GOVERNMENT OF
WESTERN AUSTRALIA

Infant, Child, and Adolescent (ICA) Taskforce Implementation Program

Community Infant Child and Adolescent Mental Health Services (ICAMHS): A Model of Care

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1 Introduction

This document will guide the delivery of a new model of community mental health services for children, families and carers – known as Community Infant, Child, and Adolescent Mental Health Services (Community ICAMHS). Operated by Child and Adolescent Health Services (CAHS) in Perth and WA Country Health Services (WACHS) in country areas, Community ICAMHS will provide local, consistent and integrated mental health care for children aged 0-17 years old with mental health difficulties through a hub-and-spoke model that ensures access across the Western Australian community. Community ICAMHS will also work with and complement local services to deliver care to children within the community, and collaborate with specialist services, when required.

Community ICAMHS is the central point of contact for all children, families and carers requiring mental health support, and the most critical service of the future infant, child and adolescent (ICA) mental health system. That is, children will receive the majority, if not all, of their care through Community ICAMHS – from access through to transition. Throughout their childhood, Community ICAMHS will remain a constant, adapting in mode and intensity to the need of the child. Community ICAMHS will also support children with more complex needs to access specialist expertise that will be embedded locally, and access support from a range of statewide specialised services where required.

Community ICAMHS will be made up from the current CAHS and WACHS Child and Adolescent Mental Health Services (CAMHS) teams, which are located in all regions of Western Australia (WA), extending their coverage and scope of care for all ages of children. These existing services will be re-organised into local ‘networks’, which will include a central ‘hub’ in each region, and a network of local services and clinics or ‘spokes’ providing place-based, consistent care in their respective catchment areas or communities. This will enable Community ICAMHS to ensure that care is provided closer to home, including supporting the capability of other organisations that care for children in other settings, including primary health care, community services, justice and other major services.

What is a model of care?

A ‘model of care’ broadly defines the way a specific health service is delivered. It outlines care and services for a person, population group or patient cohort as they progress through the stages of a condition or event.

This Model of Care has been developed by people with living and/or lived experience of mental health issues, clinicians and system leaders

The Final Report of the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years (the ICA Taskforce) articulated a vision for the future ICA mental health system, which had Community ICAMHS at its centre. The ICA Taskforce outlined what it saw as the essential functions of the Community ICAMHS Model of Care to address the challenges identified by children, families and carers with living and/or lived experience of mental health issues, clinicians, system leaders and the broader WA community. This included: a consultation liaison and shared care function to improve the capacity of primary mental health services to support children with mental ill-health; enhanced capacity to support children with complex, co-occurring and specialised needs; a continuous, flexible and recovery-oriented approach to care; and a single point of entry for all children, families and carers.

Based on these key functions, this Model of Care was developed through the establishment of a Working Group that was responsible for designing the key features of the Community ICAMHS Model of Care, with support from relevant good practice models in other jurisdictions and a review of existing capabilities in CAMHS resources across WA. The Working Group provided a forum for people with knowledge and experiences of ICA mental health services to share their expertise to inform the design and development of this Model of Care, with a broad range of voices including clinicians, children, families and carers with lived and/or living experience of mental health issues, and other system leaders. To ensure a broad reach, a survey was subsequently designed and shared with a broader cross-section of stakeholders across the ICA public mental health system.

Service Guarantee, and ICA Culturally Safe Care Principles underpin this Model of Care

A Service Guarantee has been developed to outline what children, families and carers should expect to experience in their interactions with the ICA mental health system. The Service Guarantee has eight principles, outlined in Figure 1. These principles apply to all ICA mental health services and are intended to guide how all Models of Care, including the Community ICAMHS Model of Care, are implemented. Alongside the Service Guarantee, ICA Culturally Safe Care Principles have been developed to guide and enable the delivery of culturally safe and appropriate care to Aboriginal and Torres Strait Islander children, families and carers across all ICA mental health services, including this Model of Care. Figure 2 provides a summary of the ICA Culturally Safe Care Principles.

Figure 1 | Service Guarantee principles

Figure 2 | ICA Culturally Safe Principles

1	**Spiritual:** *We respect you, your connection to inner-self and your culture.*
2	**Accessible:** *Your journey of healing begins now.*
3	**Responsive:** *You are precious and your time matters.*
4	**Trauma-informed:** *Let us better understand the journey walked to now.*
5	**Wrap-around:** *Let us walk this journey side by side.*
6	**Empowering:** *Your story, your health – you are the driver.*
7	**Connected to the community:** *Your relationships and place in the community matter to us.*

ICA CULTURALLY SAFE CARE PRINCIPLES

Child, family, carer

SOCIAL AND EMOTIONAL WELLBEING DOMAINS

1	**Connection to community:** *Opportunities for individuals and families to connect, support each other and work together.*
2	**Connection to mind and emotions:** *The ability to manage thoughts and feelings.*
3	**Connection to body:** *Feeling physically strong and healthy and able to physically participate as fully as possible in life.*
4	**Connection to family and kinship:** *Connections to family and kinship systems are central to the functioning of Aboriginal and Torres Strait Islander societies.*
5	**Connection to culture:** *Connection to a culture provides a sense of continuity with the past and helps underpin a strong identity.*
6	**Connection to Country:** *Connection to Country helps underpin identity and belonging.*
7	**Connection to spirit, spirituality and ancestors:** *Spirituality provides a sense of purpose and meaning.*

Purpose of this document

The purpose of this document is to describe the Community ICAMHS Model of Care and how mental health care will be delivered across the ICA mental health system in WA to ensure care is accessible, high-quality and integrated across various services. This document is not intended to define specific approaches, provide clinical advice, or outline specific workforce, infrastructure or other resource requirements. Further, it is not intended to provide guidance for specific regions, districts or communities. Rather, for these communities, this Model of Care provides an overarching framework to create consistency, while also allowing scope and flexibility for care to be adapted to the local context and needs.

A note on language and terminology

The intention of this document has been to use language that is clear and inclusive. However, it is recognised that there is not always consensus around the language associated with infant, child and adolescent mental health. For this Model of Care, the term children, family and carers has been used and is inclusive of all children, family, carers, supporters and community members. Section 6 contains a list of the key terminology used within this document.

The term ‘Aboriginal peoples’ has been used throughout the document and is intended to refer to all Aboriginal and Torres Strait Islander peoples.

2 Background: Case for change

2.1 Why does change need to happen?

Mental health continues to be a critical challenge for WA children and families, with increasingly complex issues and needs

Mental health is arguably the biggest challenge facing children, families and carers across WA; with approximately 14 per cent of children experiencing mental health issues of some form. While demand increased across all aspects of the system, the complexity of conditions has also risen. Services are seeing greater numbers of children with challenging family circumstances, and are often more complex to assess, treat and support than in the past. This is largely due to an overall increase in the severity of mental ill-health – which means there is less capacity to support 0-17 year olds with less severe mental ill-health issues. There is also increased complexity of external factors facing children; including trauma, domestic violence, neglect, poverty and homelessness – requiring other agencies being involved to support the child.

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

Community ICA mental health services are increasingly hard to access, and vulnerable groups of children are missing out from receiving equitable care

Rising demand that has exceeded funding increases particularly impacts community treatment services. Acceptance into a community treatment service is based upon assessment of a referred child against eligibility criteria for the service. The number of referrals to community treatment services has increased by 112 per cent over the last ten years, meaning that services are having to prioritise those with the greater severity of need and risk, with only one in five referrals accepted in 2020. As a result, there are growing numbers of children, families and carers waiting to access the care they need. The impact on children is that they feel that they are being ‘rejected’ from care. They have been told they are too unwell to be supported by their GP (or a service such as headspace) only to be then told by specialist services that they are ‘not unwell enough’ or their needs are ‘too complex’. Often this happens after months of waiting for treatment they have been told they need. This challenge disproportionately impacts younger

children; vulnerable children across WA, including regional and remote families; Aboriginal and Torres Strait Islander children; children from ethnoculturally and linguistically diverse (ELD) backgrounds; LGBTQIA+ children; children with neurodevelopmental conditions; children in care; and children in contact with the justice system. Further, the ICA public mental health system does not effectively meet the needs of children with complex, co-occurring or specialised needs, as specialised capabilities are insufficient and statewide services are increasingly difficult to access.

Children are falling through the gaps, as primary care, community and specialised services are not sufficiently connected

For children, families and carers, the system is experienced as a series of disconnected services, with no clear pathways and complex eligibility criteria that appear to be focused on exclusion, rather than inclusion. Services tend to operate in siloes, with no common mechanism to bring them together. As a result, children, families and carers struggle to understand and navigate services, with some children 'cycling' through services, being referred from one to another. 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, without sufficient consideration of the unique needs of the individual. As a result, transitions from child to youth or adult services can be abrupt, poorly coordinated and take place before some children are ready or without appropriate transition arrangements.

2.2 What needs to happen?

Increase the capacity of metropolitan and regional community ICA mental health services to meet the needs of children, families and carers

On the whole, the ICA public mental health system needs to operate at greater capacity (i.e. scale) and capability, including the ability to provide specialist support via consultation liaison and shared care so that more children who require it have access to metropolitan and regional community services, specialised services and inpatient services. In doing so, staff feel motivated and supported through strategies to increase the capacity, safety and stability of the workforce. Further, building the capability of local community mental health supports (including primary care settings) requires the establishment of assertive and intensive outreach services in the community that reduce the number of children attending emergency departments (EDs) in times of crisis, as well as dedicated support from ICA mental health services to contribute to the capability building of primary care providers, and other community mental health services in responding to the needs of children, families and carers.

Transform community-based services and models of care to ensure children, families and carers are supported in their own communities

Community-based services need to be transformed to ensure children, families and carers can access the care that fits in with their lives, including accessing services after-hours, at home, in the community and through telephone or virtual platforms. Further, children, families and carers

need to have access to community-based care that reduces the time they need to be in hospital and promotes community-based rehabilitation and recovery. To achieve this, the needs of children, families and carers should be identified and supported earlier in life and earlier during the onset of mental health issues, with access to specialised capabilities in the community that will be embedded at a regional level.

Integrate mental health services so that all children, families and carers are supported to access services that meet their needs

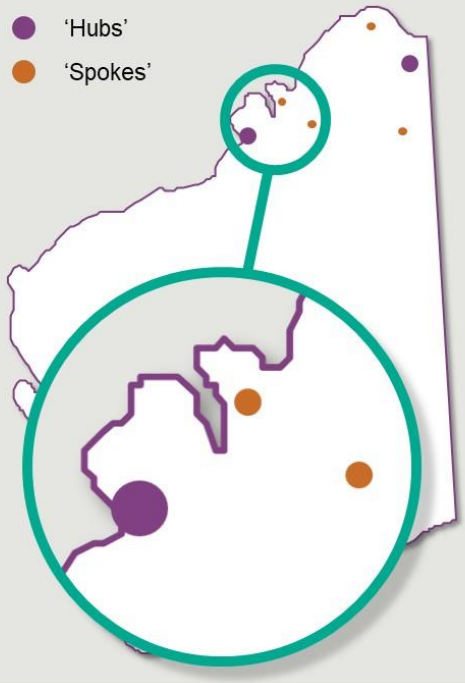
Children, family, clinicians and service providers have identified the integration of mental health services as a key priority to improving their access, experience and outcomes. By establishing a 'single front door' that brings together disparate services and supports into a coordinated system, it is easier for children, families and carers to find and access the right services and supports independently or through any service provider within the system. This means that all children, families and carers experience care which is continuous and reflects their needs and circumstances, including primary care, community-based care, specialised care, inpatient care, crisis care and psychosocial support. Consequently, transitions between services, including from child to youth or adult services, are coordinated and well-timed, supported by appropriate referral pathways to ensure the child continues to receive care that best meets their needs.

3 Overview of the Community ICAMHS Model of Care

3.1 What is the Community ICAMHS Model of Care?

Community ICAMHS are a re-imagined version of the current Community CAMHS services – delivered by CAHS and WACHS, to provide local, consistent and integrated care across the state. Community ICAMHS will be at the centre of the future ICA mental health system, acting as a single point of entry to support children, families and carers to maximise access, equity and continuity of care. Across WA, each region will have area-based networks – where all regions will have at least one central 'hub' to lead the provision of mental health supports and be a single point of entry for all children, families and carers. Each hub will coordinate across a small number of local clinics ('spokes') that can deliver care close to home.

Figure 3 | Community ICAMHS will be organised into area-based networks of hubs and spokes[1]



Community ICAMHS will be delivered by re-organising all current child and adolescent mental health services into **area-based 'networks'**.

Each region will have area-based networks, with at least one **'hub'**, a central access point that can provide a broad range of mental health supports, including dedicated specialised capabilities embedded to improve access to supports for children with complex needs.

This hub will lead the provision of mental health care across that network, supported by a small number of local ICAMHS clinics, or **'spokes'**, ensuring they have the capacity to meet local needs.

Note – this diagram is to be used as an example only. It does not indicate confirmed locations of any given hub or spoke, as that will be determined through further planning.

[1] It will ultimately be a decision to be made locally by Health Service Providers as to the format of Hubs and Spokes within each region, to ensure the best support can be provided to children, families and carers.

As per the recommendation of ICA Taskforce, all Community ICAMHS Hubs will be connected system-wide through joint oversight, monitoring and planning by both CAHS and WACHS to foster coherence and equity of service across all networks, thereby ensuring sustainable levels and quality of service for all WA communities.

