Government of **Western Australia**
Mental Health Commission

Infant Child and Adolescent Implementation Program

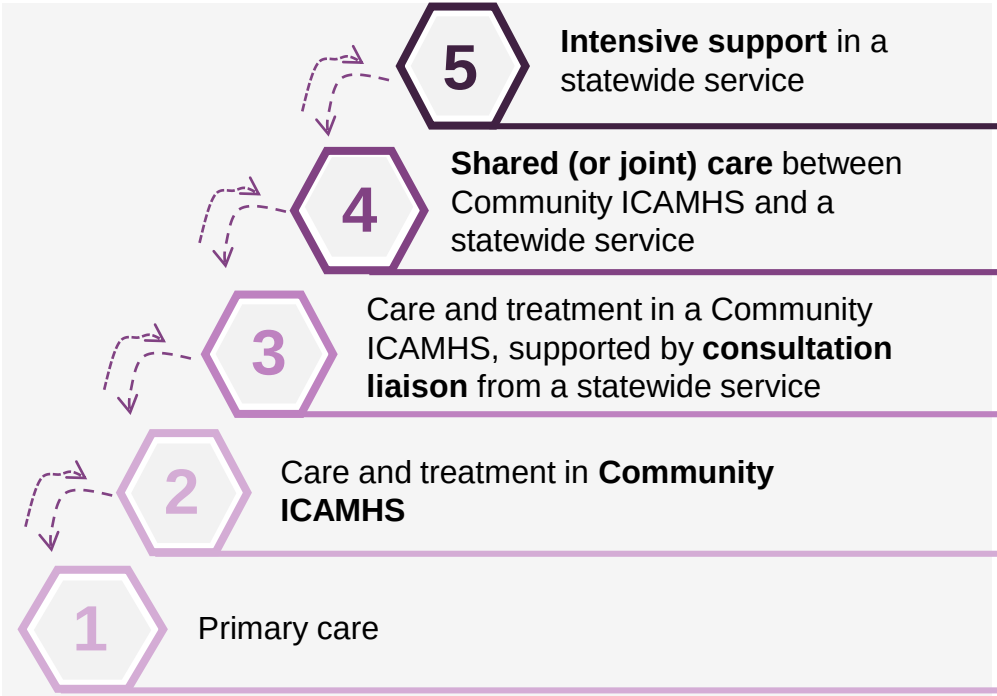
Models of Care

ICA Taskforce has provided direction on the logic of the future system

Five pillars of the future ICA mental health system

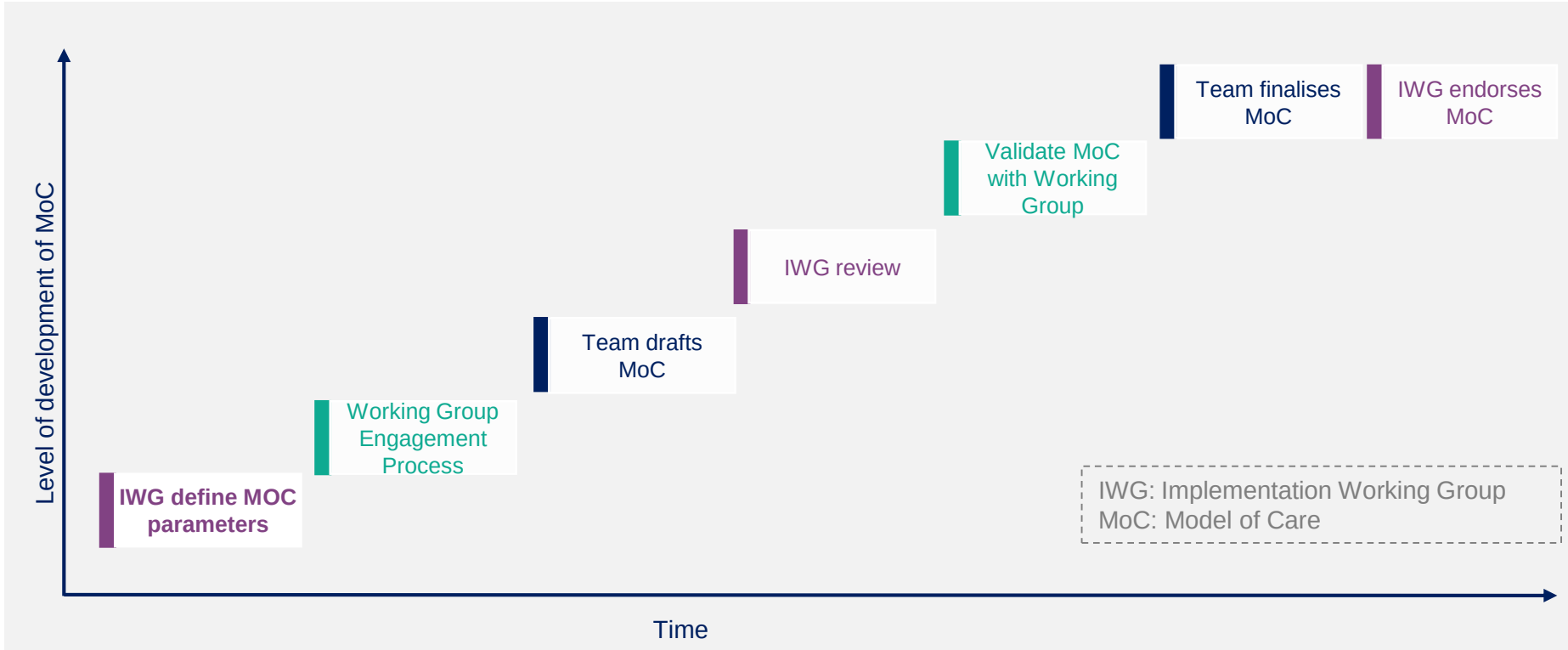
1. PREVENTION AND EARLY INTERVENTION
2. ENHANCED PRIMARY CARE
3. COMMUNITY ICAMHS
4. STATEWIDE SERVICES
5. ACUTE AND INTENSIVE RESPONSE

Stepped care model and shared care approach



High-level process steps

A structured development process will be followed for each Model of Care (MoC)



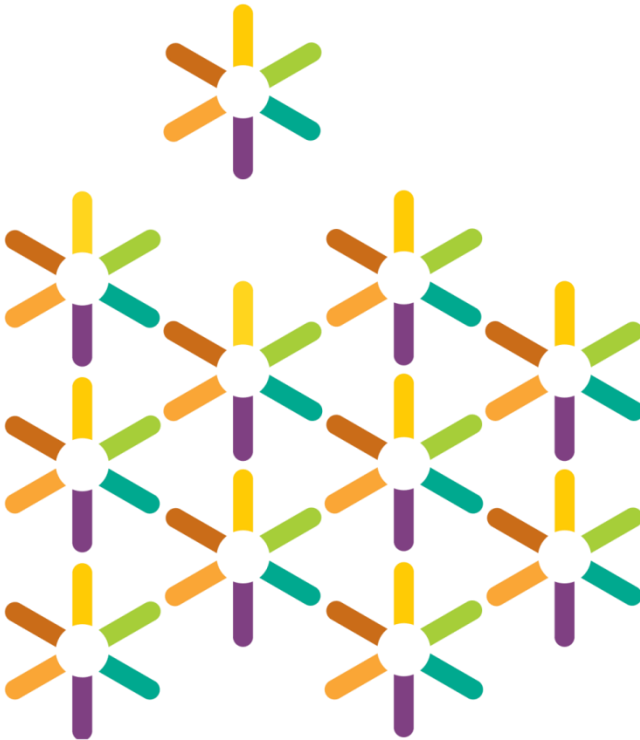
Model of Care design process

Objective 1

Present information for each model of care that was obtained through the ICA Taskforce process

Objective 2

Present high-level model of care working group workshop agenda



Model of Care Parameters

Twelve MoC have been prioritised for development

Priority MoC	
1	Community ICAMHS
2	Infant mental health (0 – 4)
3	Child mental health (5 – 11)
4	Acute Care and Response Team (ACRT)
5	Emergency Departments and Child Safe Spaces
6	Eating Disorders
7	Forensics (Police/Justice)
8	Support to schools
9	Intellectual disability, neurodevelopmental disorders, or neuropsychiatric conditions
10	Early psychosis
11	Complex trauma
12	Personality disorders
Other deliverables	
13	Service guarantee
14	Cultural safety and SEWB principles
15	Aboriginal Mental Health Workforce Model

NOTES

- There are existing services that form part of the system of care are will be considered as part of the design of the models of care, they are: Gender Diversity Services (GDS), Multi-Systemic Therapy (MST), and the Complex Attention and Hyperactivity Disorders Services (CAHDS).
- These will be **considered as components of MoC 1, 7**, and **9** respectively, but **will not be** developed as individual MoC.

