not to the division within CAHS.

[3] Since Taskforce was announced, the Health and Mental Health portfolios have been separated. Taskforce now reports to both the Minister for Mental Health (Minister Dawson) and the Minister for Health (Minister Cook).

developing a vision for the public specialist mental health services for children, families and carers across WA.

In addition to being advised by the EAGs, Taskforce will continue to actively engage children, young people, families and carers, clinicians, staff and other key stakeholders in the design of public specialist infant, child and adolescent mental health services for children, families and carers[4] that fit the unique metropolitan, regional, rural and remote circumstances of WA.

What will Taskforce do?

Taskforce will provide recommendations as to how public infant, child and adolescent mental health services in WA should be configured to meet the mental health needs of children; achieving better and more equitable mental health outcomes for children, families and carers in WA. The objectives of Taskforce are to:

- Identify how current services can be optimised, enhanced, reconfigured, or expanded, as well as identifying where new services may be required.
- Identify the investment required to implement a sustainable whole-of-system plan to meet demand and improve mental health outcomes for children, families and carers across WA.
- Maximise the opportunity to align state funded specialist services with Commonwealth funded services.
- Define the conditions needed to support implementation and deliver sustainable infant, child and adolescent mental health services.

What is the purpose of the Emerging Directions paper?

The Emerging Directions paper has been prepared to provide key stakeholders the opportunity to provide feedback on what we have learned to date and Taskforce's emerging vision for the future, including the scale of change required to achieve it.

Taskforce also wishes to understand from stakeholders what is most important. We want to understand what is missing, what we may have got wrong, and which of the directions are the highest priority in the short term and the longer term.

What is next for Taskforce?

Taskforce will be working to complete a number of activities. These include:

- Research good practice approaches to infant, child and adolescent care.
- Further engagement with the expert advisory group members.
- Targeted consultation with community members and services.
- Understanding future service demands and potential gaps.
- Defining the high-level model of care for the infant, child and adolescent system.
- Understanding the future resource requirements including workforce and funding.
- Developing an implementation plan and supporting governance measures including an evaluation framework.

These activities will support Taskforce to submit a final report to the Minister for Health and Minister for Mental health in November 2021.

[4] The term 'children' is used in this document as a general term to mean infants, children, adolescents aged from 0-to-17-years-old.

2. The case for urgent change and investment

Infant, child and adolescent mental health services are overwhelmed and not meeting the needs of children, families and carers

Taskforce has found that over the last ten years an increasing number of WA children aged 0-to-17 years-old are presenting to services with serious mental health issues. Children are presenting in crisis at a younger age than in the past and the complexity of the mental health issues they face has increased. These issues have far-reaching effects, impacting not only the child but also their family, carers and community.

There is no single reason for this disproportionate increase in the demand for mental health services for children. Possible factors include changes to family and peer relationships; changes to access to primary care and to intervention early in childhood; changes in the pattern of substance misuse; changes to children's relationships and connectedness due to rapid evolution of technology; the increased prevalence of social media that may normalise self harm and make children vulnerable to peer pressure and bullying, low self esteem, anxiety and depression; an increased awareness of mental health problems in schools and the community; and in some cases a lack of child mental health services.

This large increase in children and adolescents presenting with severe mental health issues to services and emergency departments has been seen internationally and across Australia for the last ten years

Although there has been some public investment in the capacity of infant, child and adolescent mental health services during this period, it has been vastly outstripped by the growth in demand. This has resulted in only the most severely unwell and at-risk children being able to access public services, and others with less severe issues or with lower levels of risk being left without support until crisis escalates to warrant support.

Many of the children fall into a growing gap; too unwell to be adequately supported by their GP, but not unwell enough to access the support they need to effectively manage their mental health. For many, this contributes to deteriorating wellbeing, helplessness and crisis.

The trends over the last few years indicate that these issues are likely to continue to worsen rapidly. This trend has arguably been exacerbated by COVID-19 – with further negative impacts on mental health and wellbeing of children and young people.

Without significant change, an increasing number of children will experience severe mental ill health without being able to access timely and appropriate support.

There is a clinical and economic imperative to address the mental health needs of children earlier in life.

- Research has shown that infants and children presenting with mental health

issues need to receive treatment as early as possible in their lives and during the early onset of their mental health issues to deliver the best outcomes for children, families, carers and the broader communities. [5]

- There is strong evidence that mental ill health in childhood and adolescence predict mental illness in adulthood.[6] Prevention and early intervention gives children the best opportunity for good mental health and wellbeing, particularly those from at risk groups.
- Investing in the early years is the most cost-effective and sustainable strategy to promote optimal mental health. The high social and economic return on investment for intervention in early childhood is widely documented.[7] Failure to act early leads to compounding costs over time, with recent Australian data estimating the cost of late intervention at $15.2 billion per year.[8]

Taskforce has found that there is consensus among children and families, clinicians and services that current public services are not designed or equipped to meet the current and future needs of WA's children, families and carers, and that significant change is required urgently in the short-term and enduring change in the long-term.

There are multiple causes to the current challenge

The most evident cause of the current issues is that funding, and therefore, the capacity of services has not kept up with demand; but there are other factors that have contributed to the current situation.

First, there has been insufficient focus on the mental health of children by successive State and Commonwealth governments, despite calls for systemwide reform. While the focus on adult and, to some extent, youth mental health has grown, it has not in the case of infants, children and younger adolescents. The *Report of the Inquiry into the mental health and wellbeing of children and young people in Western Australia* (2011), stated that:

> "*The overwhelming evidence…was that the mental health needs of children and young people have not been afforded sufficient priority and there is an urgent need for reform*."

Second, in WA, there are over 30 mental health services for children and adolescents. Taskforce has not seen evidence that services have been properly established as a connected system of care. Children, families, carers and clinicians experience the system as a fragmented set of standalone services, and confirm that as demand has increased, eligibility and access criteria have become more stringently applied, and accessing services has become harder.

Third, there are critical gaps in the system. For example: there are very few services for children who need intensive and assertive

[5] Silburn S, Robinson G, Arney F, Johnstone K, McGuinness K. The first 5 years: starting early. Northern Territory Government, 2011.

[6] World Health Organisation. Social determinants of mental health. World Health Organisation, 2014.

[7] Nores M, Barnett WS. Benefits of early childhood interventions across the world: (Under) Investing in the very young, *Economics of Education Review*. 2010.

[8] Teager W, Fox S, Stafford N. How Australia can invest early and return more: A new look at the $15b cost and opportunity. The Front Project and CoLab at the Telethon Kids Institute, 2019.

support in the community; children and families in regional, rural and remote WA have restricted access to community and state-wide services; there are no public mental health services for infants; and there are few services designed to support children with multiple complex needs broader than just their mental health; such as children in care and within the justice system.

> ***"We are having to ration care to children every day."***

Fourth and finally, there are ongoing issues with the supply of suitably skilled mental health workers in WA and more broadly Australia; and increasing competition for staff given significant investments in adult, youth, aged care and disability services. The *Sustainable Health Review* confirmed that there are also fewer General Practitioners (GPs) per capita in WA than in other parts of Australia. This means that children, families and carers with emerging mental ill health are less able to be supported when they first need it.

The impact is profound, distressing and places children at risk

Young people have spoken of their experience. Their accounts have been distressing. They have spoken of being unable to access services due to not being unwell enough; and feeling traumatised when presenting at Emergency Departments. Some young people stated that the reason they resorted to self-harm when they were a child was to show clinicians how unwell they were.

Families and carers feel helpless and fearful, unsure of how to best help their loved ones. As an alternative, private services are often also at capacity or too expensive to access.

Clinicians and staff have described their despair at turning away children who they believe need public mental health care, stating that their services that are overwhelmed, and that the impact on staff wellbeing is profound. Taskforce has heard that staff are leaving the service or reducing their hours because of how they have been impacted.

Taskforce will be putting forward an ambitious and sustainable plan

There is an urgent need for investment and increased capacity, especially in community infant, child and adolescent mental health services across metropolitan and regional WA. The current capacity and model of care is not meeting the needs of children, families and communities that are facing increasingly complex mental health issues at increasingly younger ages.

However, simply increasing resources of current services will not address the concerns that children, families and carers have raised about the quality of care they receive, nor the gaps in services that exist. Taskforce has consistently heard from children, families, carers, clinicians and services that there is an immediate capacity issue to address; but sustainable change requires investment in establishing a functional, coordinated system that supports the mental health of all children, families and carers in need.

Gaps in services need to be addressed and access to services needs to be easier and equally accessible for all children. Public mental health services need to be well connected and coordinated with each other and with other agencies that support the wellbeing and development of 0-to-17 year-old children.

Urgent change and prioritised, targeted and sustained investment in infant, children and adolescent mental health is critical to ensure that children and their families are supported.

"The system feels cruel to me. We are turned away. It's just cruel."

3. The key insights of Taskforce

The need to improve mental health is a national challenge requiring significant investment in change

Taskforce is building on the insights of previous state and national reports. The *Targeted Review: Chief Psychiatrist's Review into the Treatment of Ms Kate Savage by Child and Adolescent Mental Health Services* that led to Taskforce was one of over 120 separate inquiries, reports, reviews and strategies that have been published in Australia since 2011 that relate to the mental health and wellbeing of children, families and carers. Collectively, they highlight key themes relevant to Taskforce aims.

> ***"We have been talking about this for a long time. This isn't new."***

Among these, there have been two landmark mental health reviews published in the last 12 months: the Productivity Commission's report into the mental health of Australians (2020), and the Royal Commission into Victoria's Mental Health System (2021). These have clear relevance to the key work of Taskforce, highlighting that mental ill health of infants, children and adolescents is growing, and public systems across states and territories are struggling to meet demand.

The Productivity Commission's report focused on the nation's mental health, concluding that:

- Most people with mental illness have seen the onset by the age of 21.
- Suicide is the leading cause of death for Australians aged 15 – 44 years old.
- The direct economic cost of mental ill health is over $43 billion a year.

The Royal Commission into Victoria's Mental Health System concluded that *"Victoria needs a new infant, child and youth mental health and wellbeing system to meet the needs of its future generations."* The Victorian Government has since made a series of funding commitments including:

- $266 million to deliver services for 12-to-25 year-olds through a dedicated youth mental health and wellbeing system.
- $200 million for schools to deliver mental health programs that meet the needs of their students and school community.
- $141 million for five new Youth Prevention and Recovery Care Units, for 16-to-25 year-olds.
- $16 million for four Child and Youth Hospital Outreach Post-Suicidal Engagement sites.
- $16.3 million to expand the Youth Mobile Targeted Assertive Outreach teams, which provide in-home support.
- $21 million to expand support for the mental health of trans and gender-diverse young people.
- Expanding the Forensic Youth Mental Health Service for specialist mental health interventions for youth in custody.
- Supporting Aboriginal children and adults with $116 million to fund Aboriginal-led centres and services.

The issues identified in Victoria and by the Productivity Commission resonate with what

Taskforce has found in WA. Further, the issues Taskforce have identified are also consistent with the issues identified in the *Sustainable Health Review* published in 2019 that looked at the wider health system in WA, including:

- ongoing health inequity
- a focus on acute care over prevention and early intervention
- poor coordination, which makes services difficult to navigate
- challenges in access and coordination for rural, regional and remote patients.

"Many of these challenges are very similar, if not the same as the those faced by the health system."

Taskforce has identified a number of major systemic issues

Taskforce has identified a series of key insights which relate to the current challenges and constraints within mental health services for infants, children and adolescents across WA, and the profound impact they have had on the experience and outcomes of children, families and carers with regards to their mental health.

These insights have been drawn from the data and information that Taskforce has gathered to date. The work of Taskforce is ongoing and new insights may emerge as more information is gathered.