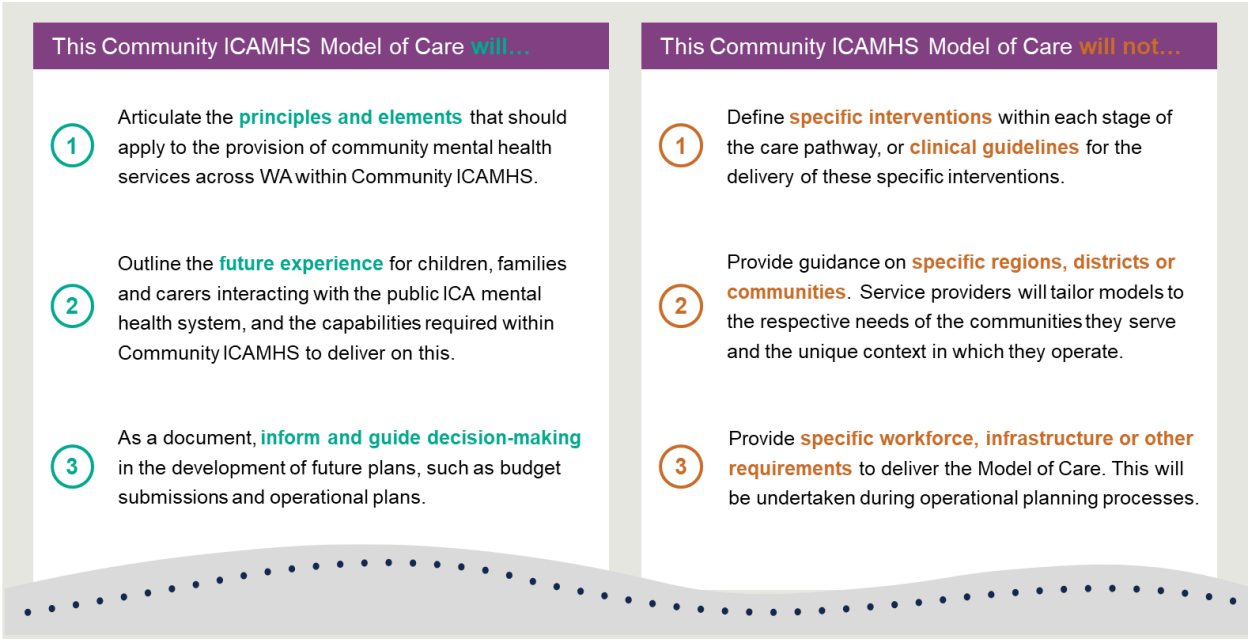
Community ICAMHS will provide comprehensive, community based mental health support, including assertive outreach, assessment, treatment, psychotherapy, psychoeducation, case work, and other support for children, their families and carers. This includes providing care through home visits and in reach to other services. Community ICAMHS will have increased capacity to support children with complex needs by embedding specialised capabilities within all 'hubs', with options for statewide specialised services to provide advice, support, or care in acute or highly complex cases, so that children can 'step up or down' based on the intensity of their needs. The care will be underpinned by a continuous, flexible, and recovery-oriented approach that would see children remain in the care of Community ICAMHS throughout their childhood, as long as is necessary.

Further, Community ICAMHS will be responsible for integration across the ICA mental health system and the broader landscape of services that support children, families and carers. This will involve each area-based network coordinating the care of children, families and carers in a way that supports access to local supports that meet their broader wellbeing needs, building the capability of services and organisations that support children in other settings to respond to and manage mental health needs, and facilitating seamless transitions into youth and adult settings.

Model of Care's purpose and objectives

The purpose of the Community ICAMHS Model of Care is to define the future delivery of ICA mental health care across WA. Given the broad nature of a Model of Care, Figure 4 below outlines the objectives and limitations of this Model of Care.

Figure 4 | Objectives and limitations of the Community ICAMHS Model of Care



3.2 Model of Care's outcomes

Community ICAMHS will seek to achieve a number of outcomes for children, families and carers, staff and the broader system.

Community ICAMHS will be at the centre of the future ICA public mental health system, and deliver a number of key outcomes to…	
 **Children, families and carers**	**A 'single front door' that guarantees equitable, timely access to care.** All children, families and carers will know where and how to access support in the ICA public mental health system, and feel empowered to seek further help when required. Community ICAMHS will act as a 'single front door' for all children, families and carers to access various levels of support through the ICA mental health system, ensuring that children will not be turned away in a time of need.
	Children and families receive continuity of care to promote a seamless journey. Community ICAMHS will coordinate the ongoing care of the child, family and carer to ensure they receive care as long as required, and that it feels like a 'seamless journey'. This means ongoing and clear communication, coordination with other services to meet their broader wellbeing needs, clear transitions and shared care options, and a 'tell your story once' approach.
	Services are safe, holistic and inclusive for all children, families and carers. Community ICAMHS will respond holistically and therapeutically to children so they feel safe, included and supported. This means services are culturally secure and trauma-informed, there are specialist capabilities to meet the needs of children who have historically struggled to access care, and there are options to connect to other services to support the broader wellbeing of the child. Family members and carers have increased agency, are actively involved in the child's care, and have also received supports for their own wellbeing.
	Children and families can receive flexible support when and how it suits them. Community ICAMHS will provide flexibility to deliver care in various settings, as well as flexible levels of intensity so that the child can 'step up' and 'step down' to access care in line with their needs.
 **Staff working in Community ICAMHS**	**A stable, supportive environment that supports recruitment and retention.** In a workforce-constrained system (particularly in the regions), a focus will be on providing the right conditions to support the recruitment, development and wellbeing of all staff.
	Clear workforce planning to support effective delivery and avoid further workforce constraints. Adopting a regional model underpinned by contemporary HR practices that support a more strategic approach to contracts, job availabilities and permanency.
	A multi-disciplinary team that are empowered by clear roles and responsibilities. Staff should know what their roles are, how they should work together, who they can access for specialist support and advice, and what services they can support the child to access for follow-up care.
 **The broader system and WA community**	**Stronger communication and partnerships between services and organisations.** Community ICAMHS will drive integration and coordination across the system, improving shared care between services, including public services, primary health care and Aboriginal community-led services. This will make it easier to work in partnership to meet the needs of children and their families or carers, including mechanisms to support schools, GPs and other community services.
	Reduced pressure on EDs and acute inpatient services. Community ICAMHS will re-orient the ICA public mental health system towards early identification and prevention, rather than treatment for acute illness. By expanding the capacity and capability of local community mental health services to address the social determinants of mental health, Community ICAMHS will play a critical role in providing a sufficient range of local community mental health supports and facilitate access to alternative settings that can prevent rising acuity of mental health issues in infants, children and adolescents.

4 Community ICAMHS Model of Care in practice

This section defines what the future Community ICAMHS will look like in practice, that is, what supports will be delivered to children, families and carers requiring mental health care across WA, and what their experience will 'look and feel' like.

4.1 Who is this Model of Care for?

As the 'single front door' to the ICA public mental health system, this Model of Care is for **all children from 0-17 years old** across WA with mental health difficulties, as well as their families and carers. This includes children who are experiencing a range of emotional, psychological, behavioural or other mental health challenges, and require more dedicated support than what is available in primary care settings. **As a result, access to Community ICAMHS is intended to be as broad and inclusive as possible, but limited to those who require more intensive supports that cannot be met by general mental health supports in their region.**

While not all children will need to access Community ICAMHS throughout their childhood, there should be flexibility in the intensity of supports available to meet the needs of children, families and carers, such that all children can access Community ICAMHS if required. It will achieve this by **providing a broad range of mental health supports, but also by working closely with existing primary and secondary services that are already providing mental health support.**

The target cohort of Community ICAMHS, those with mental health issues that require support beyond primary and secondary settings, encompasses a broad range of situations related to mental ill-health from the perspectives of children, family members and carers, and service providers. Therefore, 'children requiring access to Community ICAMHS' should be treated as a broad definition with various presentations, and is not confined to any particular cohort, situation, acuity level or timepoint. It is critical that this flexibility is communicated with all potential referrers.

Community ICAMHS will be at the centre of care for all children within the public ICA mental health system, and **increase access of children with complex needs to access specialist support through specialist capabilities being embedded in local Community ICAMHS Hubs**, as well as support from a range of statewide specialised services. Finally, this Model of

Care will support adolescents to transition to other settings such as youth or adult services, and build capability of organisations in other settings to respond to the needs of children with mental health issues.

Note, alcohol and other drug (AOD) use is not seen as exclusion criteria for this Model of Care, that is, these children will still be supported to access the mental health care they need, with supported access to AOD services where required.

Vulnerable cohorts and communities

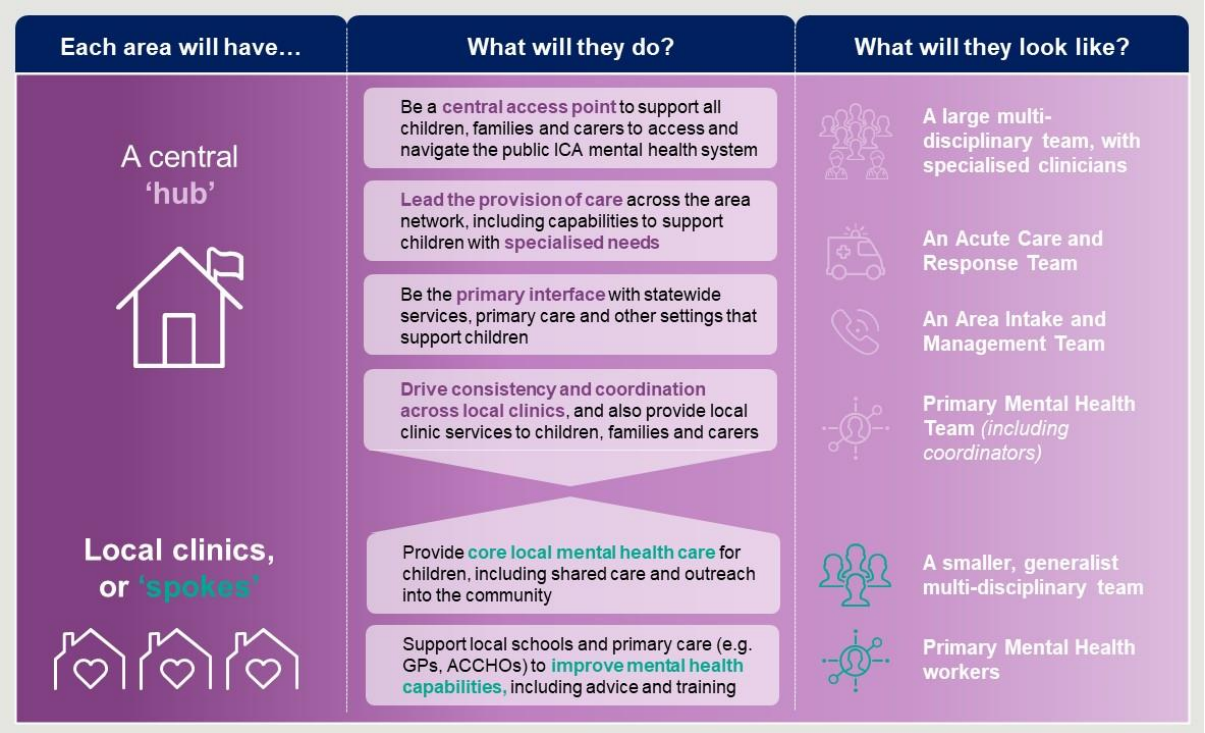
This Model of Care is particularly cognisant of the historical and disproportionate barriers to accessing appropriate mental health care for vulnerable children and families across WA. This includes: regional and remote families; Aboriginal and Torres Strait Islander children; children from ELD backgrounds; LGBTQIA+ children; children with neurodevelopmental conditions; children in care; and those in contact with the justice system.

4.2 Who will provide care to children, families and carers?

Area-based networks of Community ICAMHS teams

Community ICAMHS will be delivered by re-organising all current CAMHS teams into area-based ‘networks’. Each network has a central access point that can provide a broad range of mental health supports, including dedicated specialised capabilities embedded to improve access to supports for children with complex needs. This ‘hub’ will lead the provision of community mental health supports in that region. This regional hub will also be responsible for coordinating and driving consistency across a small number of local clinics, or ‘spokes’ and ensuring they have the capacity to meet local needs. Within Community ICAMHS, Figure 5 outlines the difference in key functions the central ‘hub’ and the local clinics that provide place-based care, or the ‘spokes’.

Figure 5 | Overview of how the 'hub and spoke' model will work for Community ICAMHS



There will be an integrated Community ICAMHS Hub in the Perth South, Perth North, and Perth East metropolitan regions, as well as hubs across regional WA. It will ultimately be a decision to be made locally by Health Service Providers (HSPs) as to the format of hubs and spokes within each region, to ensure the best support can be provided to children, families and carers.

Outward-facing functions to deliver care in partnership with other services

Furthermore, Community ICAMHS will be an 'outward-facing' service – that is, it will establish formal and informal partnerships both within and outside the ICA public mental health system – from acute services, EDs and statewide services, through to primary care, secondary services, schools and child protection settings. This will involve fostering local level coordination, multi-agency support, prevention initiatives and coordination of care across the public mental health system, facilitating care coordination and transitions. Some of the key relationships that Community ICAMHS will establish and build on include:

- **Specialised services within the ICA public mental health system.** Improving access to statewide specialised services for children with complex needs, including supporting children with eating disorders, complex trauma, early psychosis, personality disorder, neurodevelopmental and neuropsychiatric disorders, and intellectual disabilities.
- **Acute and crisis response services.** This includes close working relationships with local EDs to ensure continuity of care, as well as embedding Acute Care and Response Teams (ACRTs) in all Community ICAMHS Hubs to ensure children can receive crisis response care closer to home.

- **Primary care and local community services.** Community ICAMHS will work with local GPs, non-government organisations (NGOs) and other community-based health and mental health services (including Aboriginal Community Controlled Health Organisation (ACCHOs)) to improve the capacity of primary and secondary health services to respond to and better support the needs of children with mental health issues.
- **Organisations that support children in other settings.** Community ICAMHS will work with agencies that support children in other settings who may require mental health support. This includes contributing to the development of capabilities within justice, child protection, and other systems to better support the needs of children with mental health issues.