Model of Care framework

FRAMEWORK FOR A MODEL OF CARE

Who is this service intended for?

Why does this service exist?

At what **stages** in the continuum of care for an individual is this service intended for?

At each stage in the continuum of care…

What activities and services are delivered?

How should services be delivered?

Who delivers the activities and services?

Where are the activities and services delivered?

What **principles** underpin the model of care?

How does the model of care **integrate** into the broader system?

What **outcomes** will be sought from the model?

NOTES

- Models of care will be **informed by** relevant **existing services**.
- Each model will define **approaches to shared care and stepped care**.
- Each model will be **sufficiently flexible** to allow for local adaptation
- Models will **not dictate clinical decisions** of patient and clinician.

1. Community ICAMHS

QUESTIONS FOR CONSIDERATION DURING THE DESIGN WORKSHOP

- What is the distribution of responsibility in a multidisciplinary team (taking into consideration capacity)?
- What is the single point of entry for ICAMHS? How does this single point of entry function?
- Who is going to steer which clinicians do what functions?
- What core capacities will ICAMHS offer?
- What is the MDT that allows for necessary case management and depth of counselling?

RATIONALE

Currently, there is **no organised ICA mental health 'system**'. For children, families and carers, the system is experienced as **discrete services lacking cohesion and coordination** at population and individual levels. Consequently, children, families and carers **struggle to find and access** the services that they require, and experience abrupt transitions between services. Services are **much harder to access** than they were in the past and **access to care is not the same for all children** (i.e., those in the regions). There is a need for Community ICAMHS **to act as the 'engine-room' for the future ICA mental health system.** That is, a **single entry-point for children**, families and carers to access and navigate the ICA mental health system.

OVERVIEW

Community ICAMHS will provide **local, consistent, and integrated care**, and **connect and support local services** to deliver care to children, families and carers through a hub-and-spoke model.

SOME KEY FEATURES

1. **Hub and spoke model.** In the future ICA mental health system, Community ICAMHS will be made up from the current **WACHS CAMHS** and **CAHS Community CAMHS** teams, **re-organised into regional 'hub and spoke' teams.** There is a stepped care model **outwards to primary care** and an **inwards for specialised care, and** individuals can **easily move in and out** of the system as needed**.**
2. **Three new core functions for Community ICAMHS.** Community ICAMHS will need to deliver three new core functions in local clinics, in addition to core functions currently delivered by Community CAMHS services. These include a **consultation liaison and shared care function with primary and secondary services; a continuous, flexible, and recovery-oriented approach**; and enhanced capability to **support children with complex, co-occurring and specialised needs.**

2. Infant Mental Health (0 – 4)

QUESTIONS FOR CONSIDERATION DURING THE DESIGN WORKSHOP

- To what extent does this service support families and carers?
- Will the design of this MoC largely be based on existing models of good practice?
- What is the interface between this model and the perinatal model?
- What does King Edward do and don't do in this space?

RATIONALE

The **most common problems** during infancy include **emotional, behavioural, sleep, and eating difficulties**, along with **child abuse** and **neglect**. In some cases, these problems can have **serious consequences for early learning, social competence**, and **lifelong physical and mental health**. In other ICA mental health systems, including Queensland and Victoria, there are public specialist perinatal and infant mental health services. Currently, infants are **eligible for ICA mental health services in WA**; however, these services **do not provide specialist interventions** for this age group.

OVERVIEW

A new service which can intensively work with **infants and young children aged 0-4**, whose social, emotional, or developmental wellbeing **is at risk.**

SOME KEY FEATURES

The ICA Taskforce Final Report **does not provide a detailed outline of service parameters** for a new infant mental health service. Across most interventions, there are **three consistent areas of good practice**:

1. **Universal and preventative support** to promote nurturing and responsive relationships.
2. **Targeted interventions** for high risk and/or vulnerable families that promote parent-child relationships and early development.
3. **Intensive and tertiary interventions** which provided therapeutic outcomes for children and/or parents.