These insights are summarised below and described in more detail in the subsequent pages:

1. Challenges are not unique to but reflect a wider system under stress.
2. Infant, children and adolescent mental health services are being left behind.
3. The experience of some children, family and carers is poor and is potentially harmful.
4. Current services do not operate as a coherent infant, child and adolescent system.
5. Demand for services is increasing at a much higher rate than investment in capacity.
6. Community infant, child and adolescent mental health services are increasingly hard to access.
7. The clinical needs of infants and children under 12 years-old are not being met.
8. A lack of community alternatives places increasing demands on emergency departments that are already under pressure and can be traumatic environments.
9. There are critical gaps in the range of services currently provided to children and families.
10. 0-to-17-year-old children are presenting with increasingly complex issues.
11. Access to children and families in regional, rural and remote WA is not equitable.
12. Public services are not designed to meet the needs of Aboriginal children and families.
13. At-risk children with specific needs are missing out on treatment and support.
14. Capacity and capability issues with the workforce impact service delivery.
15. Health workers are distressed and are leaving the service.
16. Infrastructure, facilities and technology are not fit for purpose.

Key insight 1: Challenges are not unique to the Child and Adolescent Health Service but reflect a wider system under stress

The focus of the Chief Psychiatrist's *Targeted Review* was on the infant, child and adolescent mental health services provided by Child and Adolescent Health Service (CAHS). However, CAHS is not the only public provider of mental health services that support 0 to 17-year-olds across WA. As such, Taskforce has also sought to understand the experience and outcomes related to all infant, child and adolescent mental health services, including those that were not covered by the *Targeted Review.*

In metropolitan Perth, 16- and 17-year-olds requiring community mental health services are cared for by CAMHS or by youth community services (delivered by the three other Metropolitan Health Services - North, South and East. Most 16-to-17-year-olds requiring inpatient admission are admitted to youth inpatient services (East Metropolitan Youth Unit or Fiona Stanley Youth Unit). Children and young people aged 0-to-17-yers-old also present to all Emergency Department across Perth for a mental health related reason.

In regional and remote WA, the WA Country Health Service (WACHS) provide specialist mental health community treatment (WACHS CAMHS) as well as managing children, families and carers with mental health issues in Emergency Departments across its network of more than 80 hospitals and health centres. Children are also sometimes admitted for mental health treatment in paediatric, general adult or adult mental health inpatient wards at larger regional hospitals.

Taskforce has found that many of the Chief Psychiatrist's *Targeted Review's* findings are not unique to the services provided by CAHS – many are statewide issues affecting all services.

It is critical to recognise that there are also some unique issues in regional WA, which will require different approaches. Improving future outcomes will require systemwide change.

> ***"This is a system-wide problem – we need to meet the needs of children across the state."***

Key insight 2: Infant, children and adolescent mental health services are being left behind

The Productivity Commission Inquiry and the Victorian Royal Commission have both called for substantial investment in mental health programs for all ages and National and State/Territory governments are increasingly investing more in mental health. Whilst this includes some recommendations or initiatives specific to infant, child and adolescent mental health, the majority of governments' focus more on youth and adult mental health programs. This applies in WA also.

In May 2021, the Commonwealth released the *National Mental Health and Suicide Prevention Plan* with an additional investment of $2.3 billion into mental health allocated in the latest Commonwealth budget. This included the expansion and introduction of some primary care infant, child and adolescent mental health services

(specifically, an expansion of headspace centres and establishing HeadtoHelp for Kids centres).[9]

Similarly, the WA Government has made a series of election commitments related to mental health services for young people aged 16-to-24-years-old.[10]

Investment at national and state levels is welcomed by Taskforce, but relatively little of it is directly targeted at or sufficiently addresses the mental health challenges for children under the age of 16.

The Productivity Commission report has highlighted the importance of investing in infant, child and adolescent mental health. Such investment not only improves the mental health of children and their families immediately and into the future, but in the long-term saves significant government expenditure by: (i) lowering the risk of children disengaging from their education and improving their future training and employment outcomes; (ii) reducing the need for more intensive care and supports through their adulthood, and (iii) increasing their likelihood of leading meaningful and contributing lives.

The World Health Organisation reports that over half of adults with enduring mental ill health had issues before the age of 14 but most cases are undetected and untreated. [11] The relative lack of focus on and investment in mental health services for children aged 0-to-15 is missing a critical opportunity to intervene and change the trajectory of mental health at an individual, community, state and national level.

Key insight 3: The experience of some children, family and carers is poor and is potentially harmful

Children and their families have reported to Taskforce that they did not always feel listened to or respected when they attended services for mental health issues. Seeking care at Emergency Departments, can potentially be a traumatic experience for some children and their families.

> ***"It's not just mental health staff but all health staff. They need to understand how to treat children in crisis with respect."***

Children, and their families have provided many examples to Taskforce of the negative experience when trying to access or accessing treatment and care. They describe being 'handballed' between services and of being told that they are not unwell enough to be accepted into a service. Of particular concern, are the stories that young children and adolescents are resorting to self-harm in order to gain access to treatment.

Taskforce has learned that some families and carers are putting themselves into financial hardship to pay for private treatment. However, in circumstances where private or other services are financially accessible, children and families

[9] The number and location of these that will be established in WA is, as of yet, unknown.

[10] Note, where possible, recent commitments made by the WA Government are cited in the Emerging Directions sections of this paper.

[11] World Health Organisation, Adolescent mental health. World Health Organisation, 2020.

continue to experience long waitlists, due to high demand.

> ***"It's not just the public services, you can't get an appointment with private clinicians either – in some cases, all the money in the world won't help."***

Key insight 4: Current services do not operate as a coherent infant, child and adolescent system

Publicly funded mental health services that support 0-to-17-year-olds across WA are not connected into a well organised system. They typically target different age cohorts, different levels of need, and in some cases different diagnoses. There are no defined pathways as there are in the wider 'physical' health system, where a clinician refers a patient to another service that then takes on that patient's care. Instead, child and adolescent mental health services use eligibility criteria and severity assessments to determine whether a child can access services. As a result, children, families and carers must often wait long periods to hear whether they have been accepted by a service or not.

> ***"Children and families are tired of bouncing around from service to service."***

Further, the mental health system is separated from other parts of the health system due to siloed governance, funding, and information management. Information is neither shared between services, nor readily accessible to children, families and carers. Ultimately, this fragmentation has a huge impact on the experiences and quality of care.

The disconnect between specialist health services funded and governed by the state, and primary health services funded and governed by the Commonwealth is not new. The *Sustainable Health Review* identified this as a fundamental challenge for the health system in WA. Other national reviews have identified that this is an issue across Australia.

Services use different patient information systems that gather different information from each other. This disconnect creates barriers to sharing information and makes providing consistent and coordinated support to children and families especially challenging. Services are not easily integrated with adjacent services which play a critical role in the development and support of children, families and communities (for example, education, justice, and child protection).

The WA Government has recently announced funding for around 100 additional school psychologists over the next four years. This presents a valuable, but undefined, opportunity for different government departments to work together, and doing so will be critical to meeting future need.

Key insight 5: Demand for services is increasing at a much higher rate than investment in capacity

For many years, the growth in demand for infant, child and adolescent mental health services has substantially exceeded the growth rate of funding for services and the population growth of children in WA. Whilst the population of 0-to-17-year-olds in WA

increased by approximately 2.8 per cent between 2017 and 2020, during that same period the number of 0-to-17-year-olds who:

- attended an emergency department for a mental health reason grew by 25.7 per cent (an average growth of 5.9 per cent per year)
- were admitted to a hospital bed for a mental health reason grew by 31.0 per cent (an average growth of 7.0 per cent per year)
- were referred to a community mental health treatment service grew by 36.6 per cent (an average growth of 8.1 per cent per year).

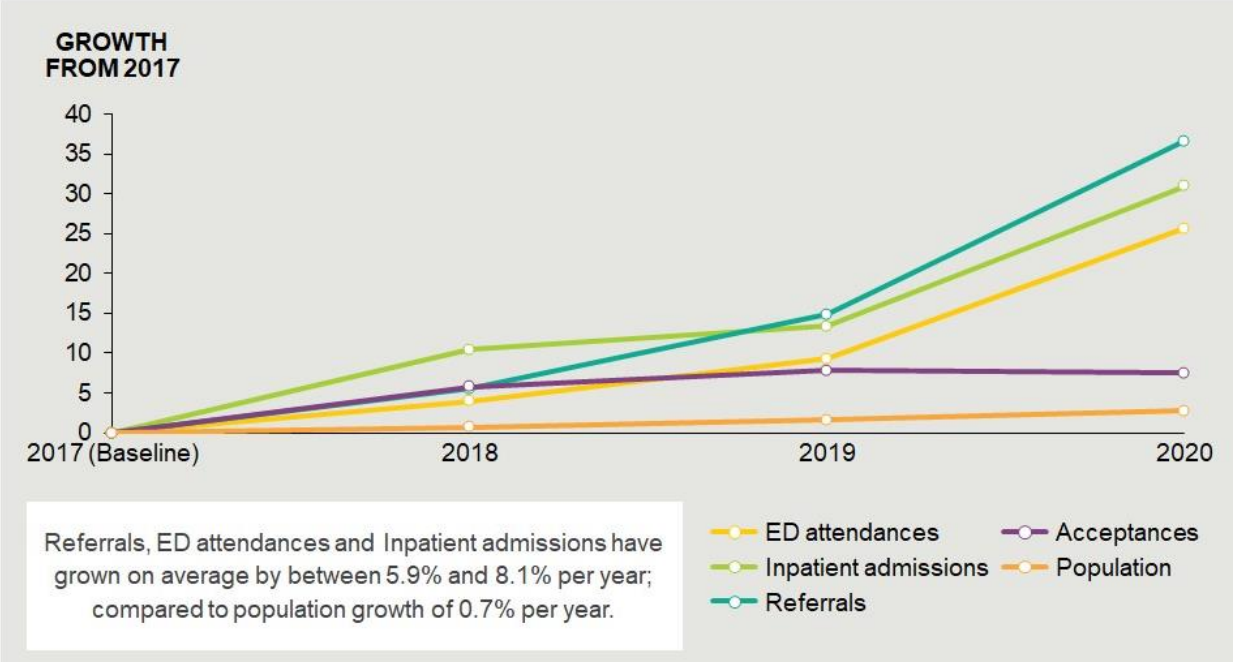
Funding for community treatment services has grown by 8.9 per cent over the same period (an average annual increase of 2.2 per cent – slightly above inflation). As *Figure 1* shows, the rate of growth in demand for services has grown at a rate far greater than population growth and funding during 2017 to 2020. This has meant that the capacity of services, especially community treatment services, has been unable to keep up with the mental health needs of children, families and carers. As referrals to community treatment have increased the capacity of those services to accept a referral has been constrained due to a lack of resources.

This has a knock-on impact. As proportionally fewer children are able to access community treatment, more children are experiencing episodes of crisis – as demonstrated in the significant growth in emergency department attendances.

The data represented in *Figure 1* only goes back to 2017 due to changes in reporting of funding, but the growth in demand for services dates back beyond 2017. *Figure 2* overleaf for example shows that referrals have grown by over 70 per cent since 2013.

This challenge is not unique to WA. Accelerating demand for mental health services for infants, children and adolescents is an issue in all jurisdictions.

Figure 1 | Change in service activity for 0 to 17-year-olds from 2017 to 2020



For example, the Victorian Royal Commission found that there is a need to significantly increase the capacity of the mental health system to better meet the needs of future children.

The data in activity growth only represents 0-to-17-year-olds who actually access services. Taskforce has heard that there are many who are not accessing services, which means their needs are unmet. Further, these issues are not limited to the public sector alone; there are capacity challenges within the private and community sectors also.