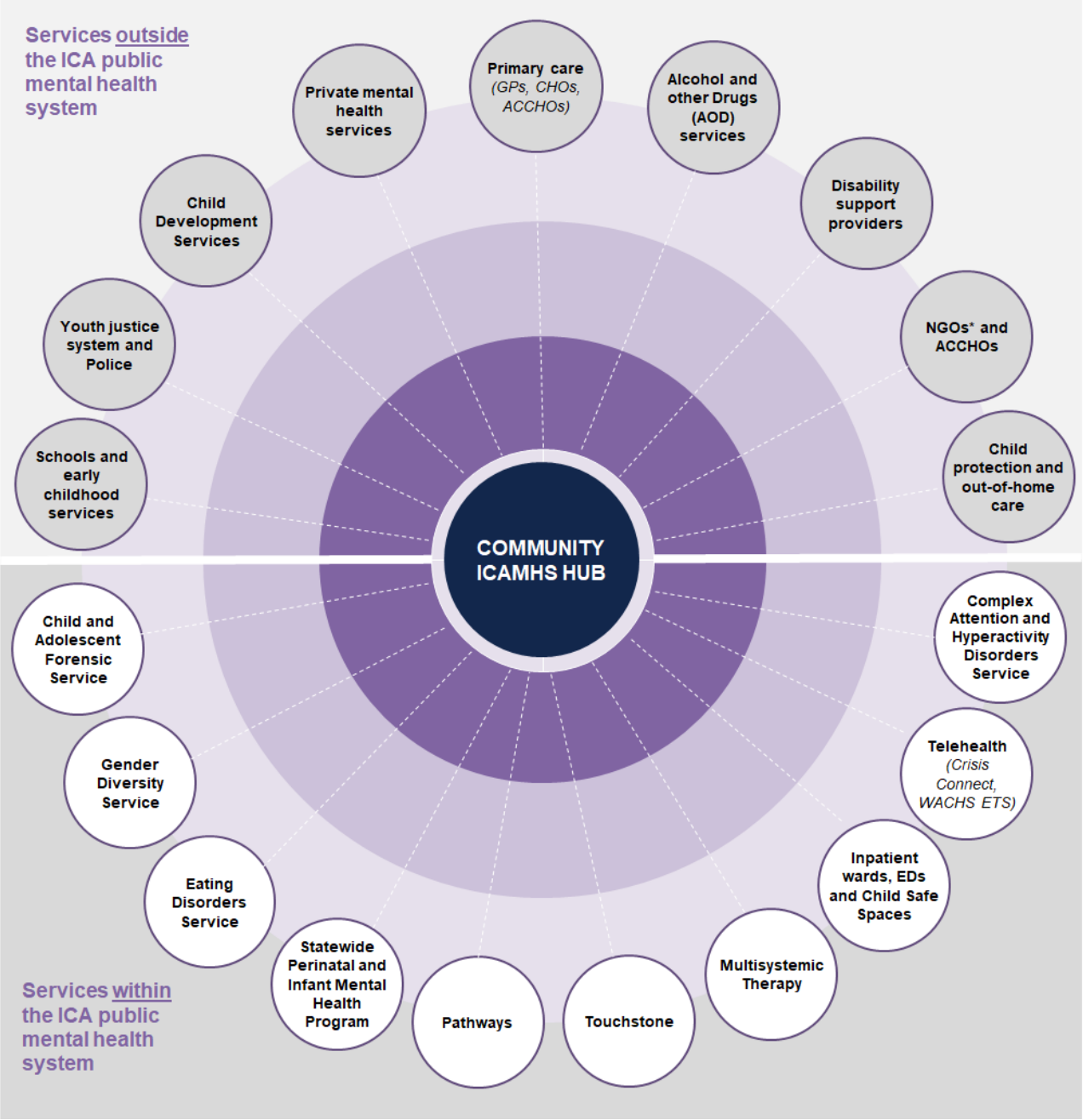
How will Community ICAMHS interact with primary health services and other settings?

Through region-wide coordination from **Primary Mental Health Teams** in each Community ICAMHS Hub and **a small contingent of Primary Mental Health Workers** in local clinics, Community ICAMHS will support and provide outreach and other forms of support to GPs, other community mental health services such as headspace, counsellors, Child Protection and Family Services, justice settings, and paediatricians in Child Development Services (CDS) across each region.

These teams will be responsible for providing **consultation liaison and shared care, assertive outreach and education, and capability building support** to local services and improving cooperation and coordination with Tier 1 and Tier 2 services. Primary Mental Health Teams will act as the 'bridge' between Community ICAMHS and primary and secondary health services in all regions by increasing the capability of local services to meet demand and facilitate early intervention, ultimately reducing excessive referrals into Community ICAMHS clinical support teams.

Community ICAMHS will be the most critical mental health service for children, families and carers across WA – sitting at the centre of both the ICA public mental health system, and other settings that support these children and their networks. Primary Mental Health Teams will form a key function of Community ICAMHS, and will be a key mechanism to fostering these relationships and providing care and support to other settings. This concept is summarised in Figure 6 overleaf, highlighting examples of the organisations and services both within and outside the ICA public mental health system that Community ICAMHS will form strong relationships with.

Figure 6 | Community ICAMHS at the centre of the system – with many key relationships to be established



4.3 What and how will care be provided to children, families and carers?

Given the multi-dimensional nature of Community ICAMHS' role in coordinating care both within and outside the ICA public mental health system, this section covers three key components:

Figure 7 | Community ICAMHS provides three levels of support

4.4 What will Community ICAMHS provide to all children, families and carers?

The following describes the range of general mental health supports available within all Community ICAMHS, as well as the intended experience for children, family and carers receiving care, across three broad stages (Figure 8).

Figure 8 | Stages of the care pathway for children accessing Community ICAMHS

4.4.1 Access

Community ICAMHS will identify and receive requests to provide mental health care to a child, family and carer, or provide indirect access through inreach to primary care services.

There are a variety of channels and referral pathways available into Community ICAMHS to ensure there is no wrong door

Access to Community ICAMHS will be welcoming, equitable and responsive. Community ICAMHS is the 'single front door' to all children, families and carers requiring support, and therefore can enable access through a broad range of referral pathways. This includes an option for self-referral by a child and referrals from family or carers, GPs or community health services, schools, justice services, child protection services, or other services such as NGOs and Aboriginal community controlled organisations (ACCOs). Children can also access Community ICAMHS through 'warm handovers'[2] from a range of services including EDs, the Crisis Connect phoneline, schools, and government agencies such as the Department of Communities and the Department of Justice. Note, while Primary Mental Health Teams will play a key role in ensuring other settings can support children effectively and potentially reduce referrals into Community ICAMHS, they will also be involved in facilitating access to Community ICAMHS' multi-disciplinary team if and when required.

A broad range of referral pathways 'in' will be complimented by assertive outreach and community education to promote awareness and early intervention, and reduce stigma

Community ICAMHS' Primary Mental Health Teams will provide assertive outreach to primary and secondary care, justice services and other settings – identifying children that may require mental health support. While not all children that receive assertive outreach in these settings will necessarily need to come under the care of Community ICAMHS, this is critical to building local familiarity and trust of Community ICAMHS supports, and more generally raising awareness, understanding and knowledge around mental health in children and adolescents.

[2] In line with the Service Guarantee, referring services will follow up with the child, family and carer within four weeks or until the referral is activated to provide support while waiting for service intake, and check in with the child, family and child three months after referral to follow up on the care received since.

Equitable access for vulnerable cohorts and communities

This Model of Care is particularly cognisant of the historical and disproportionate barriers to accessing appropriate mental health care for vulnerable children and families across WA. This includes: regional and remote families; Aboriginal and Torres Strait Islander children; children from ELD backgrounds; LGBTQIA+ children; children with neurodevelopmental conditions; children in care; and those in contact with the justice system.

Alternative referral pathways such as assertive outreach and partnerships with local services (e.g. ACCHOs, cultural services) allow engagement with marginalised communities who experience physical, social, cultural or psychological barriers to accessing care. CAHS and WACHS should also embed strong data collection mechanisms to ensure equitable access to services, and that ‘hard-to-reach cohorts’ are being proactively supported in the community.

Further, there will be enhanced mechanisms for managing referral pathways between Community ICAMHS and a range of priority channels, given the prevalence and risk of mental health issues in settings including but not limited to: Youth Justice Services, Child Protection and Family Services, Department of Education and ACCHOs. Such mechanisms may include referral coordination meetings between the Community ICAMHS Intake and Management Teams and relevant organisations to discuss recent referrals and referral trends, and provide updates on referral outcomes or progress.

In terms of equitable access and engagement, specific Community ICAMHS Hubs can determine the need to identify staff who provide 'practice lead' like roles regarding the access and engagement of specific vulnerable cohorts, and ensure assertive outreach and proactive education is being targeted at ‘hard-to-reach’ groups in an accessible and culturally sensitive way.

The referral process should be simple and easy to access, with multiple modes available to children, families, carers, and others to initiate contact and seek support

Referrals can be made via multiple modes to ensure access for young people in all social settings, including face-to-face, virtual (i.e. telehealth or video conference), written documentation or walk-in. The referral process must be simple and transparent to ensure that all children, families and carers (particularly those who have historically struggled to access care) feel comfortable and empowered to do so. This means minimising barriers to successful referrals into Community ICAMHS, such as confusing or vague questions that children, family members or carers may be unable to answer without support. Further, clear promotion of Community ICAMHS, including details about services provided, locations of facilities and details about the referral process are important to improving knowledge of local supports.

Community ICAMHS access via online portal

Referrals into Community ICAMHS will be accessible via an online portal that is available to the whole community. The portal may include:

- an overview of the services and supports that Community ICAMHS provides, and in what locations
- a simple, easy referral form – mapping postcodes of requests to the relevant hub
- phoneline support options, including what to do if a child is in crisis
- a directory of local services that could support broader wellbeing in children and families (including GPs, ACCHOs, NGOs, and other community-based services)
- information, resources, and tools to educate community members on mental ill-health in children, including both general wellbeing advice and information on specific conditions, disorders and complexities.

Community ICAMHS will have dedicated teams and resources to improve intake and referral management

Children, families and carers will experience an improved intake and referral process that is seamless, transparent and supportive. All referrals in a Community ICAMHS area will come through the central hub, rather than to individual community clinics (with the exception of walk-in self-referrals, which can occur at any local clinic). To achieve this, all hubs will include an **Intake and Management Team** that manage referrals end-to-end and ensure all children are receiving some level of immediate support. Their role is to gather comprehensive information about the reason for the referral and to then talk with the referrer, and where possible the young person, about what help is available. To build rapport and trust, the Intake and Management Team will include peer workers as part of the workforce model. To ensure continuity of care, the Intake and Management Team can also provide ongoing, proactive follow up to the child, family member and/or referrer regarding progress of their referral, information regarding the referral progress, and any other relevant context. The intake team should be able to provide all-hours contact, community outreach and home-based service options, ensuring Community ICAMHS is engaging with ‘hard to reach’ populations.

If Community ICAMHS is identified as being a suitable and beneficial service to provide support, then the intake team will work with the local hub or spoke to coordinate ongoing care (through a care coordinator). The Intake and Management Team will also provide immediate follow-up after intake contact, so that children and families know when and where they will next be receiving support.

In the interim, the Intake and Management Team can connect the child and their family to a range of relevant services, support groups, information and resources (see below).

A 'care coordinator' acts as the first point of contact and ongoing representative for the young person and their family/carer[3]

Once accepted, children, families and carers will be assigned a care coordinator who listens to the young person's story, coordinates liaison with other services to explore how they can meet the holistic needs of the young person – providing some therapeutic supports where required. This care coordinator will be a mental health professional from a hub or a spoke, is drawn from the multi-disciplinary team and can come from a range of professional backgrounds. Determining which mental health worker is assigned to the young person will be based on consideration of presenting needs, child and family identified supports, cultural, gender and other preferences, and operational factors. In effect, this person functions as the central point of contact for the child, family and/or carer.

It is critical that children, families and carers feel safe, supported, included and heard. Therefore, to reduce the number of times a child re-tells their story and therefore avoid traumatisation, Community ICAMHS will adopt a relationship-driven model by ensuring the care coordinator remains engaged with the child, family and carer as much as possible throughout their childhood when they require care. The care coordinator should develop trust and rapport with the child and family, and act as their advocate to ensure they have choice and control of next steps in terms of when, where and how they receive support. Community ICAMHS' Intake and Management Team will provide flexibility of options to 'match' the needs of the child and their family with an appropriately skilled care coordinator, considering social and cultural needs.

Children, families and carers have a range of options to access information and support while waiting for care

It is recognised that Community ICAMHS will take time to grow in capacity, and that as it grows, it is likely that there will be a wait for many children and families to access care. All children, families and carers will have access to a range of information, resources and supports while waiting for more formal provision of care. This includes but is not limited to:

- Proactive communication as to the current status of their referral, and estimated waiting times for service/access to clinicians.
- Access to a range of online resources and information about the child's wellbeing, and improve education of mental health and potential issues.
- A pamphlet of relevant ICA-specific services that may be required at any point, including: telehealth contact points such as Crisis Connect, a nearby Child Safe Space, ACRTs, and other local services.
- Contact information for local drop-in centres that could be available to provide interim support if required, as well as local mental health services that could provide support.

[3] In some cases, due to personal, social or cultural needs - a child and/or family member may wish to speak with an Aboriginal Mental Health Worker or peer worker to make them feel comfortable and safe, prior to their initial conversation with their dedicated care coordinator.

- Contact information for a range of peer and/or lived experience support groups that are available to provide emotional support to children, families and carers in what can be a distressing time.
- Contact information for other local services including GPs, school support services and the justice system.
- A range of support resources to parents and carers to manage the child's wellbeing, as well as their own, so that they feel empowered to manage the situation in the interim and are not at risk of crisis.

Additionally, all Community ICAMHS Hubs will provide age-appropriate group sessions that focus on social connection, self-care and general psychological education to children, families and carers. In the interim stage, referrals will be encouraged to attend some of these group sessions to create a 'warm entry'. If available, the care coordinator can look to connect the family with a peer worker who could provide emotional support and advice to the family, provide context to the range of supports available to them, and what their journey may look like.