3.
Child Mental Health (5 – 11)

QUESTIONS FOR CONSIDERATION DURING THE DESIGN WORKSHOP

- Is this likely to be a new service, or an extension of Pathways?
- How do ensure Pathways has equity of access (i.e., not solely metropolitan focused)?
- Will there be service principles that are embedded into ICAMHS?

RATIONALE

Individuals aged between **5-11-years old with mental health issues** have increasingly **experienced difficulties accessing public mental health** services due to being **perceived as 'lower risk**'. Whilst the existing Pathways service is dedicated to supporting this cohort, it is **limited to supporting** a very **small number of children** that are very '**high risk'.**

OVERVIEW

A **stepped model of service** for **children aged 5-11** with mental health issues that **builds on Pathways** and **integrates into Community ICAMHS**, so that they are **not lost within the system**.

SOME KEY FEATURES

1. The stepped model of service for 5–11-year-olds **needs to build on the existing Pathways service.** Pathways is a statewide service providing assessment, treatment and support for children aged 6 to 12 years with complex and longstanding mental health difficulties.
2. Children can **access the Pathways program** through **other CAHS services**, such as Community Health or through a CAMHS service**.**
3. This Taskforce is based on community-based services, not hospital-based services.

4.
Acute Care and Response Team (ACRT)

QUESTIONS FOR CONSIDERATION DURING THE DESIGN WORKSHOP

- How do we frame the ACRT in relation to the stepped model of care and ICAMHS?
- How do we make this equitable for people in the regions?
- How do we keep everyone (ACRT teams and patients) safe?
- How do we collaborate with other organisations / link this to other services?

RATIONALE

More children are **seeking support in a crisis** than 10 years ago but **struggle to access the care they need**. The **number of children** that have **attended an emergency department** for a **mental health reason** has increased by **almost 50 per cent since 2014**. Currently, there **are no alternatives to emergency departments** for ICA mental health crises. There is a need for a service that provides a **mobile and intensive crisis response** for children that are in a mental ill-health crisis, in a **space they feel safe**. The service needs to be **flexible and serve the 'hard-to-reach'** cohorts.

OVERVIEW

A **mobile, intensive and timely service** to support children that are in a mental ill-health crisis, **at home, in school, in a community setting, or in a hospital setting**, as appropriate.

SOME KEY FEATURES

1. Acute Care and Response Teams **will be established in all Community ICAMHS Hubs** across the State to provide **mobile, highly intensive**, and **timely care** to children that are in a mental health crisis or who require intensive support.
2. In addition to crisis response, **Acute Care and Response Teams need to provide intensive treatment to children with severe** and **enduring mental ill-health**. This needs to form part of a 'stepped' care response.

5.
Emergency Departments and Child Safe Spaces

QUESTIONS FOR CONSIDERATION DURING THE DESIGN WORKSHOP

- How do we frame this MoC in relation to the stepped model of care and ICAMHS?

RATIONALE

Despite preventative measures, when a **child experiences a severe mental health crisis**, sometimes the best option is to **present at an ED**. Anecdotal evidence describes **EDs as an intense, chaotic environment** that involve **long delays** whilst children await access to a service. In many cases, their experience at an **ED only served to exacerbate their distress**. It is critical that children who present to EDs have a **safe, therapeutic and culturally safe experience**, as well as **ongoing care once they leave EDs**. Some mental health crises can be **safely and more appropriately** supported in the community, subsequently reducing further strain on EDs. Children need to have the **option of attending a 'child safe place'.**

OVERVIEW

A MoC for ICA-specific **mental health emergency department presentations**, and **child safe places** in the community.

SOME KEY FEATURES

A **two-level system** that responds to **children in crisis**. The **first level** deals with children who **require immediate ED response to a mental health** crisis. This needs to include a response to people waiting in ED for a bed until there is a safe discharge and adopt a trauma informed approach.