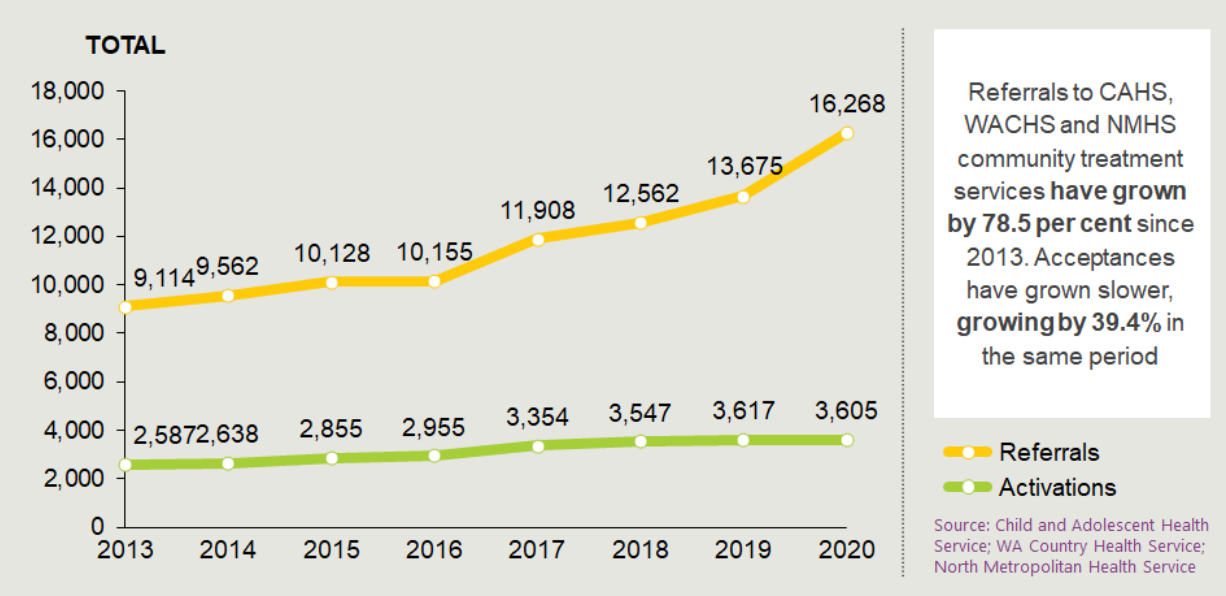
"The referral rates don't even account for the number of children in need. There are children we don't refer because we know services are full."

Challenges accessing services may occur for several other reasons, including:

- a poor experience in the past causing children and families to be reluctant to seek more support
- services that are culturally inadequate and not seen as safe
- clinicians not referring to community treatment due to an expectation that the referral will not be accepted (technically referred to as being 'activated') or will take too long to be assessed
- the ongoing stigma of mental health issues within some communities
- a lack of awareness in parents/carers of emerging signs of mental ill health in infants and children
- a lack of support when problems are starting to emerge or after discharge.

Each of these issues need to be addressed; but doing so absence of additional investment will further increase pressure on services who are already unable to meet demand.

Figure 2 | Referrals and acceptance levels for community treatment services from 2013 to 2020



Key insight 6: Community infant, child and adolescent mental health services are increasingly hard to access

The number of referrals to community treatment services has increased by 78.5 per cent since 2013 (see *Figure* 2, previous page). However, number of acceptances has only increased by 39.4 per cent during the same period. The probability of a child that is referred accessing the service to which they are referred is decreasing. In 2013, one in every 3.5 referrals was accepted; in 2020, one in every 4.5 referrals was accepted. As a result, there are growing numbers of children, families and carers waiting to access the care they need.

Some referrers indicated they are not referring because they know services are at capacity.

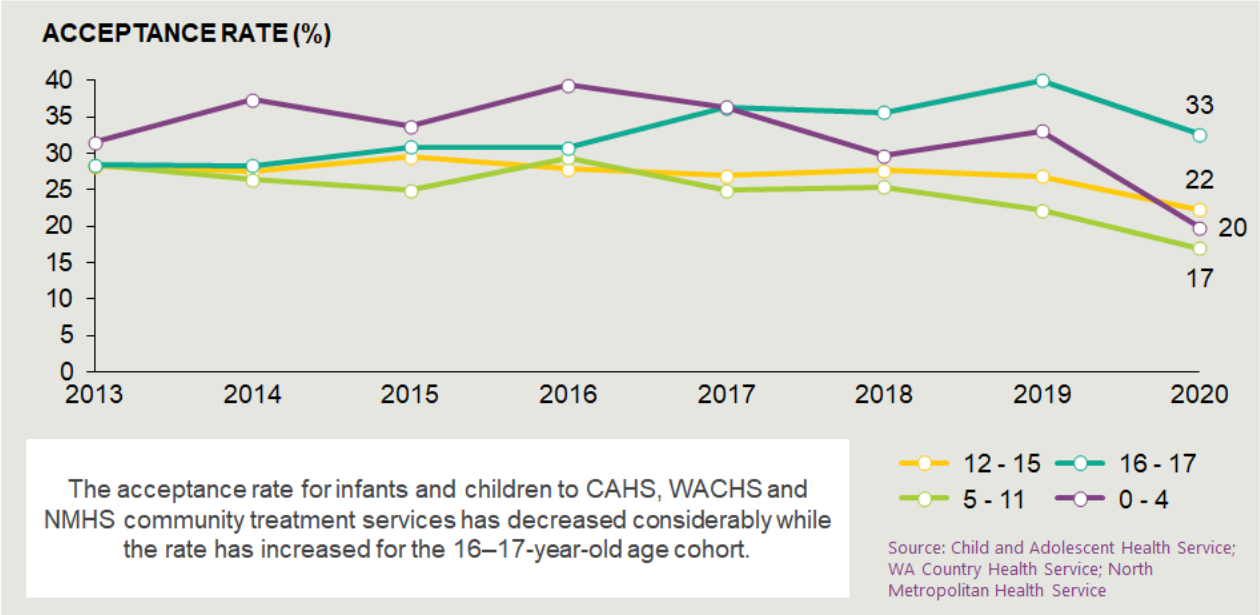
Key insight 7: The clinical needs of infants and children under 12 years-old are not being met

A consequence of demand growing faster than capacity is that every day clinicians are assessing referrals and prioritising access only to the most high-risk children, usually aged between 12-to-15. This has led to proportionally fewer infants and children under the age of 12 being able to access specialist mental health services than in the past, even if they are severely unwell.

Over the last ten years, whilst the number of referrals to community treatment for children (5-to-11-year-olds) has increased by 47.4 per cent, the number of service acceptances for children has reduced by 13 per cent. In 2020, fewer than one in six referrals for a 5-to-11-year-old child to a community treatment service were accepted.

The latest data (see *Figure* 3) shows a considerable drop in the acceptance rate for

Figure 3 | Acceptance rate for different age cohorts at WACHS CAHS and NMHS community services from 2013 to 2020



all age cohorts, in particular those aged 0-to-12 years-old. In 2013, over one in four referrals for 0-to-12 year-olds were accepted into community treatment, but in 2020 that has dropped to less than one in five. The rate of acceptances for adolescents (12-to-15 year-olds) is only slightly higher.

Whilst other states, such as Queensland, have established dedicated public perinatal and infant mental health services, the reduction in acceptance rates in WA indicates that there has been a substantial reduction in the capacity of existing community treatment services to respond to the needs of infants and children under 12-years-old.

Services for infants and children under 12 is a critical gap that needs to be addressed.

Key insight 8: A lack of community alternatives places increasing demands on emergency departments that are already under pressure

Episodes of poor mental health should not be left to escalate to a crisis level. Attending an emergency department should be a last resort; for when an individual's health cannot be managed at home or in the community.

In 2020, there were 8,340 separate attendances at an emergency department by 0-to-17 year-olds for a mental health reason. This is an average of 22 attendances per day, and a 55 per cent increase from the 5,382 presentations in 2013.

In particular, there has been a 105 per cent increase during this period in the number of attendances by adolescents (12-to-15 year-olds) and a 65 per cent increase in the number of presentations by children (5-to-11 year-olds) – see *Figure 4* overleaf. [12]

This increase in emergency department attendances by 0-to-17 year-olds for a mental health reason comes at a time when emergency departments Australia wide are under increasing pressure.

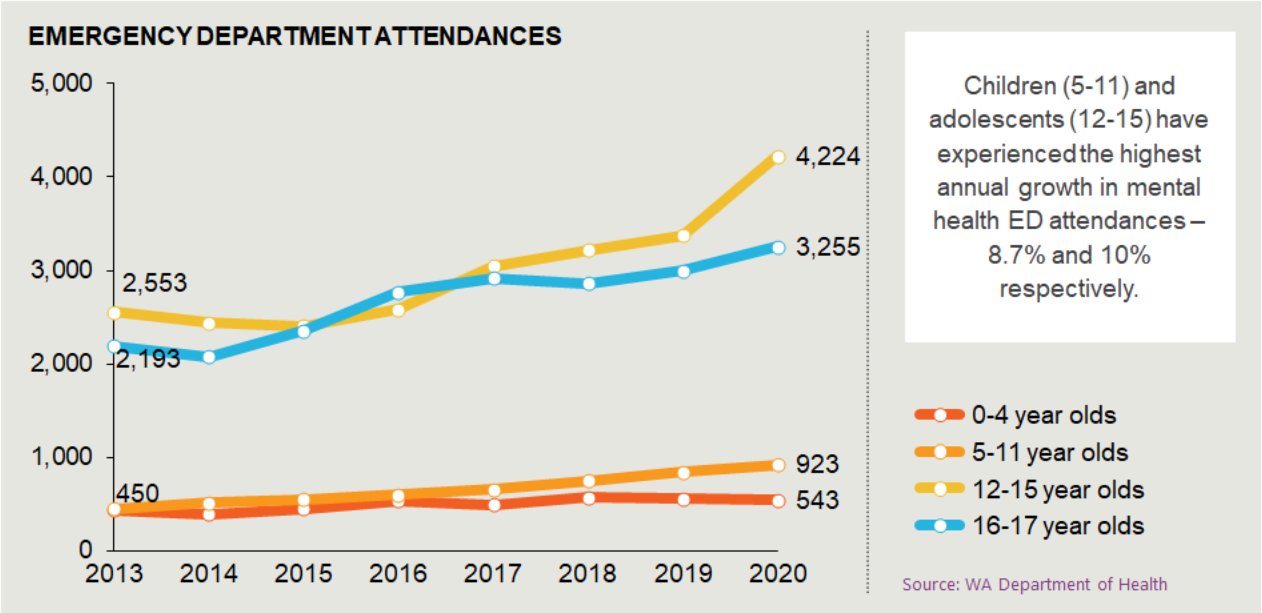
Taskforce has heard from those with lived experience that they have attended emergency departments because of no alternative. In some cases, children are self-harming because this is often the only way for them to receive appropriate treatment.

The Chief Psychiatrist's Targeted Review reported that the nature of these ED attendances is also changing. The Targeted Review found that ED attendances for 0-to -15 years for attempted suicide, suicide risk, or intentional self-harm have increased by 214 per cent between 2009-10 and 2019-20.

It is a reasonable conclusion that one of the reasons for the substantial increase in emergency department attendances is the reduced access to community treatment services summarised in Key insight 7.

[12] As mentioned later in Key insight 9, the reliance on EDs for 0-to-17 year-olds with mental ill health is greater in regional and remote WA than in metropolitan Perth.

Figure 4 | Change in ED attendances between 2013 and 2020



Key insight 9: There are critical gaps in the range of services currently provided to children and families

There are significant gaps in the overall range of services provided to meet the needs of children, families and carers. These gaps include but are not limited to:

- Specialist services that focus specifically on infant and perinatal mental health.
- Higher-intensity services in the community that support children as an alternative to inpatient care or after they are discharged from hospital. This may be in a residential bed-based services (such as step-up/step-down facilities) or in-reach/outreach services to the home, school or other settings.
- After-hours services for community treatment.
- Specific services for Aboriginal children, families, carers and communities.
- Crisis response services, both in the community and supporting emergency departments when an individual presents in a crisis.
- Forensic mental health services for children interacting with the justice system.
- Children in out of home care.