Throughout this access process, there will be regular and ongoing communication with the care coordinator

Once the Intake and Management Team has linked the child to an appropriate care coordinator, it is critical that the child, family and carer feel safe, supported, connected and heard. While being supported to access care through the early phases of the child's engagement with Community ICAMHS, the family should have ongoing communication with the care coordinator to receive emotional support, provide a mechanism for navigating other supports and asking questions, and providing a platform for transparent communication to provide updates and any other important information.

To ensure equity of access, the assessment process should be flexible and ongoing

When receiving an assessment from local Community ICAMHS staff, children can be assessed for treatment through various modes including a face-to-face meeting in a local clinic, virtual assessment over the phone or via video link, or even in the community at places that are safe and comfortable for the child and family (this could be in the home, or at a local nearby community centre). In regional locations, there may be local community centres that are deemed more suitable for Community ICAMHS staff to provide outreach assessments.

The assessment process should also be ongoing, gradual and open to change, acknowledging that the child and family's circumstances may change over time and require flexibility of supports. To achieve this, local Community ICAMHS clinics should consider the requirement to undertake multiple sessions with the child and family prior to any treatment, so to build rapport and gradually introduce supports to the child and their family. This could include a one-to-one session with the child (if appropriate) to consider private needs and information, and then a subsequent session with family to discuss more systemic factors and considerations to best understand the family's situation.

The assessment and formulation process will be holistic, recovery-focused and safe, in order to best meet the broader needs of the child and family

Community ICAMHS includes an in-depth and holistic assessment of the child and family's needs, and will consider factors beyond just clinical symptoms or medical needs. This should include consideration of social, cultural, behavioural, biological and developmental factors. As part of this, the assessment process will include robust information collection from all relevant 'systems' around the child, that is, involving family members and carers, friends, schools and other services the child may be accessing. This is to ensure the assessment process captures the broader wellbeing factors and circumstances of the child and family.

Regardless of location, the assessment process should take place in a safe environment that is conscious of cultural and social needs, and can include tools to make the child and family feel safe. This may include considerations around sensory awareness, with Community ICAMHS incorporating therapeutic tools such as visual cues to support the child in communicating how they are feeling. A key feature of all Community ICAMHS assessments and the determination of need will be the perspective of the children and their family and/or carer. As much as possible, the child's framing of their experience and needs will be documented.

4.4.2 Support

Community ICAMHS will plan and deliver care to the child, family and carer, and will coordinate involvement of other services and organisations to best meet their needs.

A care plan will be developed by the care coordinator in collaboration with the child and family to establish their support needs and recovery goals

Overall, the assessment process will provide the child and family with a positive understanding of mental health, context behind the child's needs, and choice and control of relevant supports that they can access in the future. The care coordinator will develop a care plan in collaboration with the child and family to outline what supports they will receive and how they will receive them. This process can be supported through input from a multi-disciplinary team as needed.

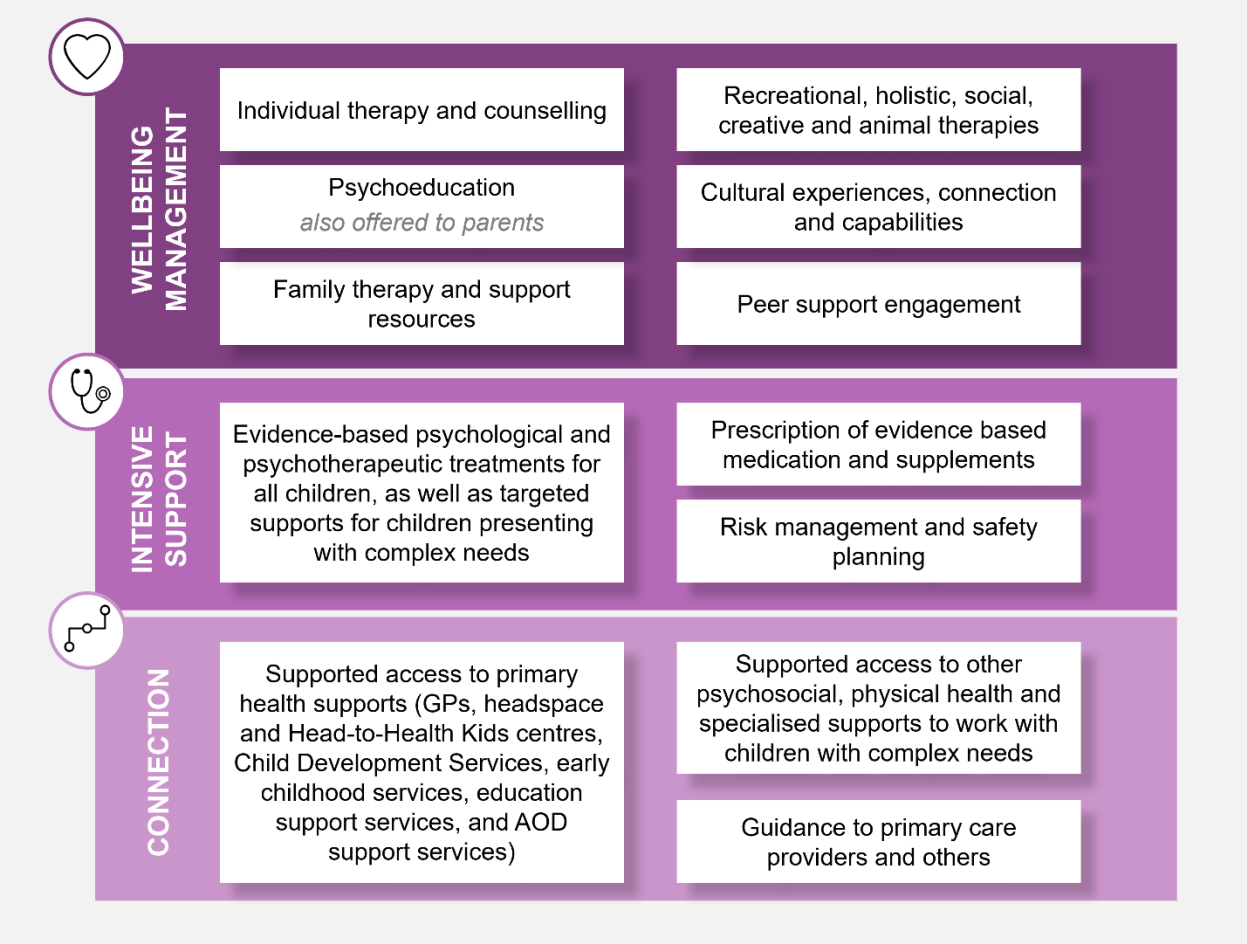
It is critical that the young person and their family have a voice throughout this process, and are supported by the care coordinator to articulate what they want their care to 'look and feel like'. The child and family should be involved in all decision-making and provided with education as to why certain services could be beneficial, and why they are relevant to the child's circumstances. This will ensure care is planned with the young person front of mind, such that the written document is developed in a way that has meaning for the young person and is not too clinical. Further, the care coordinator can work with the child and family to develop a safety risk management plan, if required. Subject to the child and family's consent, these care and risk management plans can be accessible by other services involved in providing care to the child – which will contain updated information on current support needs, services engaged with, and ongoing recovery goals. This will support a shared understanding of the child's needs, but also ensure safety across different settings (including schools).

Children and families are offered a broad range of options for clinical supports, embedded into local Community ICAMHS clinics

Throughout their childhood as long as is needed, children and families should have access to a broad range of mental health supports to meet their recovery goals and wellbeing needs. It should be noted that while some of these services and supports may be physically located in regional 'hubs'[4], they will be accessible to all communities across the area in some form. All children accessing Community ICAMHS will have access to a multi-disciplinary team that includes but is not limited to Aboriginal Mental Health Workers (AMHWs), nurses, occupational therapists, paediatricians (if feasible), peer workers, psychiatrists, psychologists, social workers and speech pathologists, in addition to specialised roles within respective hubs and the contribution of peer workers. Holistic treatment options will also be available to support the broader social and cultural wellbeing needs of various cohorts. Note, this includes a focus on building the capacity and capability of parents and carers through psychoeducation, family therapy and support resources in a Community ICAMHS setting. Collectively, these teams will contribute to treatment plans being developed by care coordinators in collaboration with children, families and/or carers, which can include:

[4] Note, WACHS intends to develop a 'virtual Hub', which may also deliver similar functions to physical regional Hubs. Further planning is intended to finalise the service delivery model for this virtual Hub.

Figure 9 | An illustration of the range of supports offered by Community ICAMHS



Cultural supports for diverse cohorts and communities

Figure 9 above includes various social, cultural, and other holistic supports available within all Community ICAMHS settings. This acknowledges the historical lack of culturally appropriate and holistic supports available to vulnerable cohorts of children (including Aboriginal and Torres Strait Islander children, those from ELD backgrounds), and barriers to care such as health literacy, limited English language proficiency, social difficulties or other cultural factors, in addition to limited cultural awareness of health professionals, lack of diverse mental health professionals, and experiences of prejudice. A broad range of cultural supports, interpreter services, partnerships with community-specific organisations (such as ACCOs, ELD-specific organisations, and others), and a diverse workforce profile (e.g., AMHWs, cross-cultural workers) are recommended to be embedded across Community ICAMHS.

Further, all mental health care in Community ICAMHS settings should be delivered in line with the ICA Culturally Safe Care Principles. These principles are intended to guide the delivery of culturally safe, responsive and quality health care to Aboriginal and Torres Strait Islander peoples, but in practice will also benefit culturally safe care delivery to other cohorts from diverse backgrounds and experiences.

Treatment and support from Community ICAMHS can be delivered in multiple settings to promote equitable access and mental health outcomes

Children, families and carers can access services in an appropriate and timely manner through Community ICAMHS, regardless of location. There can be flexibility in how these supports are delivered, including face-to-face at local clinics, virtually via telehealth, or via outreach in the community in an environment that is safe and appropriate for the child and family, as well as clinicians. For regional and remote areas, every major regional ‘hub’ should have a core suite of therapeutic supports and provide capability training and support to smaller ‘spoke’ clinics, so to ensure all children can receive appropriate mental health support. Most importantly, children can remain in the care of Community ICAMHS throughout their childhood, as long as is necessary, with fluctuating levels of intensity based on their needs.

Primary Mental Health Teams – shared care to other settings

As discussed in Section 4.2 Primary Mental Health Teams will represent the core 'outward-facing' function of Community ICAMHS, providing shared care, consultation liaison and capability building support to other settings across the system.

Primary Mental Health Teams can work with GPs, schools, primary and secondary services, justice, and other settings to provide indirect mental health support to children, families and carers in these settings. This can include care, expertise and advice, or even training and resources to equip staff within these settings to better identify, respond to and support the mental health of children, their families and carers. Some examples of this support include:

- A child and their parents present to a local GP with some mental health concerns including mood difficulties, impulsive behaviours and suspected trauma. The GP feels comfortable supporting the child to access local supports, but is struggling to understand the circumstances and needs of the child, and requires expert mental health advice. The GP receives consultation liaison support from a Primary Mental Health Worker in a follow-up session, where they undertake a mental state examination to provide a clear picture of the child's support needs, which indicates they should be referred onto Community ICAMHS.
- A local ACCHO runs a social and emotional wellbeing program for children and adolescents. Staff at the service notice that a child has been struggling with school attendance and general motivation, and is facing ongoing mental health challenges. The ACCHO staff have a strong relationship with the child, who is scared of accessing support in a 'clinical environment'. Once a week, it is arranged for an AMHW who is part of the Primary Mental Health Team in a local spoke to come out and provide psychological and emotional support to the child, with ACCHO staff present. During this period, the AMHW also provides psychoeducation to staff at the service.

Note, specific Community ICAMHS Hub and spoke clinics can determine other priority relationships based on existing service provision and relationships at a local level.

Community ICAMHS will coordinate the care of the child on an ongoing basis to ensure continuity of care and suitability of services

Within Community ICAMHS, the dedicated care coordinator will be responsible for coordinating all of the 'moving parts', that is, all of the services both within and outside of Community ICAMHS that the child and family are receiving within their care plan. The care coordinator will have the ability to provide updates and clinical information to service providers that will impact care plans, and will act as the central point of liaison between all relevant supports to manage the needs and recovery of the child and their family, ensuring information is shared effectively so that the child feels as if they only need to 'tell their story once.' This requires the care coordinator and all Community ICAMHS clinics to cultivate strong, ongoing relationships with a broad range of local community services and foster collaboration between various clinical and non-clinical supports.

A young person should experience ongoing communication and transparency throughout their care with Community ICAMHS

The care coordinator also has a critical role in ensuring there is clear, frequent and ongoing communication with the child from supports within Community ICAMHS and across other services, as well as updates around their care plan and any other information relevant to the child's needs. Community ICAMHS clinics will adopt a standardised approach to sharing information by confirming the level of involvement of family and friends, and other confidentiality considerations based on the preferences of the child and family. This may also include a discussion on the level of information that the child may want to be shared, and with whom. The care coordinator will then also establish preferred channels of communication with the child and family based on their needs.

Community ICAMHS will adopt a flexible, continuous and recovery-oriented approach to supporting children, families and carers

When children are receiving support from Community ICAMHS, the intensity of service and frequency of contact can 'dial up and down', subject to the child's needs. This allows for periods of frequent, potentially daily contact, and times of less frequent interactions, or even cessation of supports for a period of time (noting there will be no barriers to re-accessing support – see next section). Importantly, this will ensure that care is continuous, and the connection is maintained in those circumstances where a child's mental health may deteriorate or fluctuate. This also means that children will not be 'pushed out' or exited from engagement with Community ICAMHS because of caseloads or limited interaction, and have support from Community ICAMHS when they need it throughout their childhood.

4.4.3 Transition

When it is safe and suitable to do so, Community ICAMHS will support children to transition into other settings, ensuring continuity of care.