The **second level** is for children who **do not need high-intensity**, short-term psychiatric interventions, but **rather can be safely and appropriately supported in the community.**

6.
Eating Disorders

QUESTIONS FOR CONSIDERATION DURING THE DESIGN WORKSHOP

- What is the definition of eating disorders?
- What are the areas for change?
- Is there an expectation that eating disorders go via ICAMHS or through a separate referral?
- Who is leading the care for this group? Is it physical or mental as the lead provider?
- Are 16–17-year-olds included here?

RATIONALE

The **prevalence of eating disorders** for children and adolescents in WA is **increasing rapidly**. Regional hospitals have experienced a similar trend in admission rates. The services to respond to children with eating disorders, and their families and carers, **need to radically change to meet the demand** across the state and to **provide the right level of care and support, at the right time**. This can be achieved by **progressively implementing a stepped service model** for eating disorders.

OVERVIEW

This MoC will be a review of the **existing Eating Disorders Service (EDS)** through the development of a **statewide, stepped care model of care** to support children with eating disorders across WA.

SOME KEY FEATURES

This service should provide **consultation liaison, shared care and intensive treatment**. It will **impart expertise to enhance the core capabilities** of all services in their treatment of children and adolescents presenting with eating disorders, while also **being responsible for joint or sole service provision** based on an **individual's level of acuity and need.**

7.
Forensics (Police/Justice)

QUESTIONS FOR CONSIDERATION DURING THE DESIGN WORKSHOP

- How does this service interface with existing services?
- How does this fit with conduct disorders?
- How can we divide this into supporting Banksia Hill and to supporting children in the community that are known by the youth justice system?
- How do we support children from regional and rural areas that are in Banksia Hill?
- Where is the crossover with ICAMHS, and what sits in the forensics system?

RATIONALE

Children who have been **exposed to the justice system are disproportionately represented** amongst those **experiencing mental ill-health**. This is largely due to **co-occurring family, social and neurodevelopmental issues**. In recent years, there has been **considerable progress** in the development of coherent approaches to the assessment, care and **support of young people who present with high-risk behaviours** and significant **emotional and mental health difficulties** in the justice system. However, there is **no agreed standard that exists for forensic mental health services, pathways, or models of care.**

OVERVIEW

A MoC for **vulnerable and at-risk children**, **families and carers** who are **in contact** with the **police and justice system**.

SOME KEY FEATURES

A **forensic child and adolescent mental health service** should have **specialised forensic mental health**, and **child and adolescent mental health capabilities**, and adopt **a multi-disciplinary approach** which can address the **needs of a child in multiple settings**, **at multiple stages** of their journey in the youth justice system. This may include **community or home-based treatment, in-reach care to Banksia Hill Detention Centre, assertive wrap-around care in transition**, **in-reach care in inpatient settings**, **dedicated forensic mental health inpatient services**, and **mental health assessments** for children who appear **before the Children's Court**. The new forensic child and adolescent statewide service should work closely with **youth justice services** to provide **consultation liaison, shared care, and capacity building**.

8.
Support to Schools

QUESTIONS FOR CONSIDERATION DURING THE DESIGN WORKSHOP

- Do we need to increase the capability of school nurses in relation to mental health?

RATIONALE

Schools and early childhood services can have a **profound impact** on a **child's cognitive development**. As such, they are in a unique position to provide a range of **prevention, intervention, and referral services**. They can play a vital role in **identifying, facilitating, and providing mental health support** to children and adolescents. Often schools will have **social workers, counsellors** and/or **school psychologists** responsible in part for supporting **students at-risk of developing**, or those **already with mental health issues**, however these staff can be **overworked and under resourced. Teachers** at schools are in a **pivotal position** to notice changes in **students' behaviour** and as such, provide appropriate action to support young people.