The focus of Taskforce over the coming months will be to identify the specific services and models of care that are needed to address the gaps identified.

Key insight 10: 0-to-17-year-old children are presenting with increasingly complex issues

While demand has increased across all aspects of the mental health system, the complexity of conditions has also increased, including among younger children. Services are seeing greater numbers of children, often with more challenging family circumstances who are often more complex to assess, treat and support than in the past.

Consultations with clinicians who deliver infant, child and adolescent mental health services have identified at least four factors related to increasing complexity:

- An overall increase in the severity of mental ill health. This means there is less capacity to support 0-to-17 year-olds with less severe mental ill health issues.
- An increase in the number of children with dual or multiple diagnoses, including mental, neurological and physical health issues. This means that coordinated care is required.
- An increased complexity of the external factors facing 0-to-17 year-olds, including greater trauma, exposure to domestic violence, neglect, poverty, and homelessness. This means the involvement of other agencies and organisations, who themselves are under pressure, is required.
- An increase in family complexity, including the impact of intergenerational mental health issues, where the significant mental health issues of a parent are complicating the mental health issues and treatment of a child.
- The impact of COVID-19 on children is still being understood; however, there are worrying signs that COVID-19 has had a profound impact on the mental health of children and their families. Data shows that there was an 18 per cent increase in referrals to community treatment services across WA in 2020, compared to an average annual increase of approximately 7.5 per cent over the previous five years. There was a 47 per cent increase in referrals to the Eating Disorders Service.

Key insight 11: Access to children and families in regional, rural and remote WA is not equitable

Accessing all health services, including mental health services is an enduring challenge for children and families in regional and remote WA (as highlighted in the Sustainable Health Review).

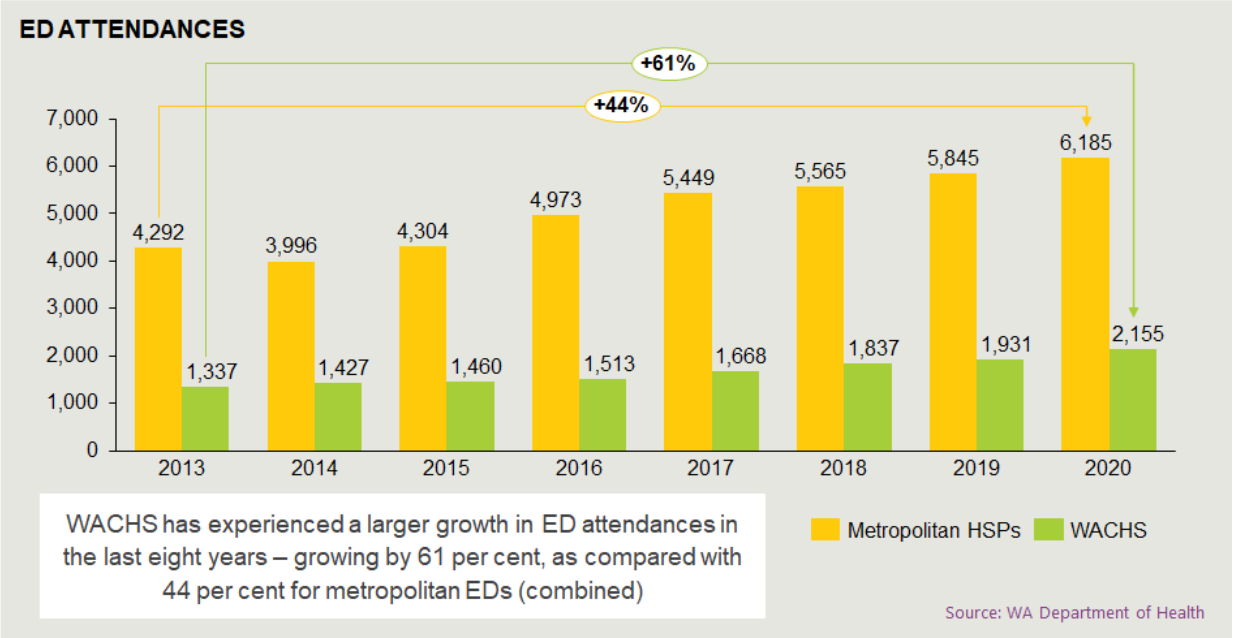
The only dedicated state funded mental health services for children and adolescents available outside of Perth are the community treatment services provided by WACHS. State-wide specialised services are provided from Perth by CAHS for conditions such as gender diversity and eating disorders.

Data shows there is a greater reliance on emergency departments for 0-to-17-year-olds with mental health issues in regional remote WA. In 2020, on average[13] 1 in 65 0-to-17-year-olds in regional and remote WA presented at an emergency department for a mental health related issue, and 1 in 83 0-to-17-year-olds in metropolitan Perth presented at an emergency department for a mental health related issue.

This reliance is growing. As shown in *Figure 5 overleaf*, between 2013 and 2020, the number of emergency department presentations at a WACHS hospital by a 0-to-17-year-old for a mental health related issue has increased by 61 per cent. Over the same period, there has been a 44 per cent increase in emergency department attendances within the metropolitan area.

[13] This is based upon total ED attendances at hospitals in remote and regional WA and hospitals in metropolitan Perth.

Figure 5 | Change in metropolitan versus country emergency department attendances between 2013 and 2020



Although referrals to WACHS CAMHS have steadily increased over the same period, they have not increased at the same rate as they have to CAMHS in metropolitan Perth. It is not clear why this is the case and further analysis is being undertaken to better understand why.

However, some WACHS clinicians report they do not refer all children they believe require a public mental health service due to experiences of referrals not being accepted.

0-to-17-year-olds in regional and remote WA are also less likely to be able to access state-wide specialist community treatment services (e.g., eating disorders and gender diversity services), with only 11 per cent of referrals to these services being for 0-to-17 -year-olds living outside of Perth; despite 21.5 per cent of 0-to-17-year-olds in WA living outside of Perth.

Key insight 12: Public services are not designed to meet the needs of Aboriginal children and families

Aboriginal children, families and their communities, continue to experience significant mental health challenges due to the historical legacy of colonisation resulting in an array of contemporary risk factors and experiences. These include intergenerational trauma, racism, socio-economic disadvantage, poorer health and shortened life-expectancy.

As a result, Aboriginal children and families are disproportionately impacted by mental health issues. Research shows that Aboriginal children are at significantly higher risk of suicide (see next page).[14]

Aboriginal children and families can face specific challenges and have unique needs

[14] De Maio JA, Zubrick SR, Silburn SR, Lawrence DM, Mitrou FG, Dalby RB, Blair EM, Griffin J, Milroy H, Cox A. The Western Australian Aboriginal Child Health Survey: Measuring the Social and Emotional Wellbeing of Aboriginal Children and Intergenerational Effects of Forced Separation. Curtin University of Technology and Telethon Institute for Child Health Research, 2005.

which are not being consistently met by 'general' services. However, there are no dedicated public mental health services for Aboriginal 0-to-17 year-olds.

Aboriginal suicide risks in WA

WA has the highest Aboriginal suicide rate in Australia, with Aboriginal people living in WA dying by suicide at a rate that is 3.3 times higher than non-Aboriginal people. There have been more than 700 recommendations arising from 40 inquiries into Aboriginal youth suicide and related factors since the early 2000s.

Most recently, these have included the **State Coroner's Inquest** into the deaths of thirteen children and young persons in the Kimberley Region, Western Australia, and the 2016 Parliamentary Inquiry, Learnings from the **Message Stick: the report of the Inquiry into Aboriginal youth suicide in remote areas**.

Themes from these reviews include:

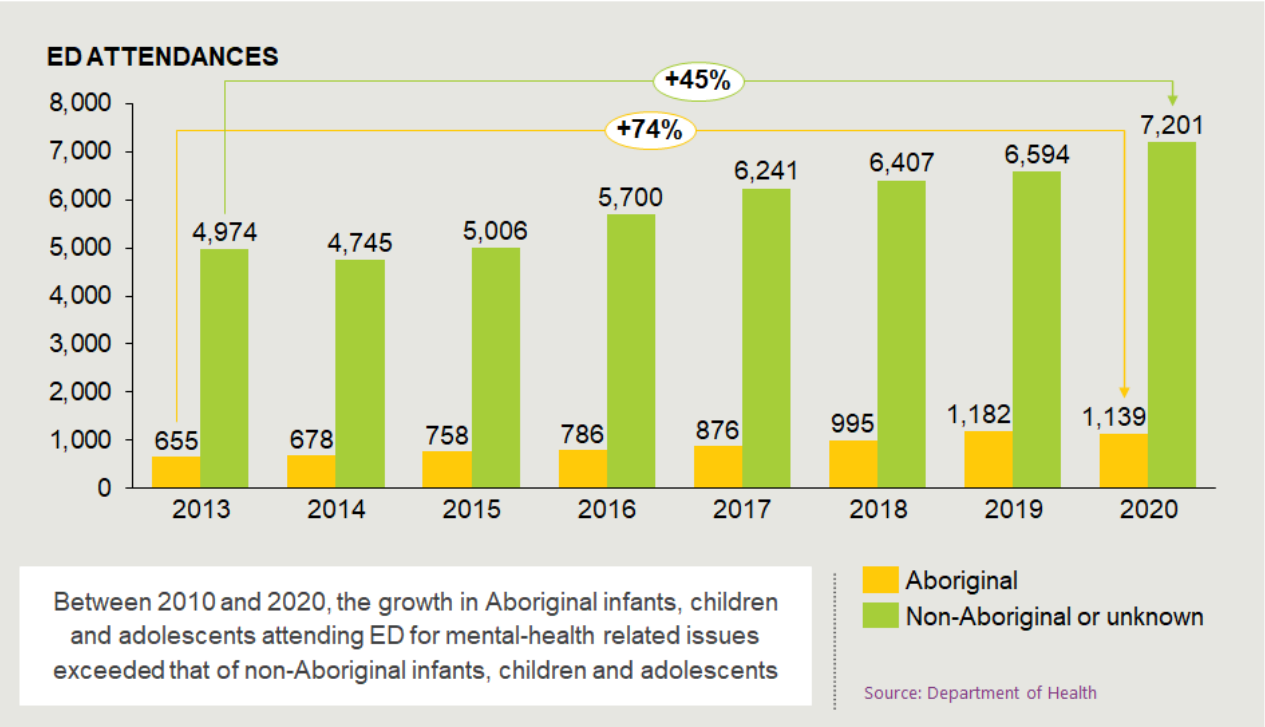
- A need to focus on addressing *immediate* and *underlying issues*. Clinical interventions are necessary but must be addressed concurrent to cultural, emotional and social factors.
- Programs should be *culturally-based*, designed to help Aboriginal people to develop a strong sense of cultural identity and connection to place.
- Programs should be *culturally-appropriate*, applying knowledge and capabilities of local culture, customs and resources to service delivery.
- Policymakers should *empower Aboriginal communities*, by involving Aboriginal communities in the design of programs, supporting community-run programs; and developing the capacity of community members.
- *Coordination of service delivery* to Aboriginal people should be improved to address the lack of inter-agency collaboration and coordination, which restricts effectiveness.
- Policymakers and service providers should work to address and be sensitive to *intergenerational, community and individual traumas*.

Emergency department attendances by Aboriginal children for a mental health reason have increased by 75 per cent since 2013 (see *Figure 6 overleaf*), and Aboriginal children are presenting at emergency departments in a substantially greater proportion than non-Aboriginal children.

"Services are not good at catering to the cultural needs of Aboriginal people – different approaches are needed which reflect the strengths of Aboriginal people."