All handovers must be well-communicated with the child and their family, as well as future service providers

Strong, ongoing partnerships between Community ICAMHS and local support services will be required to ensure smooth transition of children into community-based settings or otherwise, which will require Community ICAMHS staff to conduct 'warm' handovers with service providers, and provide ongoing communication to the child and family as to how they will transition to a new setting. Community ICAMHS should also provide timely contact with the child and family post-transition to ensure their new suite of services and supports are suitably meeting their needs.

Transition from Community ICAMHS should be gradual, with contingency plans in place to ensure continuity of care

When a child is being supported to transition away from the care of Community ICAMHS, it must be informed by a clear plan including outreach support and linkages to other services. This could include when transitioning to receiving low-intensive support from primary care settings, or private mental health services. The transition process is likely to be gradual to enable the child and family to adjust to new services and supports, with Community ICAMHS adopting a continuous and flexible post-transition role to promote recovery. Under this concept, the potential for re-entry into Community ICAMHS should be discussed and planned with the child and family, so to ensure they will not be refused access to support if they require it again throughout their childhood.

Community ICAMHS will support clear transitions into youth and adult settings

Children with mental health needs often experience the transition between CAMHS supports and youth or adult settings as challenging and fragmented, with negative influences on continuity of care. Community ICAMHS will provide supported transitions for children, families and carers into youth or adult services when appropriate. This will be facilitated by each Community ICAMHS Hub developing strong relationships with regional youth and adult mental health services and supports. As much as possible, where children are receiving long-term care within the ICA public mental health system, Community ICAMHS will lead the coordination of a transition plan 3-6 months in advance. The care coordinator will be responsible for communicating with the child and family as to appropriate pathways into these settings, and conducting joint sessions with the future service provider to provide a robust summary of the child's current circumstances, support needs and recovery goals. This will be underpinned by a warm handover period, in which the child will begin to access supports in the new setting, but with ongoing communication support from the ICAMHS care coordinator for up to 6-12 weeks post-transition to ensure the child and family are receiving appropriate supports that meet their needs.

4.5 How will Community ICAMHS support children with complex, co-occurring or specialised needs?

Community ICAMHS will lead the provision of mental health supports for all children, families and carers across WA, providing the majority of general mental health supports including for those with complex, co-occurring and/or specialised needs. To achieve this, Community ICAMHS will have embedded specialised capabilities and strong relationships with other ICA public services to acknowledge the various complexities of need facing children, families and carers.

Community ICAMHS will support access to statewide specialised services through a 'stepped model of care'

The ICA mental health system will be equipped to safely, sustainably and appropriately respond to children with complex, co-occurring needs and specialised needs, beyond what is available to all children, families and carers.[5] Community ICAMHS will have increased capacity to support:

- Children with **specific disorders, conditions and needs**, including but not limited to children with mental health issues who also experience eating disorders, personality disorders, early psychosis, complex trauma, intellectual disabilities, neurodevelopmental conditions or neuropsychiatric disorders.
- Cohorts of children who have previously had limited access to services, and require more age-appropriate mental health supports, including specialised resources to support **infants aged 0-4 years of age and children aged 5-12 years of age**, respectively.
- Children who have acute needs due to severe and enduring mental health issues, and/or **children in a mental health crisis**.

Community ICAMHS and statewide ICA specialised services will work together through a 'stepped model of care' to meet the complex needs of children, and their families and carers. This will see increased specialised capabilities embedded in all Community ICAMHS Hubs, with options for children to 'step up' to receive care from a statewide specialised service if and when required.

This requires a re-design of the core functions of all statewide specialised services. The majority of their care for children with specialised needs will be indirect through the provision of capability building via advice or consultation liaison from Community ICAMHS, who will provide the majority of direct care. A smaller proportion of their care for children with specialised needs will be direct care, including either shared care – in which statewide services and ICAMHS operate concurrently – or lead care, in which children are transitioned to these statewide specialised services for intensive care.

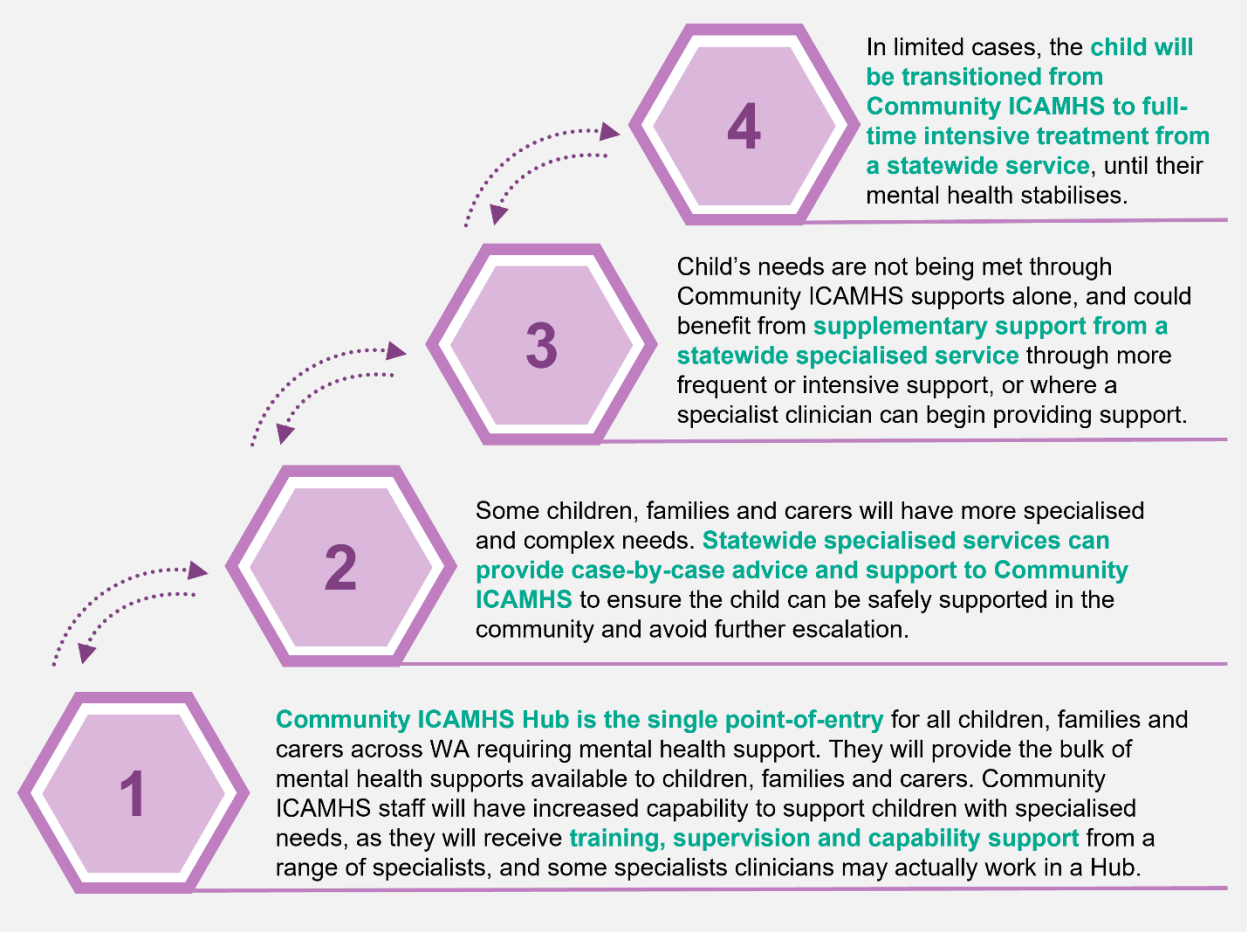
All Community ICAMHS services will have embedded specialised capabilities, consistent with the range of specialised statewide capabilities

Within each Community ICAMHS Hub, the multi-disciplinary team responsible for delivering mental health care (i.e. the **Community ICAMHS Team**) will have capacity to primarily deliver care for many of these cohorts, due to upskilling and training provided by these services to Community ICAMHS staff. As above, in some cases, Community ICAMHS can coordinate involvement from a statewide specialised service while remaining connected to the child's overall care within the system. Below in Figure 10 is a summary of how Community ICAMHS

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

will provide specialised supports to meet the needs of these children through embedded capabilities in partnership with specialised statewide services.

Figure 10 | Children might 'step up' to receive support from a wide range of specialised services while in Community ICAMHS



A summary of how Community ICAMHS will support various cohorts of children with specialised, co-occurring or complex needs

All Community ICAMHS Hubs will have embedded specialised capabilities, further to the generalist capabilities of their multi-disciplinary teams. Table 1 provides a summary of how each of these cohorts will be supported through dedicated capabilities and resources to implement a stepped approach in practice, based on specific considerations within each of these Models of Care. Within each Community ICAMHS Hub, there is flexibility to embed specialists with capabilities to support children with any of these complex needs[6], depending on local need. This could include:

- **Dedicated resources.** A discrete role with specialist expertise, that focuses exclusively on supporting a particular cohort of children (e.g. a dedicated infant mental health worker).

[6] Specialisation within Community ICAMHS must be based on community need, not the professional interests of clinicians.

- **Distributed resources or ‘Practice Leads’.** A member of the multi-disciplinary team who has experience or associated capabilities with a specific cohort. They provide a broad range of mental health supports, but also lead the provision of care for complex children within this cohort. Further, the Practice Lead would provide supervision to other Community ICAMHS staff working with this cohort, and lead partnership with associated services and stakeholders, including statewide services. For example, this role could be delivered by a senior mental health worker with expertise in supporting children with eating disorders.

In this context, all Community ICAMHS Hubs will have dedicated resources for a small number of cohorts, and then distributed resource (Practice Leads) for all other relevant capabilities.

Note – related Models of Care

Specific Models of Care have been developed for these cohorts of children, which should be referred to for more detailed guidance on how care should be provided to best meet their needs.

Table 1 | How Community ICAMHS will embed specialist capabilities and work with other services within the system to support children with complex, specialised, or co-occurring needs.

Cohort with specialised needs	Capabilities and/or resource(s) required within Community ICAMHS	What can Community ICAMHS directly provide to specifically support these children?	What will the specialised service provide across levels of the stepped model?	How will this specialised capability support local capacity?
Children with **eating disorders and/or disordered eating behaviours** *Source: Eating Disorders Model of Care*	Community ICAMHS Hubs will have: ▪ A 'distributed' Eating Disorders Practice Lead. ▪ Generalist mental health and physical health clinicians with eating disorders expertise.	▪ Care coordination to the child, family and carers. This includes working closely with the statewide Eating Disorder Service (EDS), WA Eating Disorder Specialist Services (WAEDSSs), hospitals (e.g. Perth Children's Hospital (PCH)), GPs, paediatricians, schools, and other community services. ▪ Supports, such as meal support (including conducting in-home visits), family-based therapies, cognitive behaviour therapy and medical monitoring. Community ICAMHS clinicians may provide these supports independently; with case-by-case advice from EDS; or in a shared care arrangement with EDS. ▪ Child and parent/carer friendly resources for children, families and carers on eating disorders and disordered eating.	EDS will work in a multi-disciplinary team to provide: ▪ Case by case advice to Community ICAMHS. ▪ Shared care with Community ICAMHS and other services, such as GPs, hospitals, and paediatricians. ▪ Provide intensive supports for children with eating disorders. This includes day programs, outpatient programs, medical inpatient programs, and group, family and peer sessions. ▪ Care coordination when a child transitions to EDS to receive intensive supports. ▪ In reach care to hospital-based settings.	EDS will provide: ▪ Training and professional development to Community ICAMHS' clinicians, community organisations and primary care providers. ▪ Clinical supervision to Community ICAMHS' Eating Disorders Practice Leads and other clinicians working in this space. ▪ Educational resources for Community ICAMHS staff, and key partners within the system. ▪ Child and parent/carer friendly resources (e.g. information booklets, handbooks, etc.) that Community ICAMHS and other key partners can distribute to children, families and carers. ▪ Research on new and emerging practices in eating disorders.
Children who have experienced **complex trauma** *Source: Complex Trauma Model of Care*	Community ICAMHS Hubs will have: ▪ Generalist mental health workers with basic knowledge of complex trauma. ▪ A distributed Complex Trauma Practice Lead within Community ICAMHS' Hubs with expertise in managing complex trauma. ▪ Dedicated Forensic and Child Protection Liaison Officer (see Section 5.2). ▪ Training and support from a new Complex Trauma Service. ▪ Increased capability (through training) to apply trauma-informed frameworks, evidence-based therapies and the 'soft skills' to effectively support children with complex trauma.	▪ A Model of Care that supports an understanding and provides support for children with difficulties that were informed by trauma and attachment, viewed from a holistic and systems perspective. ▪ A broad range of referral pathways 'in' will be complimented by assertive outreach and capability uplift education support ▪ Assessment will use NMT frameworks to understand their experiences, functional challenges, and recovery goals ▪ A broad range of evidence-based therapeutic treatments and supports that are neurosequentially informed and specific to managing complex trauma. ▪ Care plans for children and adolescents with complex psychological and behavioural needs due to complex trauma will consider holistic wellbeing supports that consider the needs of children and their 'systems' ▪ Embedding Social and Emotional Wellbeing (SEWB) principles into practice to provide holistic care – including access to peer workers, AMHWs, and a diverse workforce profile.	A new, dedicated Complex Trauma Service (CTS) will provide specialised support to all children with complex trauma needs. It will: ▪ Have the expertise to apply evidence-based frameworks such as NMT. ▪ In a small amount of highly complex cases, deliver an intensive recovery program and intensive and specialised therapies ▪ Provide case-by-case advice via phoneline to Community ICAMHS staff. ▪ Providing scheduled in-reach to Community ICAMHS Hubs and support all complex cases. ▪ Where more intensive care is required, providing shared care with Community ICAMHS through facilitating a joint assessment process, additional sessions, or complex case reviews. ▪ Virtual group sessions to support children with experiences of complex trauma and their parents or caregivers.	The CTS will support local capacity through: ▪ providing training to Hub Complex Trauma Practice Leads to support them to undertake assessments and deliver trauma-informed mental health supports ▪ providing clinical supervision to Community ICAMHS staff, where required ▪ in more complex cases, provide case-by-case advice to Community ICAMHS staff ▪ developing educational resources on complex trauma ▪ provide scheduled inreach to Hubs and conducting 'clinic circuits' in country areas. Community ICAMHS and the CTS will provide specialised support to better support children in child protection settings: ▪ Partnering with Child Protection and Family Support (CPFS) and out-of-home care (OOHC) providers. ▪ More comprehensive assessment upon entry to OOHC, facilitated by CTS. ▪ Complex Trauma Mental Health Training (e.g., TCI) provided to child protection staff.