In 2020, 13 per cent of all emergency department presentations by a 0-to-17-year-old for a mental health reason were by an Aboriginal child. This is despite only 6.5 per cent of 0-to-17-year-olds in WA being Aboriginal. In regional and remote WA, the proportion is higher. Thirteen per cent of 0-to-17 -year-olds living in regional and remote WA are Aboriginal, but in 2020, 32 per cent of all emergency department presentations by a child for a mental health reason were by an Aboriginal child.

Figure 6 | Change in Aboriginal versus non-Aboriginal emergency department attendances between 2013 and 2020



Key insight 13: At-risk children with specific needs are missing out on treatment and support

In addition to Aboriginal children and their experience of infant, child and adolescent mental health services (as per Key insight 11), Taskforce is aware that there are a range of other at-risk groups who have issues in accessing timely and/or appropriate infant, child and adolescent mental health services, this includes:

- children from culturally and linguistically diverse backgrounds
- LGBTQIA+ children
- children in the justice system
- children with autism spectrum disorder and other neurodevelopmental disorders and/or disabilities being supported by NDIS services
- children in out of home care
- children that are homeless or at risk of homelessness
- children with eating disorders
- children with emerging personality disorders
- children with alcohol and other drug issues.

Taskforce is gathering data related to these groups, but this takes longer to compile than the other data presented in this report, as it comes from multiple government agencies. Taskforce expects to have more specific information in relation to these groups in the final report.

Key insight 14: Capacity and capability issues with the workforce impact service delivery

Taskforce has been established at a time when there have been many calls for extra resources in infant, child and adolescent mental health services, including in the

Targeted Review. While Taskforce has concluded that there is insufficient workforce capacity in current services, it also acknowledges the challenges both nationally and locally in rapidly expanding this specialist workforce to meet current demands, while also addressing the need for planning for and training an appropriately skilled workforce to meet future needs.

The Productivity Commission inquiry identified that there are national shortages in the mental health workforce. In particular, access to child and adolescent psychiatrists was highlighted as a gap in all states and territories. The Productivity Commission inquiry also identified that challenges

> ***"The environment of the ED and other services aren't appropriate for children at all."***

associated with training, as well as the inflexibility of the current mental health workforce model, have contributed to these shortages.

Taskforce has learned that there are ongoing issues with recruiting mental health roles across many disciplines, across HSPs. Concurrently, retention of staff is also becoming an enduring challenge for mental health services. New solutions are required to ensure that WA services can move nimbly to attract, recruit, and retain the workforce required to serve children and their families.

The WA health and mental health systems have traditionally relied upon a net inflow of interstate and overseas resources to supplement the health and mental health workforce. This flow of resources has become significantly compromised during the COVID-19 pandemic. It is too soon to predict the long term impact that the pandemic will have on this critical source of qualified workers.

Key insight 15: Health workers are distressed and are leaving the service

As identified in Key insight 14, there is an ongoing challenge around workforce shortages. Current demands on staff have direct and immediate consequences on workplace place health and safety and the longer-term attraction and retention of key staff. Service leads, managers and clinicians across the state all tell the same story: that of a system that is buckling under the weight of increasing demand and progressively failing to deliver the level of support required.

This is impacting the safety, wellbeing and resilience of the workforce. Taskforce has heard stories of highly committed staff asking to work part-time because they cannot cope with the stresses and expectations that are being placed on them.

> ***"We know it's not easy on the health workers either – it's been really hard for them."***

At a time when all areas of the mental health workforce in Australia will be looking to invest in more resources for mental health services, working in an infant, child and adolescent mental health service is increasingly less attractive.

Attracting and retaining skilled and committed staff will be integral to the delivery of an effective infant, child and

adolescent mental health system. Changes to working conditions including support for staff will be a fundamental component of both short and sustained change.

Key insight 16: Infrastructure, facilities and technology are not fit-for-purpose

Taskforce has heard that some infrastructure and built environments used to support infant, child and adolescent mental health services are not conducive to delivering high-quality care. Children, families and clinicians all reported that facilities are not suitable for children, with many reflecting adult models of care.

Taskforce has heard accounts of inadequate privacy in rooms used for consultations with children, families and carers, and some facilities lacking basic internet connectivity needed to use operational tools.

The health and mental health systems are also not leveraging contemporary information systems to underpin service delivery. There is no standard Electronic Medical Record used across health and mental health services. This means that as individuals move between services the information related to their condition and treatment plans may not follow. Not only does this create a risk in continuity of support, but it also risks re-traumatising individuals as they must repeat their personal circumstances and experiences.

Telehealth is a critical capability that helps connect consumers with clinicians in different locations. WA has been a leader in the use of telehealth to connect regional and remote communities with specialist clinicians typically based in Perth, but the use of telehealth specifically supporting the mental health of children is limited in its capacity.

Much of this is consistent with the findings of the *Sustainable Health Review* and again in the recent *State Infrastructure Strategy* which highlighted mental health digital infrastructure as a priority.

4. Recent government developments

Concurrent with the work of Taskforce, the WA and Australian governments have made a wide range of commitments or initiated actions to further meet the needs of child, families and carers. Although not exhaustive, the below list is indicative of some of the progress that is being made. These have been aligned with the relevant Emerging Directions identified in the report.

WA Government commitments

- The Government has committed to an investment of 55 new professionals into Community CAMHS in the Perth metropolitan area (direction #1).
- Additional resource is also being invested in Eating Disorders and the Gender Diversity Service, as well as the Emergency Telehealth Services to enhance the level of services and access. These commitments are made with immediate effect and recruitment is already underway (direction #1).
- The WA Government, as part of the election commitments, has committed to fund the expansion of youth mental health community treatment services provided by South Metropolitan Health Service and new services for NMHS and EMHS for 16-24 year olds. $35 million (direction #1).
- The WA Government, as part of the election commitments, has committed to increasing access to appropriate specialist mental health assessment treatment and case management for vulnerable youth throughout the Perth metro area. $10 million (direction #1).
- A metropolitan Youth Step Up/Step Down community mental health service for children aged 16 and over has been committed through the WA Governments election commitments. It will provide a 10 bed facility with 24/7 24/7 psychosocial and clinical supports. $11 million (direction #1).
- An Independent Panel will inquire into the Emergency Department at Perth Children's Hospital, including customer service within the ED in relation to children and their families (direction #1).
- The WA Government has announced more than $1 million to launch new perinatal pilot services in the metropolitan and SouthWest to support the mental health of vulnerable Australian parents.
- As part of the WA Government election commitments, 30 psychosocial support packages have been funded for young people aged 16-24 in the metro area to assist them to live in the community. $10 million (direction #2).
- As part of the WA Government election commitments, the individualised community living strategy program has been funded with 20 additional packages for young people ages 16-24. $18 million (direction #2).
- The 2021 McGowan Government committed to a $17.6 million investment in Social and Emotional Wellbeing services at 5 Aboriginal Community Controlled Health Service (ACCHOs) to deliver culturally situated brief intervention support, outreach and group work with young people and community members (direction #3).
- On 1 July 2021 the Aboriginal Community Liaison Officer program was launched with 9 successful Aboriginal Community Controlled Organisations receiving contracts to lead the implementation of the regional Aboriginal suicide prevention plans (direction #3).

- As part of the WA Government election commitments, expansion of the Strong Spirit Strong Mind Project to the regions. $9 million (direction #3).
- WACHS recently completed the roll out of Mental Health Emergency Telehealth Service that supports the EDs at over 80 hospitals and health services across regional WA (direction #3).
- In July 2020, the McGowan Government invested $2.7million into the Preventing Fetal Alcohol Spectrum Disorder Project aiming to decrease the prevalence of alcohol use in pregnancy (direction #4).
- 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 (direction #4).
- The expansion of WA's Eating Disorder Treatment services will include the treatment for people aged 16 years and above (direction #4).
- The interim Youth Mental Health and Alcohol and Other Drug Homelessness service is scheduled to open in mid to late 2021 for 16-24 year olds. Government committed $25.1 million funding in the 2020/21 budget (direction #4).
- As part of the Western Australian Government election commitments, the Aids Council was provided a grant to improve the support and counselling services provided to LGBTIQA+ young people in our regions. $8 million (direction #4).
- The WA Government has committed $7.3 million to the Child and Adolescent Health Service to pilot a Community Health Hub in Midland. The facility will bring together Community CAMHS, Child Health Nursing, School Health Nursing, Child Development Service, Aboriginal Health and Immunisations (direction #6 and #7).
- The WA Government, as part of their election commitments, has committed to funding up to 100 additional school psychologists over the next four years. $42 million. (direction #7).
- The Mental Health Commission are partnering on a Healthway funded community sport and mental health project which aims to strengthen mental health initiatives and support in community sport settings in Western Australia (direction #7).
- The WA Government has committed to a program to create 400 new nurse graduate placements over two years which will include some mental health nurses (direction #8).
- The WA Government has commenced an initiative to develop a national and international pipeline of skilled workers to support the WA mental health system (direction #8).

Commonwealth Government commitments

- The Australian Government has committed to expand Headspace mental health services and introduce HeadtoHelp for Kids centre (direction #2).
- The Australian Government has committed to funding universal perinatal mental health screening across public antenatal and postnatal care settings (direction #2).
- The Australian Government has committed to providing funding to grow the whole mental health workforce across Australia (direction #8).
- The Australian Government has committed to providing funding to establish a comprehensive evidence base to support real time monitoring and data collection for Australia's mental health and suicide prevention systems (direction #10).

5. Future vision, purpose and principles

Taskforce has developed a proposed **vision**, **purpose** and set of underpinning **principles** to guide the future public infant, child and adolescent mental health system. This has been tested with the members of the Expert Advisory Groups and will be revised through the ongoing consultations undertaken by Taskforce. Collectively, the vision, purpose and principles provide a foundation for the development of the future system.

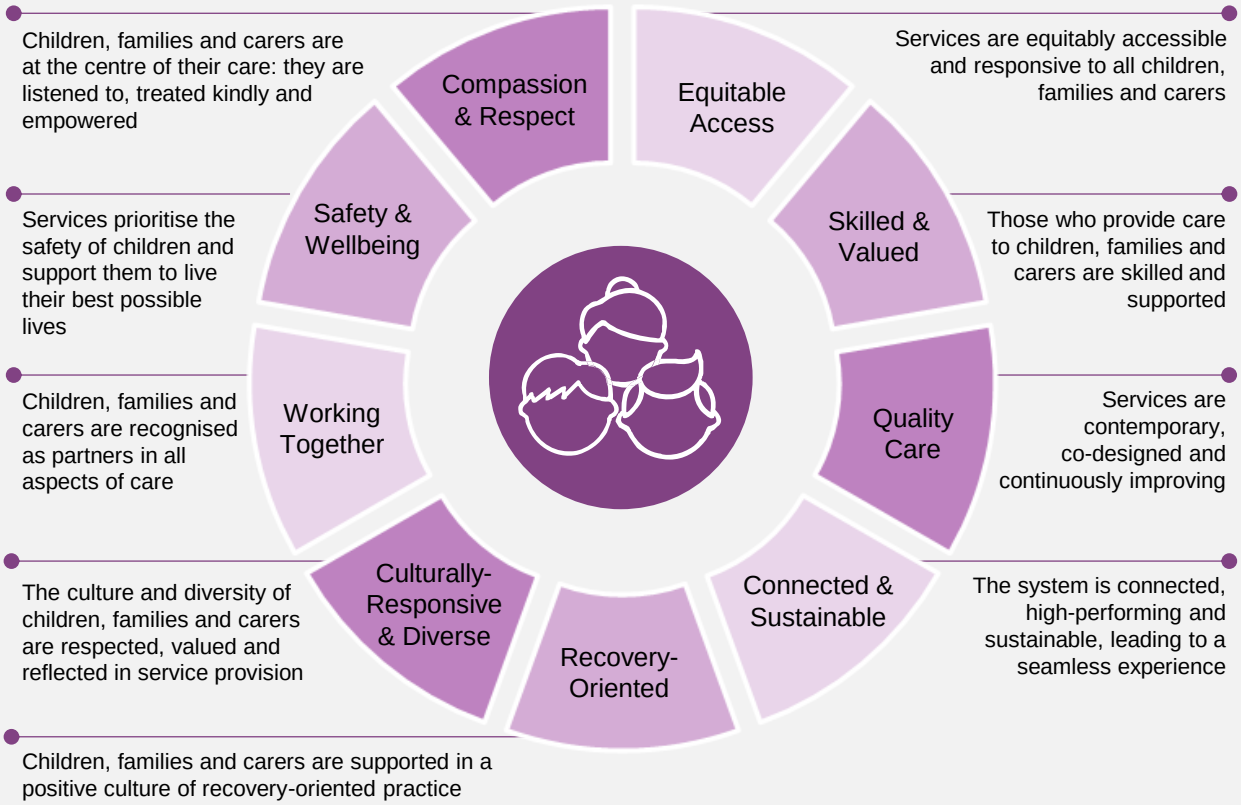
VISION FOR THE FUTURE

All infants, children, adolescents, families and carers are empowered to achieve and maintain their best possible mental health and wellbeing.