Cohort with specialised needs	Capabilities and/or resource(s) required within Community ICAMHS	What can Community ICAMHS directly provide to specifically support these children?	What will the specialised service provide across levels of the stepped model?	How will this specialised capability support local capacity?
				▪ Greater capacity for child protection providers to consult with specialist capabilities within Community ICAMHS.
Children with **personality disorders** *Source: Personality Disorder related needs Model of Care*	Community ICAMHS Hubs will have: ▪ Generalist mental health workers and other practitioners with basic knowledge of personality disorders. ▪ A distributed personality disorders 'Practice Lead' within Community ICAMHS' Hubs with expertise in managing personality disorders. ▪ Increased capability (through training) to apply trauma-informed frameworks, evidence-based therapies and the 'soft skills' to effectively support children with complex trauma.	▪ A 'dimensional' approach to personality disorders that acknowledges the broad variety of personality traits and behaviours that can result in functional impairment and distress, rather than being limited to any given definition or strict categorisation. ▪ A broad range of referral pathways 'in' will be complimented by assertive outreach and education to the community to promote awareness and early intervention, and reducing stigma. ▪ Community ICAMHS and Touchstone can provide a broad range of psychotherapy treatments and holistic wellbeing supports that are specific to managing personality disorders, above what is available to all children. ▪ Assessment that aligns to a dimensional model that focuses on functional needs and recovery goals. ▪ Embedding SEWB principles into practice to provide holistic care – including access to peer workers, AMHWs, and a diverse workforce profile.	The model seeks to expand the capabilities of the existing Touchstone service to deliver care in partnership with Community ICAMHS. The augmented Touchstone service will provide: ▪ Training, education, and supervision to upskill Community ICAMHS staff. ▪ In-reach care to patients in acute settings. ▪ Case-by-case advice to Community ICAMHS either virtually or face-to-face as is appropriate. ▪ Shared care with Community ICAMHS and other services, including GPs, hospitals and paediatricians. ▪ In a very small number of cases, intensive care, delivering evidence cased therapeutic interventions in one-on-one and group settings. ▪ A broader range of treatment options and psychotherapies available that can cater to the needs of children and families.	Touchstone will provide: ▪ Clinical supervision and training to Community ICAMHS' staff. ▪ Child and parent/carer friendly resources (e.g., information booklets, handbooks, etc.) that Community ICAMHS and other key partners can distribute to children, families and carers. ▪ Research on new and emerging practices in personality disorders mental health care.
Children with signs of **early psychosis** *Source: Early Psychosis Model of Care*	Community ICAMHS Hubs will have: ▪ Generalist mental health workers and other practitioners with basic knowledge of early psychosis. ▪ A distributed Early Psychosis 'Practice Lead' within Community ICAMHS' Hubs with expertise in managing children with early psychosis. ▪ Training and support from a new Early Psychosis Leadership Centre.	▪ A Model of Care that improves awareness in the community of risks and education around early psychosis, provides timely access to holistic assessment and supports, and improves capacity of workers to address the broader wellbeing needs of children, families and carers. ▪ Early information and education about what early psychosis looks like, why support is important and the range of supports available. ▪ Assertive outreach and education into the community to reach children that may never access Community ICAMHS supports (i.e., vulnerable cohorts), children at ultra-high-risk, supporting capability uplift in doing so. ▪ Community ICAMHS will leverage the EPLC and existing youth early psychosis services to ensure access to a broad range of therapeutic treatments and supports that are	This model calls for the establishment of an **Early Psychosis Leadership Centre (EPLC)** that will oversee the support provided to children with early psychosis, and their families and carers. The EPLC will work in partnership with Community ICAMHS by providing: ▪ Training, education and supervision to upskill Community ICAMHS staff. ▪ Case-by-case advice to Community ICAMHS either virtually or face-to-face as is appropriate. ▪ Rotational visits to hubs to provide dedicated expertise. ▪ Lead the development of resources, tools, and information that Community ICAMHS can use to build the capability of primary care services and other settings in the early identification, support and	The EPLC will support local capacity through: ▪ Training to community organisations and primary care providers. ▪ Educational resources for the general public and key partners within the system. ▪ Child and parent/carer friendly resources (e.g. information booklets, handbooks, etc.). ▪ Research on emerging practices in early psychosis. Community ICAMHS will support the capability of other services providing early psychosis support by: ▪ Joint assessments between primary care and Community ICAMHS to work out who provides what supports. ▪ Primary care settings can have consultation liaison access to Community ICAMHS Hubs to receive advice and support.

Cohort with specialised needs	Capabilities and/or resource(s) required within Community ICAMHS	What can Community ICAMHS directly provide to specifically support these children?	What will the specialised service provide across levels of the stepped model?	How will this specialised capability support local capacity?
		focused on returning to premorbid levels of functioning ▪ Apply a clinical staging model to support the needs of all children experiencing early psychosis	management of children with signs of, or at risk of early psychosis.	▪ Assertive outreach to local community supports and services to foster integrated care. Note, this Model of Care acknowledges the expertise and capabilities of existing youth early psychosis services in the Perth Metro area, many of which provide intensive treatment programs. Strong working relationships are required between Community ICAMHS, the EPLC, and these services.
Children with an **intellectual disability, neurodevelopmental disorder or neuropsychiatric condition** *Source: Intellectual Disability, Neurodevelopmental Disorders and Neuropsychiatric Conditions Model of Care*	Community ICAMHS Hubs will have: ▪ Generalist mental health workers with basic knowledge of neurodevelopmental disorders and neuropsychiatric conditions. ▪ A dedicated Practice Lead within Community ICAMHS' Hubs with expertise in managing children with neurodevelopmental disorders, and neuropsychiatric conditions. ▪ A child and adolescent psychiatrist or paediatrician with part-time responsibility for providing advice on the management of children with a neurodevelopmental disorder or neuropsychiatric condition.	▪ Care coordination and support and care for children with co-occurring conditions, their families and carers. ▪ Education, training, resources and tools for families. ▪ Facilitate access to assessments (and diagnosis) for connect children with mental health needs and co-occurring neurodevelopmental disorders or neuropsychiatric conditions, their families and carers who are receiving care in Community ICAMHS. ▪ Support children, their family and carers access disability support services and the NDIS system. ▪ Embedding SEWB principles into practice to provide holistic care – including access to peer workers, AMHWs, and a diverse workforce profile. ▪ Promote Community ICAMHS and what supports they offer to/through others (e.g. police, justice, schools, NGOs).	This model calls for the Complex Attention and Hyperactivity Disorders Service (CAHDS) to be reconfigured, enhanced and expanded to become a neurodevelopment disorder and neuropsychiatric condition statewide service that will: ▪ conduct research, innovation and provide informative resources to families and carers ▪ provide short-term consultation and advice to Community ICAMHS and the Child Development Service (CDS) ▪ provide direct assessments and short-term interventions, in very few cases to children with complex needs, or where capacity is limited	The statewide service will: ▪ Provide educational resources and advice for Community ICAMHS and CDS staff to guide the delivery of mental health care to children with neurodevelopmental disorders and neuropsychiatric conditions. ▪ Develop parent/carer friendly resources (e.g. information booklets, handbooks, etc.) that Community ICAMHS and CDS can distribute to children, families and carers. ▪ Research on new and emerging practices in neurodevelopmental disorders and neuropsychiatric conditions mental health care.
Children in a **mental health crisis, or those with severe and enduring mental ill-health** *Sources: Acute Care and Response Team Model of Care; Emergency Departments and Child Safe Spaces Model of Care*	Community ICAMHS Hubs will have: ▪ An ACRT embedded within each Community ICAMHS Hub, with capacity for virtual support in harder to reach communities.	ACRTs embedded in each Community ICAMHS Hub can: ▪ Provide crisis response to children, families and carers who can be safely, appropriately, and effectively supported in the community. ▪ Support children with severe and enduring mental ill-health in Community ICAMHS to receive out-of-hours or supplementary support where required Hubs can also support access to: ▪ Nearby Child Safe Spaces. ▪ EDs and/or inpatient wards.	For children in Community ICAMHS with more severe mental health issues, ACRTs can also provide ongoing, intensive treatment to the child and their family – providing supplementary support sessions to existing care and supports provided by Community ICAMHS. This includes: ▪ out-of-hours support to the child and family ▪ supplementary outreach sessions to increase the frequency of support available to the child and family ▪ intensive care management of the child	▪ Provide crisis response care in the community through a lower-stimulus intervention. ▪ Provides education, tools and empowerment to families to better manage and potentially prevent mental health crises through identification of contributing factors and mitigation strategies. ▪ Support children, families and carers to access alternative crisis support service options to EDs. ▪ Child Safe Spaces will both provide immediate crisis support and connect children to follow-up supports that will

Cohort with specialised needs	Capabilities and/or resource(s) required within Community ICAMHS	What can Community ICAMHS directly provide to specifically support these children?	What will the specialised service provide across levels of the stepped model?	How will this specialised capability support local capacity?
		▪ Resources and training to support ED staff to respond to the needs of children in a mental health crisis in a more trauma-responsive, culturally appropriate manner.	▪ dedicated ACRT resources to provide intensive liaison support with the child's local school, if required.	promote recovery and wellbeing, including Community ICAMHS. ▪ Community ICAMHS will improve the capability of the broader ICA public mental health system, including ED staff.
Infants aged 0–4 years of age requiring age-appropriate support *Source: Infant mental health Model of Care*	Community ICAMHS Hubs will have: ▪ Dedicated infant mental health workers.	Dedicated infant mental health workers within each Community ICAMHS Hub will provide: ▪ Care coordination to the child, family and carers. ▪ Supports, such as, parent/infant psychotherapy, dyadic, attachment informed therapies, psychoeducation and parent/carer supports. This may involve the Infant Mental Health Service providing case by case advice or shared care with Community ICAMHS. ▪ Parent/carer friendly resources for families and carers on infant mental health. ▪ Peer support to families and carers.	The Infant Mental Health Service will work in a multi-disciplinary team to provide: ▪ Case by case advice to Community ICAMHS Hubs and key partners, such as GPs, perinatal and maternal mental health services, paediatricians, CDS, and other community organisations. ▪ Shared care with an infant mental health worker from Community ICAMHS Hubs. ▪ Intensive and specialised supports and treatments for children, families and carers. ▪ Care coordination when a child transitions to the Infant Mental Health Service to receive intensive supports.	The Infant Mental Health Service will provide: ▪ Training and professional development to Community ICAMHS' infant mental health workers, other clinicians within Community ICAMHS, community organisations and primary care providers. ▪ Reflective supervision to Community ICAMHS' infant mental health workers. ▪ Educational resources for Community ICAMHS staff, and key partners within the system. ▪ Parent/carer friendly resources (e.g. information booklets, handbooks etc.) that Community ICAMHS and other key partners can distribute to families and carers. ▪ Research on new and emerging practices in infant mental health.
Children aged 5–12 years of age requiring age-appropriate support *Source: Child mental health Model of Care*	Community ICAMHS Hubs will have: ▪ Dedicated child mental health workers.	Dedicated child mental health workers within the ICAMHS Hubs will provide: ▪ Care coordination to the child, family and carers. ▪ Supports, such as family therapies, play therapies, in-home care supported visits, psychoeducation and parent/carer supports. This may involve Pathways providing case by case advice or shared care with Community ICAMHS. ▪ Child, parent/carer friendly resources for children, families and carers on child mental health. ▪ Peer support to children, families and carers	Pathways will work in a multi-disciplinary team to provide: ▪ Case by case advice to Community ICAMHS Hubs and key partners, such as GPs, CDS, and other community organisations. ▪ Shared care with a child mental health worker from Community ICAMHS Hubs. ▪ Intensive and specialised supports and treatments for children, families and carers. This may include cognitive based therapy, intensive family therapies, and therapeutic crisis interventions for families. ▪ Care coordination when a child transitions to Pathways to receive intensive supports.	Pathways will provide: ▪ Training and professional development to Community ICAMHS' child mental health workers, other clinicians, and community organisations and primary care providers. ▪ Clinical supervision to Community ICAMHS' child mental health workers. ▪ Educational resources for Community ICAMHS staff, and key partners within the system. ▪ Child and parent/carer friendly resources (e.g. information booklets, handbooks etc.) that Community ICAMHS and other key partners can distribute to children, families and carers. ▪ Research on new and emerging practices in child mental health.

4.6 How will Community ICAMHS support schools, the justice system, primary health, and other local services to meet the mental health needs of children in other settings

Community ICAMHS will also have embedded capabilities and resources to support organisations that support children in other settings

While not all children with mental health needs will access Community ICAMHS throughout their childhood, Community ICAMHS has an important role to play in working effectively with other parts of the system to support the mental health and wellbeing of children across WA who are being supported in other settings. To achieve this, Community ICAMHS also has a critical 'outward-facing' role, that is, regional hubs will work in partnership with **schools, primary and secondary care services, the youth justice system and child protection settings.**

Community ICAMHS will develop these relationships through **Primary Mental Health Teams**, who will both deliver 'on-the-ground' support to children under the care of Community ICAMHS, and facilitate capability building, partnerships and liaison across the region – depending on the needs of those settings. Primary Mental Health Teams will act as the 'bridge' between Community ICAMHS and primary and secondary health services in all regions by increasing the capability of local services to meet demand and facilitate early intervention, ultimately reducing excessive referrals into Community ICAMHS clinical support teams. Further, Community ICAMHS' multi-disciplinary team, Intake and Management Team, and ACRTs will all be involved in supporting these settings to some degree.

The core interfaces are listed below in Table 2, with relevant roles described in further detail in Section 5.2 – Workforce.

Table 2 | Community ICAMHS will support services that care for children in other settings

Setting	How will Community ICAMHS support organisations and services in this setting?
Schools *Source: Support to Schools Model of Care*	▪ Work with schools[7] to support early identification, and access to Community ICAMHS for children who may require mental health supports. ▪ Communication and collaborative planning to support effective case management. This can include advice, care planning, transition planning, or in reach support. ▪ Provide crisis support to schools where required from an ACRT. ▪ Share information on Community ICAMHS' services, including details about the locations and referral pathways.
Justice system	▪ Support and care for children with mental health needs who are at risk of offending or who have offended, including for children on community orders and in Banksia Hill Detention Centre.

[7] In this context, 'schools' includes public education in government schools, as well as private education in either catholic or independent schools.

Setting	How will Community ICAMHS support organisations and services in this setting?
Source: Justice and Forensics Model of Care	▪ Work with the Child and Adolescent Forensic Service (CAFS) to support all children, from those with limited offending behaviours to those with serious offending behaviours. ▪ Provide workforce mental health capability uplift for staff in the youth justice system. ▪ Provide outreach services to children in their communities. ▪ Referral/recommendation to programs for children with challenging behaviours e.g. Target 120, Multi Systemic Therapy (MST).
Primary health	Each Community ICAMHS region will have a Primary Mental Health Team that will work with local GPs, NGOs, ACCHOs and other community-based health and mental health services to improve the capacity of primary and secondary health services to respond to and better support the needs of children with mental health issues, re-orienting the system towards prevention and early identification, allowing children, families and carers to receive support closer to home. Examples of this could include: ▪ A child and their parents present to a local GP with some mental health concerns including mood difficulties, impulsive behaviours and suspected trauma. The GP feels comfortable supporting the child to access local supports, but is struggling to understand the circumstances and needs of the child, and requires expert mental health advice. The GP receives consultation liaison support from a Primary Mental Health Worker in a follow-up session, where they undertake a mental state examination to provide a clear picture of the child's support needs, which indicates they should be referred onto Community ICAMHS. ▪ A local ACCHO runs a SEWB program for children and adolescents. Staff at the service notice that a child has been struggling with school attendance and general motivation, and is facing ongoing mental health challenges. The ACCHO staff have a strong relationship with the child, who is scared of accessing support in a 'clinical environment'. Once a week, it is arranged for an AMHW, who is part of the Primary Mental Health Team in a local spoke, to come out and provide psychological and emotional support to the child, with ACCHO staff present. During this period, the AMHW also provides psychoeducation to staff at the service.
Child protection settings	Community ICAMHS will work with child protection agencies that support children who may require mental health, including Child Protection and Family Support, and OOHC. Each Community ICAMHS Hub can provide: ▪ mental health education, training, resources, and awareness and capability building ▪ liaison with services and organisations if they require specialist mental health advice ▪ supported referrals of children in these settings into Community ICAMHS ▪ in-reach assessment for children entering OOHC

Setting	How will Community ICAMHS support organisations and services in this setting?
	▪ outreach into child protection settings, including care homes, where required ▪ supported access to the expertise of the new Complex Trauma Service. *Please refer to the Complex Trauma Model of Care for more detail on these functions.*

5 Delivering the Community ICAMHS Model of Care

There are various considerations that need be taken into account to implement and operationalise the Community ICAMHS Model of Care. These considerations have been outlined below in the following categories: key relationships and partnerships; workforce; infrastructure; and other delivery considerations.

5.1 Key relationships and partnerships

As discussed throughout Sections 3 and 4, Community ICAMHS will sit at the centre of the ICA public mental health system, and will nurture strong relationships with a range of services and organisations both within and outside of the system. Sections 4.5 and 4.6 outline in detail the ways of working between Community ICAMHS and statewide specialised services, primary care and community mental health services, schools, the justice system, child protection services and social services. Examples of these services and organisations are listed in Table 3. Please note that Community ICAMHS' **Primary Mental Health Teams** will drive the majority of liaison with primary care settings, schools, and the justice system.

Table 3 | Examples of services and organisations that Community ICAMHS may work with to provide integrated care to children, families and carers

Examples of services that Community ICAMHS may interact with *(listed in alphabetical order):*
Services within the ICA public mental health system
Acute Care and Response Teams
CAMHS Crisis Connect
CAFS
Child Safe Spaces
Complex Attention and Hyperactivity Disorders Services (CAHDS)
Complex Trauma Unit[8]
Eating Disorders Services (EDS)
Early Psychosis Leadership Centre (EPLC)[9]

[8] Note – this is being proposed as part of the Complex Trauma Model of Care
[9] Note – this is being proposed as part of the Early Psychosis Model of Care

Examples of services that Community ICAMHS may interact with *(listed in alphabetical order):*
Emergency Departments (EDs)
Gender Diversity Service (GDS)
Inpatient wards
Pathways
Perth Children's Hospital (PCH) – Child Protection Unit (CPU)
Touchstone
WA Eating Disorder Specialist Services (WAEDSSs)
Youth and/or adult mental health services
Regional Mental Health Services (MHS)
Strong Spirit Strong Mind Youth Project (SSSMYP) – Outreach Model of Service
Youth Axis
Youth Community Assessment and Treatment Team (YCATT)
Youth Focus
Youth Link
Youth Reach South
Other services and organisations
Alcohol and Other Drug (AOD) services
Child centres
Child Development Service (CDS)
Community Health Services
Community organisations
Department of Communities, including Child Protection and Family Support, Housing, Community services, etc.
Department of Education
Department of Justice – Youth Justice Services (including Banksia Hill Detention Centre)
Disability service providers
Non-government organisations (NGOs)
Out-of-home-care (OOHC) providers
Paediatricians
Primary care (e.g. GPs, ACCHOs, AMS', etc.)
Private mental health services
Police
Schools (e.g. school counsellors, psychologists, school health nurses and teachers).

Examples of services that Community ICAMHS may interact with *(listed in alphabetical order):*
Schools of Special Educational Needs (SSEN)

5.2 Workforce

The workforce for Community ICAMHS will comprise of many teams and roles, both clinical and non-clinical. The following sections describe the workforce required to deliver this model across each region, both in the regional ‘hub’, as well as local ‘spokes’. It recognises that while existing resources will be re-configured, investment in the mental health workforce and strong workforce pipeline initiatives are required to deliver this future state structure, and should be a priority in further planning processes. Below outlines the key teams for each hub and spoke, with Section 5.2.3. providing more detail on the functions of some key roles where required.

5.2.1 Hubs

In each Community ICAMHS Hub, there will be a number of key teams required to deliver integrated mental health care to children, families, and carers across the region (see overleaf).

Community ICAMHS Team

A large, multi-disciplinary team that includes a range of general and specialised clinicians.

Each Community ICAMHS Hub will be staffed by a large, multi-disciplinary team with the skills, experience, and capabilities to provide various evidence-based therapies and treatments to children, families and carers.[10] This team will include both general and specific clinical roles, as well as a strong non-clinical contingent including social and peer workers. Collectively, this team will lead the provision of care across the region, and drive consistency and coordination across local clinics, ensuring they have capacity to meet local needs.

General multi-disciplinary team

Multi-disciplinary staff capable of providing a broad range of holistic supports to children, families and carers. These roles may include, but are not limited to:

- AMHWs
- Senior AMHWs*[11]
- psychologists*
- child psychiatrist
- nurses*
- nurse practitioners
- paediatricians (potential for a hub to resource a part-time paediatrician, if feasible)
- peer support workers
- occupational therapists*
- SEWB workers
- social workers*.

[10] Note – this multi-disciplinary team will have all of the capabilities, responsibilities and functions of Primary Mental Health Teams that are located in 'spokes', but have additional specialist capabilities.
[11] Please refer to the Aboriginal Mental Health Worker Model for more detail on the functions that both AMHWs and Senior AMHWs can deliver within this space.

Roles marked with an asterisk could take on a care coordinator role for a child, and their family members and carers – this can be defined at a local level based on capability and choice requirements. See more detail in Section 5.2.3.

Specialist roles

These roles will support children with complex needs, leveraging specialist expertise and delivering on other Models of Care (outlined in Section 4.5).

- Distributed 'Practice Leads' within Community ICAMHS' Hubs[12] (they may be a clinician with expertise in managing certain conditions or disorders), including but not limited to:
  - eating disorders
  - complex trauma
  - personality disorders
  - early psychosis.
- Dedicated infant (0-4 years of age) and child (5-12 years of age) mental health workers and neuro-developmental and intellectual disability practice leads.
- Multi-Systemic Therapy (MST) staff in Community ICAMHS Hubs where appropriate.[13] It is recommended that a further planning process be undertaken to define how MST resources can be embedded within Community ICAMHS settings on a statewide basis.

Primary Mental Health Team

A small team embedded within the broader Community ICAMHS Team – leading region-wide coordination of Community ICAMHS' support to services and organisations across the broader system.

Each hub will have a Primary Mental Health Team, who will lead and coordinate Community ICAMHS' 'outward-facing' support to GPs, counsellors, Child Protection and Family Services, and paediatricians in CDS' across each region, as well as liaison with school-based services. Each Hub will have a small team who will coordinate these relationships through consultation liaison and advice to other services, and where required, coordinate involvement of ICAMHS clinicians or other Primary Mental Health team members in either hubs or spokes to provide outreach and clinical support into these settings. This will ensure that Community ICAMHS can provide local 'on the ground' support through outreach into other settings, community events and capability support to community-based organisations. This team will work closely with the Community ICAMHS clinical teams in both hubs and spokes to support children and families in other settings to access these mental health supports, and will include roles such as:

- **Community ICAMHS Primary Mental Health Workers –** A contingent of staff to support general coordination with GPs, ACCHOs, AMS', and other community-based services. It is recommended that one of these team members also takes on a leadership role, providing oversight to primary mental health workers in spoke clinics.
- **Forensic and Child Protection Liaison Officer.** The primary interface between Community ICAMHS and the Justice and Child Protection settings in that area-based network, supporting access to Community ICAMHS care for these children, and providing capability uplift support options to staff in these services.

[12] Note – it should not be deemed as compulsory for every Hub to have a distributed Practice Lead for all four specialised needs listed – these could be embedded based on regional need.
[13] The CAMHS MST program is a specialised program operated under registered licence conditions.

Note, in some cases, there may be an opportunity to embed Primary Mental Health Teams (or workers) into local AMS' or ACCHO's – fostering greater connection between Community ICAMHS and primary care services.

Acute Care and Response Teams

A small, mobile outreach team embedded within each Community ICAMHS Hub, providing crisis response and/or intensive treatment to children in the community.

ACRTs will be a mobile, intensive and timely service that can both respond to children and adolescents that are in a mental ill-health crisis, and provide ongoing care to those who require intensive support in the community. This service will improve access to mental health care for children and adolescents who are in a mental health crisis and can be safely, appropriately and effectively supported in the community, but also provide intensive treatment to children with severe and enduring mental ill-health. This also includes supporting children who have recently been discharged from an ED or inpatient ward, and require intensive support. The ACRT will be accessed via a central crisis hotline (e.g. Crisis Connect), and will work closely with the Intake and Management Team and ICAMHS Team to identify children who may require immediate and/or intensive support. This team will similarly be staffed by a multi-disciplinary team with the skills, experience and capabilities to respond to children in crisis and provide intensive acute mental health treatments to children families and carers.

Note – a separate Model of Care has been developed for ACRTs.

Intake and Management Team

A centralised team that will manage all referrals end-to-end across the whole region

All referrals in a defined Community ICAMHS area will come through the central hub to an Intake and Management Team that manages referrals end-to-end and ensure all children are receiving some level of immediate support. Their role is to gather comprehensive information about the reason for the referral and to then talk with the referrer, and where possible the young person, about what help is available. To ensure Community ICAMHS is engaging with 'hard to reach' populations, this intake team should be able to provide all-hours contact via the ACRT Crisis Connect phoneline, community outreach and home-based service options.

This team should likely consist of social or mental health workers with some clinical training, so to ensure they can engage effectively with a broad range of referrers, understand specific mental health needs, and can triage appropriately.

5.2.2 Spokes

Small, generalist multi-disciplinary care team

A small contingent of clinical and non-clinical staff who will provide core local mental health care for children in the community.

Each 'spoke' will comprise of a smaller, generalist multi-disciplinary team that will provide some local mental health supports, including care coordination, assertive outreach into the community, and some non-specialised treatments (refer to Figure 5). Each 'spoke' team could include:

- a clinical psychologist
- a small contingent of nurses or nurse practitioners
- a small contingent of social workers
- a small contingent of AMHWs
- a small contingent of SEWB and/or peer workers.

Primary Mental Health Workers

A small contingent of workers who provide local mental health inreach support to primary care settings

Each 'spoke' will comprise of a Primary Mental Health Team that will provide some local mental health supports, including care coordination, and outreach into the community, ensuring equitable access and care being delivered closer to home. These Primary Mental Health Teams will also, through coordination at a hub-level, support local primary care services to improve local mental health capabilities. These local primary mental health workers will likely be general Community ICAMHS Primary Mental Health Workers (as above in the hub section), and will vary in size as a team depending on regional need.

5.2.3 Roles

Peer workforce

Lived experience is an integral part of multi-disciplinary care. As such, peer support workers have an important role to play in supporting children, families and carers. Their responsibilities may include:

- supporting families and carers to navigate the system or navigating and coordinating the care for the child on the family and carer's behalf
- providing emotional and psychological support to families and carers
- being a safe space for children, families and carers to share their stories
- attending appointments to be 'another pair of ears' and support in the room
- being an advocate and/or champion for the child, family and carers.

It is recommended that the peer workforce comprise a diverse range of lived experiences of mental health issues, with a particular focus on having a peer workforce that can effectively engage with vulnerable and/or diverse cohorts of children and families.