PURPOSE OF THE FUTURE SYSTEM

To ensure that all infants, children, adolescents, families and carers in Western Australia have timely, enduring and equal access to holistic, integrated and high-quality public mental health care.

UNDERPINNING PRINCIPLES



6. The strategy for delivering Taskforce's vision

Taskforce has identified **10 emerging directions** that will be the basis for further research, analysis, consultation and planning over the coming months. This work will inform the development of the final report in November 2021, including a clearly articulated vision and costed implementation plan for future public specialist mental health services for infants, children and adolescents across WA. Each emerging direction defines a specific set of outcomes that Taskforce believes are necessary to secure better mental health outcomes for children, families, carers and communities throughout WA.

Achieving this aim requires **urgent action to achieve short, medium and long-term improvements** to child and family experiences and outcomes. There is a need for immediate action to address service capacity issues and gaps within current public community treatment services across WA; to better support under-served children and their families. In addition, Taskforce is clear that the work to build the future system and ensure its long-term sustainability must also commence as soon as possible.

The emerging directions presented in this paper are structured to achieve a short-term focus on addressing immediate issues, whilst at the same time establishing the long-term foundations for a sustainable and high-performing mental health system that meets the needs of infants, children and adolescents, and their families and carers across WA.

At a high-level, Taskforce has identified **four imperatives** for strengthening infant, child and adolescent mental health services, each of which are associated with the emerging directions.

Figure 1 | Key imperatives for change

Below are the **ten emerging directions** that have been identified that will collectively progress towards the vision.

Figure 12 | Ten emerging directions

1. **Address immediate service and capacity shortages** to meet the critical treatment, support and crisis needs of children, families and carers
2. **Transform community-based services** to ensure children, families and carers are supported in their own communities; when, where and how they need it
3. Design and implement flexible services that deliver the **best outcomes for rural, regional and remote communities**, including Aboriginal communities
4. Improve and extend **services for children with specific, complex and co-occurring needs** across all communities
5. Ensure that all services are **culturally-responsive and inclusive** for all children, families and carers, and their communities
6. **Integrate mental health services** so that all children, families and carers are supported to access services that holistically meet their needs
7. Utilise **multi-sector partnerships** with other national, state and non-government services to better support children, families and carers
8. Invest in a **skilled, diverse and supported workforce**
9. Strengthen the **planning, infrastructure, leadership, governance and accountability** to achieve sustainable and ongoing improvement
10. Establish dedicated structures for **research, learning and innovation** that translate to improved outcomes

Each emerging direction is summarised in the following pages, with a brief summary of why the direction matters; what future outcomes Taskforce have heard are needed; and what the next steps are for Taskforce. In the coming months, Taskforce will define how these directions will be achieved.

Emerging Direction 1: Address immediate service and capacity shortages to meet the critical treatment, support and crisis needs of children, families and carers

Why does this matter?

Current public infant, child and adolescent mental health services are focussed on supporting children most at risk. However, they are unable to meet current or predicted future needs for all children who require support. As the system is oriented to crisis care, the opportunities for children and families to access the care they need has narrowed. Immediate action is required.

"I'm told that I'm not unwell enough for crisis services in the hospital – it's like I have to threaten my own life to be seen."

Community care is currently being rationed. There are immediate capacity constraints which limit access to community treatment services to children with the most severe symptoms and elevated risk. As a result, children with less severe and lower risk mental health issues struggle to access community treatment until they are at greater risk or in crisis. This contributes to long waiting periods, individual and family stress, and, in some cases, worse mental health. Community services are currently not configured to meet the needs of children.

"When we leave hospitals, we're on our own – until the next time we are here again."

In remote and regional areas, there are substantial challenges, which include workforce shortages, increased prevalence of chronic diseases, limited primary mental health services, small and widely spread population and poor access to specialist care. Investment in digital capacity and virtual service delivery will strengthen the existing Mental Health Emergency Telehealth Service and emerging CAMHS telehealth services. Building specialist services in regional centres that are resourced to deliver face-to-face and telehealth outreach services will complement the central system telehealth wide service.

These factors contribute to increased pressure on emergency departments and their staff, with more children seeking crisis support through hospitals, which they are unable to access elsewhere. In recent years, emergency departments across the state have seen a significant increase in attendances by children in crisis. However, attending an emergency department should be a matter of last resort, and children, families and carers report further distress in this environment due to the emergency care being provided in these environments and their intrinsically stressful nature. Further, children, families and carers report that they are not sufficiently supported when leaving the care of hospitals. Community-based crisis and intensive supports for both children and families are required.

What future outcomes have we heard are needed?

Children, family, clinicians and services providers have stressed that there is an urgent need to increase the capacity of community services to meet the needs of children, families and carers. Existing services across regional and metropolitan areas urgently need more resources to treat children in the community and provide trauma-sensitive care when a child is in crisis. Long-term transformation of community services is discussed in Emerging Direction 2.

"We need to act now to address the most critical gaps within our system."

"We must be able to better support our children across WA and improve the conditions for those that work in the services."

Immediate outcomes that have been identified by Taskforce for further consideration include:

- More children have access to metropolitan and regional community-based services, services for children with specific needs and inpatient services, with shorter waiting times.
- The number of children attending emergency departments in times of crisis is reduced through the establishment of assertive and/or intensive outreach services in the community.
- The experience of children, families and carers when they attend emergency departments at times of crisis is improved, through adjustments to access processes and the environment.
- Rural and remote clinicians are supported by virtual care, improving access to services for children and families across country WA.
- Children, families and carers are proactively and appropriately supported during and after discharge from inpatient and crisis treatment.
- Health workers and other staff feel motivated and supported through strategies to increase the capacity, safety and stability of the workforce.

What are the next steps for Taskforce?

- Determine the priorities for staffing increases to bolster the current community service workforce in metropolitan, regional and remote locations so that it can better meet the immediate demands on services.
- Understand the model/s and funding required to establish an assertive outreach capability (as per the Chief Psychiatrist's recommendations).
- Determine how a sustainable telehealth capability can support WACHS to support local access to regionally based specialist ICA mental health services. An example of this would be the current e-Children and Youth Mental Health Service in Queensland.
- Identify key enhancements to existing emergency departments and other infrastructure to improve their short-term suitability for infants, children and adolescents in crisis.

Emerging Direction 2: Transform community-based services to ensure children, families and carers are supported in their own communities; when, where and how they need it

Why does this matter?

Gaps in public community-based services have contributed to more children, families and carers struggling to access the care they need in the community leading to more children attending emergency departments in a crisis than ten years ago. In addition to an immediate boost to current services outlined in Emerging Direction 1, more enduring solutions are required to improve what and how services are provided.

"We need to keep children, families and carers closer to home and out of hospital."

WA does not provide dedicated community services that specialise in infant mental health treatment; there is no facility to support children who do not need to be admitted to hospital but are too unwell to stay at home; there is limited support post-discharge; the scale of perinatal mental health services across the state is limited, and, there are no community-based alternatives to emergency departments for when a young child and their family is in crisis.

Further, children, families, carers and staff have reported issues with existing models of care for regional and metropolitan community-based services. This includes how long it takes to receive care, the duration of care, the operating hours of services, the locations where services are provided, and the extent to which care is coordinated across the system. Current models of care do not adequately reflect the needs of children and families, particularly the most vulnerable.

"The waitlists can be huge, and you don't know how long it will be until someone can see you."

This indicates that there are insufficient public infant, child and adolescent mental health services in the community and those that are established, have not sufficiently adapted to emerging needs and best practices. Change is needed to ensure they are best practice, evidence based and deliver the highest quality of care for all children across WA.

What future outcomes have we heard are needed?

Taskforce has heard that community-based services need to be transformed to ensure children, families and carers can access the support they need closer to home, and to reduce unnecessary presentations to emergency departments. New capabilities, processes, facilities and models of care are needed.

"For children in crisis, there are few options other than the ED. There needs to be investment to enable children in crisis to be managed in the community."

Future outcomes that have been identified by Taskforce for further consideration include:

- Mothers, fathers, families, babies and children under 12 have access to community-based services that specialise in the mental health and development of infants and children under the age of 12.
- Children, families and carers are able to access care that fits in with their lives, including accessing services after-hours, at home, in the community, in schools, and through telephone or virtual platforms.
- The care of children, families and carers is not inhibited by extended periods of being on a waitlist, and the duration of care is not shortened due to limited service capacity.
- Children, families and carers have access to community-based care that reduces the time they need to be in hospital and promotes recovery in the community.
- Children, families and carers have access to child-friendly, trauma-sensitive care in times of crisis, provided in the community as alternative to the emergency department.
- The mental health needs of children, families and carers are identified and supported earlier in life and earlier during the onset of mental health issues.

What are the next steps for Taskforce?

- Assess the scale and nature of future demand for metropolitan and regional community-based services.
- Identify good practice approaches used in other states and countries that might be appropriate in informing how WA can best meet the needs of children and families.
- Identify what new services or enhancements to existing services could to be introduced in WA to address current gaps, and identify how those services will work in practice.

Emerging Direction 3: Design and implement flexible services that deliver the best outcomes for rural, regional and remote communities, including Aboriginal communities

Why does this matter?

Children, families and carers in regional WA have significant issues accessing the same types of services that are available in Perth – particularly if they live in remote communities

"Some of our most vulnerable kids are even more vulnerable in regional WA."

In some rural and remote communities, there are limited health services available to children, families and carers, including no local GP or private services. While there has been investment in virtual care services supported by telehealth, which are often excellent, they are primarily staffed by general clinicians who do not specialise in child health and mental health. Further, some locations have limited connectivity, restricting the reach of telehealth. These challenges are particularly acute in Aboriginal communities, including in remote areas.

"In some places, the only service provider in town is the Police – these are often the places where children are most vulnerable."

The needs of children, families and carers differ from community to community, and region to region. For example, children, families and carers in the Great Southern have different needs to children, families and carers in the Kimberley. Further, the needs and strengths of Aboriginal communities vary, requiring tailored, Aboriginal-led models of care, which are reflective of the capabilities and needs of Aboriginal children, families and communities. Therefore, services need to be sufficiently flexible in regional, rural, remote and other communities to meet the unique needs of the children and families they serve.

What future outcomes have we heard are needed?

Children, families, carers clinicians and service providers have emphasised the need to improve the accessibility and suitability of services to regional and remote communities, while also designing and implementing flexible models of care that respond to the needs of children, families and carers in these areas.

"The services we are providing in WACHS CAMHS do not actually respond to the needs of a large population here. There is urgency to act."

Future outcomes that have been identified by Taskforce for further consideration include:

- Service delivery in regional and remote communities is place-based: reflecting the needs and circumstances of children, families and carers in those areas.
- Children, families and carers in regional and remote communities understand what services are available locally and in other parts of WA, and how they can access them when needed.
- Children, families and carers in regional and remote communities can access the care they require where they live, minimising the need to travel long distances from their communities and support networks.
- Children, families and carers in regional and remote communities have equitable access to specialised services, even if they have to be based in Perth.
- Health workers in regional WA, particularly in remote areas, have better access to the specialist clinical expertise they need to serve children, families and carers in their communities.

What are the next steps for Taskforce?

- Assess the scale and nature of need in regional WA and how this differs between regions and in comparison, with Perth.
- Consult with children, families, carers, clinicians and service providers in regional WA for their guidance on how services can best meet their needs.
- Identify how existing services, including those based in Perth, could be adapted and which new services could be developed to better meet the needs of regional and remote children.

Emerging Direction 4: Improve and extend services for children with specific, complex and co-occurring needs across all communities

Why does this matter?

The needs of children with distinctive life circumstances and experiences, and those with specific diagnoses or symptoms, cannot always be adequately met by general community or hospital-based services. However, current 'specialised' services – those that are intended to meet specific needs – are not sufficient to support all children across WA.

"Some young people have unique needs that cannot be met by mainstream services."

Some children have specific clinical and therapeutic needs, associated with their life circumstances and experiences. This includes children with disability, children in contact with the child protection system, children in contact with the justice system, children experiencing homelessness, and Aboriginal children. The needs of these children are not being adequately met by community mental health services. In some cases, these are excluded from services due to restrictive eligibility criteria.

"It's not just about specialised services – it's about the ability of all services to work together to meet unique needs."

Additionally, there are children with specific diagnoses or symptoms who may require specialised treatment approaches. This includes children with eating disorders, gender diversity, neurodevelopmental disorders, personality disorders and other complexities, including co-morbidities. The prevalence of some of these specific diagnoses or symptoms has increased over time; however, this has not been matched by an increase in the scale or adaptation to the models of, typically Perth-based, specialised services or general community-based services. For children with neurodevelopmental disorders there are no public specialised mental health services to address developmental and mental health needs and they report being turned away from community based services.

What future outcomes have we heard are needed?

Stakeholders have consistently identified that specialised services are required for children with specific therapeutic needs. They would like to see greater and more equitable access to existing specialised services, including in regional communities, and the development of new services to address unmet need.

"There's been a rise in the number of young people with eating disorders, but services have not kept up."

Future outcomes that have been identified by Taskforce for further consideration include:

- Children, families and carers experience specialised and generalised community-based services as coordinated and seamless.
- The needs of children, families and carers with unique, complex and co-occurring needs are met.
- Children at risk, including those in contact with child protection and justice services, who experience mental health issues have the same access to services as all children in WA.
- Aboriginal children are supported by culturally safe services that are designed to meet their specific needs and reflect community strengths.
- Children experiencing homelessness or at risk of homelessness who have mental health issues are supported to avoid homelessness and access secure accommodation.
- Children with mental health issues and a disability, including those with neurodevelopmental diagnoses, are supported through joined-up care, including assessment and treatment.
- Clinicians have the knowledge, skills and confidence to respond to the unique, complex and co-occurring needs of children with mental health issues.

What are the next steps for Taskforce?

- Identify emerging good practice approaches associated with priority specialised needs including the role of community-based services and their integration with specialised services.
- Assess the scale and nature of future demand for specialised services, based on available prevalence and activity data, and considering the resource intensity of specialised care.
- Consult with children, families and carers with complex needs for guidance on priorities and opportunities to deliver better experiences and outcomes.

Emerging Direction 5: Ensure that all services are culturally-responsive and inclusive for all children, families and carers, and their communities

Why does this matter?

Maximising the cultural and social safety of children, families and carers is critical to their wellbeing, engagement in services and its outcomes.

Some children, families and carers have poor experiences with services, reporting feeling a lack of understanding, and feeling misunderstood, disempowered, disrespected, and judged. In particular, some services are not sufficiently equipped to meet the needs of children and families from vulnerable, marginalised and/or diverse groups, despite the fact that these children and families experience higher rates of mental health issues.

"I was told by the hospital that I will never be considered as a man. For a transgender teenager to hear that was frightening."

"People need to see their diversity reflected in the doctors, nurses, counsellors and others that help them."

This includes Aboriginal children and families, children and families from culturally and linguistically diverse (CaLD) backgrounds, and LGBTQIA+ children, families and carers, who can face unique barriers to seeking help. Some children, families and carers have stopped seeking help altogether for their mental health until they are in crisis; in other cases, especially Aboriginal children, there is a greater reliance on attending emergency departments as their first resort.

What future outcomes have we heard are needed?

Children, families, clinicians and services providers have stressed the importance of services being safe and inclusive for all children, families and carers, particularly for those from diverse and vulnerable groups. Services need to be better configured to meet the needs of Aboriginal, CALD and LGBTQIA+ children, families and carers.

"If services aren't safe and welcoming, young people aren't going to go."

Future outcomes that have been identified by Taskforce for further consideration include:

- All children, families and carers are treated with compassion and respect by services, without discrimination or prejudice.
- Children and families have an ongoing and strong voice in the design, delivery, monitoring and evaluation of services, in order to improve their experience and outcomes.
- All staff have the capability required to work effectively with children, families and carers from diverse backgrounds, including those that work in services outside of child and adolescent mental health.
- Staff are representative of the diversity of children, families and carers accessing services in their community.
- The cultural safety of all children, families and carers is maximised through enhanced skills, knowledge, and governance across the public mental health system.

What are the next steps for Taskforce?

- Consult with children, families and carers from vulnerable groups for guidance on how the future system can best meet their needs.
- Identify good practice approaches to improve the accessibility and outcomes of services for children from diverse backgrounds, including equitable access for children and families in rural and remote WA.
- Determine whether it is better to enhance existing services or establish new services to best support children, families and carers from these groups.

Emerging Direction 6: Integrate mental health services so that all children, families and carers are supported to access services that holistically meet their needs

Why does this matter?

There is no organised infant, child and adolescent mental health system in WA. For children, families and carers, the system is experienced as a series of disconnected services that have evolved over time, with no clear pathways and with complex eligibility criteria that appear to children and families to be focused on excluding access to the service.

"I didn't know where to go for help – I ended up being pushed from one service to another."

Services tend to operate in silos, with no common mechanism to bring them together. As a result, children, families and carers struggle to understand and navigate between services, including those that are Commonwealth and state funded. Some children report that they are handballed through services, being referred from one to another then back again. As a result, many children, families and carers feel that there is little continuity in their care.

"Once you turn 18 – it changes. But not everyone is ready for adult services."

Further, many children, families and carers have negative experiences of transitioning from child to youth or adult services. There is a lack of flexibility around how and when these transitions can occur, with insufficient consideration of the unique needs of the individual. As a result, transitions from child to youth or adult services can be abrupt and, poorly coordinated and can take place before some children are ready or without appropriate transition arrangements.

What future outcomes have we heard are needed?

Children, families, clinicians and service providers have identified that integrating mental health services is a key priority for improving their access, experience and outcomes.

Future outcomes that have been identified by Taskforce for further consideration include:

- It is easier for children, families and carers to find and access the right services and supports, based on their needs and circumstances.
- All children, families and carers experience care which is continuous, including between primary care, community-based care, specialised care, inpatient care, crisis care and psychosocial support.
- Transitions between services, including from child to youth or adult services, are coordinated, well-timed and supported by appropriate referral pathways.
- Children, families and carers, and the clinicians that support them, have easy access to medical records and other information, throughout the system to enhance the continuity and impact of care.

> ***"The transitions from children to youth or adult services are really hard. They can be really jarring. Sometimes, the young person is not ready to move to an adult service, but there's no choice."***

What are the next steps for Taskforce?

- Complete mapping the current infant, child and adolescent mental health system, specifically identifying how services interact with one another.
- Identify good practice approaches to service integration and transition pathways that improve the experience and outcomes for children, families and carers.
- Consult with service providers to identify barriers to service integration, and potential solutions to these barriers.

Emerging Direction 7: Utilise multi-sector partnerships with other national, state and non-government services to better support children, families and carers

Why does this matter?

Children, families and carers often require a broad range of support from services outside of the public mental health system. However, more often than not, children, families and carers experience little or no coordination between the various services.

Many children, families and carers that require mental health care also need health, psychosocial and other care provided by community, public and private agencies, including general practitioners. A lack of connection and coordination across various services impacts their experiences and outcomes. It also impacts service efficiency and broader sustainability objectives.

"We keep having to tell our story from service to service, from system to system – everything operates in a silo. We have to live the bureaucracy of these organisations."

"It's not just about the public system – we have to bring everything closer together, around the lives and needs of the child."

With many factors influencing the mental health and wellbeing of our children, there are opportunities to work in partnership with other services and government agencies to address the underlying causes and social determinants of mental health. Infant, child and adolescent mental health services need to more connected with other services so that more holistic support can be provided to improve the wellbeing of our children.

What future outcomes have we heard are needed?

Children, families, carers, clinicians and service providers, in addition to policymakers and others, have advocated for forming partnerships across systems to enable services to wrap-around children, families and carers.

"Integrated partnerships across systems will allow people to access services without being bounced around or waiting lengthy amounts of time and becoming severely unwell."

Future outcomes that have been identified by Taskforce for further consideration include:

- Children, families and carers experience coordinated, consistent and effective care when supported by multiple services.
- The incidence and severity of children's mental health issues is reduced, by addressing the social determinants of mental health as part of broader whole-of-government initiatives.
- There is greater alignment between state-funded mental health services and Commonwealth-funded services; and a greater impact of the collective funding across all governments.
- Other services, such as schools, are supported so that they better understand and identify the signs of emerging mental ill health, and can more easily work with mental health services to assess and support children that have ongoing mental health issues.

What are the next steps for Taskforce?

- Assess the scale and nature of children with mental ill health that come into contact with multiple service systems, including education, justice and child protection services.
- Identify barriers to shared care and emerging good practices and models of care for multi-agency support to children.
- Consult with system leaders across the WA Government for guidance on the emerging directions contained in this report to identify future opportunities for whole-of-government initiatives.
- Identify and assess opportunities for collaboration with Primary Health Networks and other Commonwealth initiatives that could address issues to do with the connection between mental health services and other services that support the wellbeing of children.
- Investigate opportunities for WA to jointly progress key initiatives for children, families and carers as part of the negotiations on the National Partnership Agreement on Mental Health.

Emerging Direction 8: Invest in a skilled, diverse and supported workforce

Why does this matter?

The capacity and capabilityof the current workforce is not sufficient to meet current or future needs. Strategies to strengthen the scale, skills and sustainability of the workforce are needed.

"Even if we have the funding, we can't magically find enough workers with the skills we need."

The size and profile of the workforce across all professional disciplines does not currently align with the scale of need for infants, child and adolescent mental health. As models of care evolve, the profile, skills and scale of the workforce will need to adapt. Clinicians and other health and mental health workers are in high demand and training pathways are in short supply.

"We know it's been really hard for many mental health workers – it's really hard work, with limited resources."

Building and maintaining the supply and capability of this workforce takes time. This requires long-term planning and investment. Further, the current workforce is under significant stress and in some cases, health workers are experiencing distress. This impacts the wellbeing, professional development and retention of key clinical and non-clinical staff in a very competitive employment market.

What future outcomes have we heard are needed?

Stakeholders have described a future workforce that needs to be skilled, supported and sustainable to better meet the needs of children, families and carers. Long-term planning is required to build and maintain the workforce.