Care coordinators

Care coordinators support the child, family and carers navigate and coordinate the care they receive from Community ICAMHS, and other services and organisations. They are a point of contact for when the child, family and carers need support. They will be assigned to a child, family and carer at the point of referral. In instances where immediate linkage is not possible, the Intake and Management Team may need to provide interim care coordination support.

A care coordinator's role is also focused on: ensuring there are linkages and connections between care providers; supporting shared care; helping the family 'step up' or 'step down' from Community ICAMHS to statewide services and vice versa; and facilitating and contributing to warm handovers and follow-up care. Where possible, they will be a 'constant' throughout a child, family, and carer's journey. This care coordinator can be from a hub or a spoke, and can come from a range of backgrounds.

Further planning and decision-making that is informed by good-practice clinical governance is required to fully determine the scope of professions that can undertake the care coordinator role.

Practice Leads

As previously mentioned, all Community ICAMHS Hubs will have embedded specialised capabilities, further to the generalist capabilities of their multi-disciplinary teams. Practice Leads represent a critical point of specialised expertise at a local level. They can be appointed to a member of the multi-disciplinary team who either has dedicated experience or associated capabilities with a specific cohort, or is supported to receive intensive training and upskilling from a specialised statewide service (e.g. Touchstone, Pathways, CTS etc.). In some cases, this need not be confined to one particular resource, as it will depend on local need and operational factors. Under this role, they will provide a broad range of mental health supports, but also lead the provision of care for complex children within their dedicated cohort (e.g. personality disorders). Further, the Practice Lead would receive dedicated support, shared care and consultation liaison options and training from a specialised statewide service – acknowledging the personal, professional and clinical challenges that may come with this role. Through this, the Practice Lead can provide supervision to other Community ICAMHS staff working with this cohort, and lead partnership with associated services and stakeholders. For example, this role could be delivered by a senior mental health worker with expertise in supporting children with eating disorders.

Other roles within the workforce

To support the delivery of this Model of Care, other roles within this workforce will be required, such as administrative and management roles. Key functions include but are not limited to:

- administration
- health information management

- system management, monitoring and performance management
- training and people management
- research and policy.

These roles are needed to enable the clinical staff to focus on providing the best possible care to children, families and carers, and are explicitly required to deliver this Model of Care.

5.2.4 Other workforce considerations

Workforce profile

To ensure Community ICAMHS is delivered and supported by clinical and non-clinical staff who can meet the needs of children, families and carers, these spaces need to employ a workforce that reflects the diversity of the community it serves. This includes:

- a strong pipeline of AMHWs
- cross-cultural workers in all Community ICAMHS settings
- employment of people with lived experience of mental health issues (as mentioned above)
- a diverse range of people including those who are LGBTQIA+, Aboriginal and Torres Strait Islander and ELD
- dual-skilled mental health and AOD clinicians.

Children and families who can see themselves reflected in the staff of the service will be much more likely to engage and trust the service with their recovery and be willing to access these spaces in the future, if required.

Soft skills

Community ICAMHS staff must have the soft skills required to effectively support the mental health needs of children and families from a broad range of circumstances, backgrounds and cultures. These include:

- strong rapport building and relationship development skills
- work from a recovery and strengths-based approach
- provide non-judgemental support when interacting with children who are exhibiting challenging behaviours
- actively listen to and support children in a vulnerable state to identify what their most critical and immediate needs are, rather than being in ‘solution mode’
- ability to remain calm when interacting with children in a heightened state
- resilient and child-focussed, that is, they are willing to go the extra mile to ensure the individual is supported to access follow up supports that best meet their needs.

By recruiting a workforce who possess soft skills and share similar values with children, families and carers who access mental health support via Community ICAMHS, these teams will be able to establish a reputation within the community as a trusted and approachable provider of mental health support, increasing the number of people who access support in the community and improving community mental health outcomes. Further, it is expected that Community ICAMHS staff will have knowledge of the broader system, and the interfaces between mental health

supports and adjacent settings including community and primary health, the AOD sector, justice, schools, and more.

Community ICAMHS must ensure that staff delivering clinical and non-clinical supports are open-minded, inclusive, empathetic and have demonstratable experience working with diverse people including those who are neurodiverse, LGBTQIA+, Aboriginal and Torres Strait Islander, and ELD. Recruitment within these teams should be focussed on employing a workforce who can meet all the needs of children, families, and carers, not just the clinical capabilities they possess.

5.3 Infrastructure

5.3.1 Physical infrastructure

Physical infrastructure is a critical component in enabling the delivering of child mental health care. The following describes the key physical infrastructure required to deliver care.

Location

Community ICAMHS will be delivered in settings that make all children feel safe and comfortable and are easily accessible for children, families and carers. For example, services should be delivered away from a hospital setting, and close to a child, family and carer's home, whenever possible. Where families and carers need to attend a physical location, these should be accessible by public transport and have parking available. Note - it is likely that many of these hubs and local clinics already exist through current CAMHS services across the regions. Where possible, Community ICAMHS Hubs and spokes will be co-located with other relevant services including but not limited to CDS, primary care, child and family services, ACCHOs and others.

Facilities

Spaces will be child friendly, welcoming and culturally safe. This includes creating child-friendly spaces, such as indoor and/or outdoor playgrounds or play areas, calming spaces (e.g. quiet zones/chill out spaces), waiting areas that are non-clinical, and rooms for different types of therapies, such as play therapy and art therapy.

Physical design of facilities

Facilities should be designed with the following to enable children to feel safe and comfortable when accessing support:

- disability access
- sound proofed rooms
- spaces attuned to sensory preferences
- access to sensory/tactile tools
- bright and colourful spaces that bring the natural environment inside (e.g. natural lighting)
- strong and reliable Wi-Fi.

Physical infrastructure for Community ICAMHS facilities should be co-designed and involve young people and their families where possible.

Staff facilities and resources

Appropriate staff facilities and resources are required to support staff to deliver care – including mobile outreach care. These resources include access to transportation (e.g. motor vehicles) and accommodation, if they need to go to other areas, whether that be metropolitan staff travelling to a regional area or vice versa.

Where possible, the establishment of individual Community ICAMHS Hubs and spokes should leverage existing locations within the community or region, to both retain community familiarity of local mental health services, as well as realising significant cost savings.

5.3.2 Digital infrastructure

Reliable and suitable digital infrastructure will be a key component in enabling staff to perform their roles, whether this be delivering care and treatment via telehealth, or capturing, accessing and sharing information and resources digitally. In addition, technology can help make care more accessible, timely and easier to manage for children, families and carers. Table 4 summarises the key digital infrastructure requirements for this Model of Care.

Table 4 | Digital infrastructure requirements

Digital infrastructure requirements to support staff and children, families and carers include…	
For staff	Appropriate portable devices, such as laptops, i-Pads and smart mobile phones, with reliable internet connectivity/Wi-Fi and high-quality cameras to enable videoconferencing and telehealth.
	A data system that securely stores consumers' information and can be accessible by all those caring for the child, as long as permission has been granted by the child, family and carers. This system should allow all staff involved in caring for the child to see the care plan, the appointments scheduled and undertaken, digital medical records, clinical information, child, family and carer information, contact details, etc..
	Online/mobile applications and/or phone hotlines that enable staff to access resources and forums and seek advice from a network of clinicians or those working within the child mental health care space (e.g. posting a question on the application).
For children, families and carers	Mobile applications that enable families and carers to book and track their appointments on their mobile and/or online and access their child's care plan and any clinical information relevant to their child.

5.4 Other delivery considerations

5.4.1 Professional development, training and resources

Professional development and training

Ongoing access to contemporary and evidenced based professional development, training and resources is important in supporting staff to upskill. Professional development and training will be offered in a range of modalities, such as in the classroom (e.g. lectures/workshops via in-person, virtual, or hybrid), self-paced learning, on-the-job, job shadowing, job rotation and placements. Staff will also be supported and encouraged to upskill and should be provided with the time and resources to enable this. In particular, Practice Leads in hubs represent a critical point of specialised expertise at a local level, and will be supported to receive more intensive, dedicated and specialised training from a statewide service.

Providing online resources (e.g. research articles, FAQs, a service directory of organisations available in different locations, etc.), accessed from a central location, will provide another avenue for staff to get information they need to better support a child, family and carer. These online resources will be accessible 24/7 and enable self-directed learning.

Other supports and resources

Beyond professional development, training and supervision, other supports should be provided to staff that enable them to perform their roles effectively. Other supports may include:

- psychological supports, for example, access to a psychologist, counselling, mental wellbeing resources
- financial supports, such as those travelling to the regions for work
- stable housing, permanent contracts (where possible) and psychologically safe workplace environments.

Note, Community ICAMHS staff in regional and remote areas may require additional resources in particular, given geographical, social and cultural factors.

Communication

As previously identified, a targeted public education and promotion campaign of Community ICAMHS at a local level is critical to ensuring equitable and appropriate access to mental health care for children, families and carers. This campaign should include details about services provided, changes compared to previous CAMHS structures, locations of facilities and details about the referral process – which are all important to improving knowledge of local supports. This is particularly important for engaging with vulnerable and diverse cohorts and communities, reducing barriers to access and stigma of mental health care. Further, this communication should note that the development of Community ICAMHS will take a number of years, so to appropriately manage community expectations.

Other considerations for Community ICAMHS:

- **Changing the language that is used when providing care** to children, families and carers to be more inclusive, safe and accessible (i.e. less clinical).
- **Establishing Memorandums of Understanding** among organisations to facilitate information sharing and care coordination.
- **Rolling out education for families, carers, those interacting with children, and the broader community** to enable them to be more equipped to identify and support children experiencing mental ill-health. These resources should be in different languages and be visual (e.g. use pictures and universal symbols).
- **Conducting ongoing research into evidence-based therapies** and reviewing and evaluating service delivery regularly to improve how care is provided.
- **System-wide governance.** All Community ICAMHS Hubs should be connected system-wide through joint oversight, monitoring and planning by both CAHS and WACHS to foster coherence and equity of service across all regions, thereby ensuring sustainable levels and quality of service for all communities across WA.
- **Strong monitoring and evaluation** embedded in all aspects of service delivery for individual, cohort, and system-level outcomes.
- **Joint leadership and HSP collaboration.** Given Community ICAMHS will operate within the context of both WACHS and CAHS, working together will be a priority for this Model of Care. While there is a need to respect different operating needs, an opportunity exists to partner and collaborate across contexts to share learnings and ensure transparent communication across regions.

6 Terminology

Table 5 below contains a list of the key terminology used within this document.

Table 5 | Key terms used within this document

Term	Its intended meaning and use
ACCHO	Aboriginal Community Controlled Health Organisation
ACCO	Aboriginal Community Controlled Organisation
ACRT	Acute Care and Response Teams
AMHW	Aboriginal Mental Health Worker
AMS	Aboriginal Medical Service
AOD	Alcohol and other Drugs
CAFS	Child and Adolescent Forensic Services
CAHDS	Complex Attention and Hyperactivity Disorders Services
CAHS	Child Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Services
Carer	A person who provides care to another person, such as a child who is living with mental ill-health. They may have statutory responsibility for a child, be a family member who supports a child in their family or be another peer or community supporter.
CDS	Child Development Service
Children/Child	Any person who is under the age of 18. This term is sometimes used to describe all infants, children and adolescents aged 0-17 years of age.
Clinicians	Professionals engaged in the provision of mental health services, including but not limited to Aboriginal mental health workers, administrative staff, allied health workers, nurses, paediatricians, psychiatrists, psychologists, and others.
Clinical supervision	Experienced health professionals providing guidance and oversight to less experienced health professionals.
Community ICAMHS Hub	A central ‘hub’ in each region within WA that leads the provision of mental health supports and is a single point of entry for all children, families and carers.
Community ICAMHS clinic	A local clinic or ‘spoke’ that can deliver care close to home for children, families and carers. The Community ICAMHS Hubs will coordinate and support these clinics.
CPFS	Child Protection and Family Services
CPU	Child Protection Unit
CTS	Complex Trauma Service

Term	Its intended meaning and use
ICA Culturally Safe Care Principles	ICA Culturally Safe Care Principles are intended to guide the delivery of culturally safe, responsive and quality health care to Aboriginal and Torres Strait Islander peoples.
ED	Emergency Department
EDS	Eating Disorders Service
ELD	Ethnoculturally and linguistically diverse
EPLC	Early Psychosis Leadership Centre
Family	A child's family of origin and/or their family of choice. It may include but not be limited to a child's immediate family, extended family, adoptive family, peers, and others that share an emotional bond and caregiving responsibilities.
GP	General practitioner
HSP	Health Service Providers
ICA	Infant, child and adolescent
ICAMHS	Infant, Child and Adolescent Mental Health Service
ICA mental health system	The public specialist infant, child and adolescent mental health services. This relates to services funded and provided by the WA Government.
Mental ill-health	This is a broad term that is used to include mental health issues, mental health needs, and mental illness. It relates to an experience of mental health issues impacting thinking, emotion, and social abilities, such as psychological distress, in addition to diagnoses of specific mental health disorders, such as depression and anxiety.
Model of care	A model of care broadly defines the way health care is delivered, informed by evidence-based practice. It outlines the care and services that are available for a person, or cohort as they progress through the stages of a condition or event.
MST	Multi Systemic Therapy
NGO	Non-government organisation
OOHC	Out of Home Care
Peer support worker	Someone with lived experience who is there to support the child, families, and carers. They may provide emotional or psychological support; attend appointments; or be an advocate for the child, family and carers.
People with lived experience	A child or young person who is or has lived with the impacts of mental ill-health and a person who is or has provided care to a child who is living with mental ill-health.
Service Guarantee	The Service Guarantee outlines what children, families and carers will expect to experience in their interactions with the ICA mental health system.
SEWB	Social and Emotional Wellbeing
Shared care	Shared care involves two or more services working together to deliver coordinated care to children, families and carers.
Staff	People who work within the ICA mental health system.
WA	Western Australia

Term	Its intended meaning and use
WACHS	WA Country Health Service
WAEDSS	WA Eating Disorders Statewide Services

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