Future outcomes that have been identified by Taskforce for further consideration include:

- There is a sustainable pool of an appropriately skilled workers to meet the future demands on infant, child and adolescent mental health services.
- Children, families and carers are served by a workforce that understands their needs and the care required to support them.
- Peer workers have a clear and valued role throughout the system as part of multidisciplinary models of care.
- Staff feel safe, supported and connected across the public mental health system, with clear pathways for assistance and development.
- Individuals from diverse backgrounds and/or with lived experience have greater opportunities to thrive in the infant, child and adolescent mental health workforce.
- Health workers that seek specialised capacities can access training and other opportunities to extend their ability to meet the needs of children, families and carers.

> ***"The safety and wellbeing of our workforce is connected to the safety and wellbeing of children and families – we know it has been hard for them."***

What are the next steps for Taskforce?

- Accurately map the scale, profile and distribution of the current workforce, guided by future models of care, and identify immediate gaps in workforce capacity.
- Determine the medium- and long-term workforce requirements to deliver the services, guided by population, prevalence, and other data and estimate associated funding implications.

Emerging Direction 9: Strengthen the planning, infrastructure, leadership, governance and accountability to achieve sustainable and ongoing improvement

Why does this matter?

The current system has been unable to meet demand due to sustained underinvestment and the lack of a unified infant, child and adolescent mental health system.

Infant, child and adolescent mental health services do not operate under a unifying system. Services are provided by a number of health service providers and do not have distinct governance structures and processes that support system wide system thinking and planning. Further, in some instances, resources, infrastructure, tools and systems are based on what works in the adult mental health system.

"We have to make sure this doesn't happen again – we need an insurance policy against future crises."

"The governance is not in place to provide consistent, expert and joined-up oversight."

In order to deliver future change and ensure the performance and sustainability of the infant, child and adolescent mental health system, a number of foundations have been identified. They include:

- There needs to be coordinated stewardship of the infant, child and adolescent mental health system, which bridges health entities and adjacent agencies and is supported by clinical and lived expertise.
- The infrastructure, facilities and systems will require investment to ensure they are suitable to meet the needs of children, families and carers.
- Mechanisms for planning and governance need to be strengthened to ensure the necessary capacity, capability and performance of the system, supported by lived and clinical expertise.

What future outcomes have we heard are needed?

There is a need for more integrated planning between health system managers and funders to drive a more sustainable model of care across the infant, child and adolescent mental health system.

Future outcomes that have been identified by Taskforce for further consideration include:

- The system is sustainably resourced, including appropriate infrastructure and systems, to meet future needs of children, families and carers by linking growth to changing needs.
- System leaders regularly work together to drive the performance and improvement across infant, child and adolescent mental health services.
- Data is shared across the system to support monitoring, informs service delivery, and identify priorities to improve performance.
- There is greater clarity and accountability for an agreed set of performance measures that reflect both physical and mental health needs of children.
- There is strong mental health expertise and lived experience representation within the system leadership and governance.
- Clinical leadership and the building of a system wide body of good practice is supported by appropriate clinical governance mechanisms.

"We need to make sure that the governance in place is sufficiently robust to ensure there is shared accountability across the system to achieve better outcomes."

What are the next steps for Taskforce?

- Finalise modelling and costings for a phased implementation plan for public specialist mental health services for infants, children and adolescents.
- Identify key short-, medium- and long-term indicators that can support the ongoing monitoring and evaluation of delivery.
- Develop indicative governance and oversight structures to ensure that funding dedicated to infant, child and adolescent mental health delivers outcomes.
- Develop a phased implementation plan to support the improvement, transformation, and sustainability of the systems (this is the primary objective of Taskforce).

Emerging Direction 10: Establish dedicated structures for research, learning and innovation that translate to improved outcomes

Why does this matter?

WA has unique needs and significant challenges which will require contemporary and innovative solutions.

There is little investment in research, learning and innovation within the public child and adolescent mental health system. Evidence and innovation are required to ensure that the system is fit-for-purpose for WA's children, families, carers and communities.

Information that shows the impact of current services is limited. Evidence is required to demonstrate the efficacy and efficiency of publicly provided services in WA.

"We need to drive continuous improvement to ensure we are providing the best possible care for our children."

"WA has to have its own knowledge base of effective models of care that are fit for WA's children."

There is little data available to support research and learning, both for clinicians within the systems and for potential research partners. There are bureaucratic and other barriers to using data which could support improvements in outcomes and efficiency.

What future outcomes have we heard are needed?

Children, families and carers want the evidence that the services they access are effective and world class. Clinicians and researchers need to be supported to continuously improve services.

"Research and learning is foundational – it needs to be in place from the start."

Future outcomes that have been identified by Taskforce for further consideration include:

- Children, families and carers are valued as a source of expertise.
- Children, families and carers are integrally involved in the design, development and evaluation of services and programs, to ensure they reflect their needs and experience.
- Models of care and service provision adapt to changing needs, practices and technologies, to ensure that outcomes for children, families and carers are optimised.
- All services are supported by clear mechanisms for monitoring, quality improvement, and learning, to support the translation to better outcomes.
- Researchers and services have increased access to data and expertise from across the system to support learning and service improvement.
- Aboriginal culture and knowledge are incorporated into learning and research.
- Clinical staff have improved opportunities to balance clinical and research responsibilities, in order to contribute to improved outcomes.

What are the next steps for Taskforce?

- Identify the capabilities that are required and barriers that need to be addressed to establish research and learning capabilities within the system.
- Determine how these capabilities can be established and sustained, including the potential costs.
- Better understand what helps the uptake of effective implementation and sustainability of change, to ensure the final vision and plan can be achieved.

Appendix 1 | Taskforce and Expert Advisory Group members

Members of Taskforce

Name	Name
Robyn Kruk AO (Chair)	Jennifer McGrath (Commissioner)
Aresh Anwar (CE CAHS)	Pradeep Rao (Clinical representative)
Georgia Anderson (Consumer representative)	Robina Redknap (Chief Nursing and Midwifery Officer)
Helen Milroy (Minister appointed)	Sophie Davison (Chief Medical Officer Mental Health)
Jeffrey Moffet (WACHS CE)	Wendy Cream (Family/Carer representative)

Members of the Clinical Expert Advisory Group

Name	Name
Andrew Leech - GP	Karla Cloke - Senior Clinical Psychologist
Antonia Momber – Consultant Child and Adolescent Psychiatrist	Katie Browning - Senior Occupational Therapist
Brad Jongeling – Developmental Paediatrician	Lisa Kickett - Aboriginal Mental Health Worker
Chelsea Catchpole – Staff Development Nurse	Lisa Miller - Consultant Liaison Psychiatrist
Chinar Goel – Consultant Youth Psychiatrist	Lynn Jones - Consultant Child and Adolescent Psychiatrist
Chris Gostelow – Chief Psychologist	Mark Porter – Programme Manager
Christina Foo – Senior Social Worker	Mathew Coleman - Consultant Child and Adolescent Psychiatrist
Claire Guild – Clinical Nurse Specialist	Mathew Reichard - Clinical Nurse Specialist
Corinne Hoebert – Team Leader	Michael Verheggen - Consultant Consultation Liaison Psychiatrist
Daniela Vecchio – Consultant Psychiatrist	Nadine Caunt - Psychiatrist Training Director
David Lawrence – Principle Research Fellow	Nathan Gibson – Chief Psychiatrist
Geoff Smith – Medical Director	Neal Ruane – Senior Health Professional (Mental Health)
Hayden Wilson – Consultant Psychiatrist	Roisin Maguire - Mental Health Professional (Nursing)
Ilona Law – Clinical Nurse Specialist	Sally Green - Senior Clinical Psychologist
Jacques Claassen – Forensic Consultant Psychiatrist	Shannon McNeair - Psychologist

Jennifer Brown – Senior Social Worker	Vernon Dann - Aboriginal Mental Health Worker
Jennifer Griffiths – Consultant Clinical Psychologist	Vineet Padmanabhan - Consultant Child and Adolescent Psychiatrist
Josie Ford – Aboriginal Mental Health Coordinator	Zamia Pedro -Clinical Psychologist

Members of the Interagency Expert Advisory Group

Name	Name
Andrew Beck (Department of Justice)	Kylie Maj (Department of Justice)
Arthur Papakotsias (Youth Focus)	Laura Allison (Catholic Education Commission of Western Australia)
Astrid Kalders (Department of Communities)	Linda Richardson (Mission Australia)
Carrie Clark (Kalparrin)	Lucy Ledger (Commissioner for Children and Young People)
Deborah Roberts (headspace 360)	Mark Burgess (Department of Communities)
Eamon Ryan (Inspector of Custodial Services)	Mark Slattery (Ruah)
Ellie Carr (Lifeline WA)	Mary Butterworth (Development Disability WA)
Emma Crampin (Office of the Chief Psychiatrist)	Mason Rothwell (Youth Advisory Council of Western Australia)
Ethan James (Western Australian Network of Alcohol and Other Drug Agencies)	Merissa Van Der Linden (The Association for Services to Torture and Trauma Survivors)
Helen Jackson (Next Step)	Paul Bailey (St John Ambulance WA)
Hunter Gurevich (TransFolk of WA)	Peta Hart (Yorgum)
Ian Anstee (Investing in our Youth)	Pushpa Siroley (Multicultural Futures)
Jacques Claassen (North Metropolitan Health Service)	Rowan Brooker (Freedom Centre)
Jaide Lancaster (Department of Justice)	Ruth Noonan (Department of Fire and Emergency Services)
Jared Collins (Department of Communities)	Sandra Miller (East Metropolitan Health Service)
Jennie Burns (Life Without Barriers)	Sarah Pollock (Mental Health Advocacy Service)
Jill Rundle (Western Australian Network of Alcohol and Other Drug Agencies)	Sue Budalich (NGALA)
Jim Bell (Department of Education)	Tarryn Harvey (Western Australian Association for Mental Health)
Jo McCabe (Western Australian Police Force)	Toni Tomlin (Association of Independent Schools WA)
Joan McKenna Kerr (Autism WA)	Tony Fotios **(**Western Australian Primary Health Alliance**)**

Jon Pfaff (Western Australian Primary Health Alliance)	Tony Pietropiccolo (Centrecare)
Kate Taylor (Western Australian Police Force)	Tracey Young (Mental Health Advisory Council)
Kristen Orazi (Aboriginal Health Council of Western Australia)	Wai Chen (South Metropolitan Health Service)

Members of the Lived Experience Expert Advisory Group

Name	Name
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 who wishes to remain unnamed

Appendix 2 | Glossary of terms

Term	Definition
Adolescents	Individuals aged 12-to-15-years-old
CAHS	Child and Adolescent Health Service
CaLD	Cultural and linguistically diverse
CAMHS	Child and Adolescent Mental Health Services
Children	Individuals aged 5-to-11-years-old
Co-morbidity	The occurrence of more than one disorder at the same time
EMHS	East Metropolitan Health Service
Incidence	The rate of occurrence of a specific characteristic
Infants	Individuals aged 0-to-4-years-old
Inpatient service	A service where patients are formally admitted to a hospital
In-reach service	A service that mobilises health workers to provide services to facilities (e.g., schools), away from the location they are usually based
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, and asexual
NMHS	North Metropolitan Health Service
Outpatient service	A service where patients received medical treatment without being admitted into a hospital
Outreach service	A service that mobilises health workers to provide services to a population, away from the location they are usually based
Perinatal	The period commencing at 22 weeks of gestation and ends seven completed days after birth
Prevalence	The proportion of a population who have a specific characteristic at a given time
Primary Care	The first point of contact people have with the health system when they have a health problem or issue that is not an emergency
Referral acceptance rate	The number of referrals admitted as a service, represented as a percentage of total referrals
SMHS	South Metropolitan Health Service
Step down service	A service that provides short term residential support for people following discharged from hospital
Step up service	A service that provides short term residential care for those people in the community to avoid a possible hospitalisation.
WACHS	WA Country Health Services

GOVERNMENT OF
WESTERN AUSTRALIA

GPO Box X2299, Perth
Business Centre WA 6847

Level 1, 1 Nash Street
Perth WA 6000

T (08) 6553 0600