OVERVIEW

A MoC for **schools and early childhood services** that **increases their capability** to address **mental health and wellbeing.**

SOME KEY FEATURES

- **Universal interventions** are prevention focused services and are provided **schoolwide to all students.**
- **Targeted interventions** are services provided to **at-risk students**.
- **Individualised interventions** are supports to address **severe mental health issues** among **specific students.**

9.
Intellectual Disability, Neurodevelopmental Disorders, or Neuropsychiatric Conditions

RATIONALE

For **children and young people with an intellectual disability, neurodevelopmental disorder, or neuropsychiatric condition**, **anxiety and other mental health issues** are **highly prevalent**. However, it is very **challenging to diagnose** and effectively **treat mental health issues in this cohort**. This is due to a range of factors, such as **cognitive and language differences**, **atypical reporting of emotions, overlapping symptoms,** and **unique behavioural expressions of some mental health issues** in this cohort. This means that clinicians are **often reticent to diagnose** and **treat mental health issues** in this cohort, which leads to **narrowed or exclusionary service access criteria**. This in turn means that this cohort faces **significant barriers to access timely and appropriate mental health treatment,** placing additional pressure on childhood development and primary care providers.

OVERVIEW

A MoC for a **new statewide service for children with a primary condition of an intellectual disability and/or neurodevelopmental or neuropsychiatric condition** who also experience **co-occurring mental health issues**.

SOME KEY FEATURES

This service, operating within a stepped care model, should provide **consultation liaison, shared care and intensive care**. It will **impart expertise** to enhance the **core capabilities of all services** in their treatment of mental health issues in children and adolescents with intellectual disability, neurodevelopmental and/or neuropsychiatric conditions.

This service is **not intended to deliver intensive mental health treatment.** Instead, this will be delivered in **collaboration with the Child Development Service and other services.**

10.
Early Psychosis

QUESTIONS FOR CONSIDERATION DURING THE DESIGN WORKSHOP

- What does Headspace provide in this space?
- What are the interfaces with other community services?

RATIONALE

Psychotic disorders can cause children and adolescents, and their families, to **experience significant distress and confusion**. It is therefore important that **services are available that facilitate the early identification and treatment of psychosis** in young people, in turn **reducing any disruption to their psychosocial development** and functioning. While **Headspace currently operates an Early Psychosis program**, it **does not have the capacity or clinical capability** to provide the **intensive treatment** that may be required for this cohort of children and young people. Therefore, it **either needs to be expanded or a new specialised, statewide service** needs to be developed which **interacts with the headspace Early Psychosis program.**

OVERVIEW

This MoC are is for a **statewide stepped care model** for children and adolescents presenting with **early psychosis.**

SOME KEY FEATURES

This service, operating within a stepped care model, should provide **consultation liaison, shared care and intensive treatment**. It will **impart expertise to enhance the core capabilities** of all services in their treatment of mental health issues in **children and adolescents presenting with psychosis.** Consideration will need to be given to how the **Headspace Early Psychosis program is configured** and/or **interacts with the stepped care Early Psychosis MoC.**

11.
Complex Trauma

RATIONALE

While all mental health services should be trauma informed, **complex trauma is distinct from other kinds of trauma** and **requires specific interventions**. **Early identification and support** to children who have experienced complex trauma is particularly important, given that **early childhood, especially infancy, is a time of rapid development, and exposure to traumatic events and stressors early on** puts their **development and wellbeing at risk**. Enhancing the **capability of all mental health professionals** to respond to complex trauma in children and adolescents is critical to building an ICA mental health system that is **responsive and accessible**. This includes ensuring that mental health professionals have the **capability to detect and respond to complex trauma** in children in **appropriate and safe ways** that enhance **resilience and recovery.**

OVERVIEW

This MoC will be a **review of the existing Pathways service** through the **development of a statewide, stepped care model of care** to support children and adolescents with **complex trauma.**

SOME KEY FEATURES

1. **Consultation liaison, shared care and intensive treatment.** In addition to providing assessment and treatment for children and adolescents with complex trauma, it will **impart expertise to enhance the core capabilities of all services** in their treatment of children and young people with complex trauma. Complex trauma should not be a service in isolation. It will have to interact with 0-4, 5-11 and community ICAMHS.

2. This MoC **moves away from the 'medical model'** which is focused on **diagnosis and treatment**, and instead moves toward **a more holistic and therapeutic response to trauma.**

12.
Personality Disorders

QUESTIONS FOR CONSIDERATION DURING THE DESIGN WORKSHOP

- What are the guidelines for diagnosis of young people?
- Who are the partner organisations in this space?

RATIONALE

Adolescents with **personality disorders commonly seek help**, but **opportunities for prevention and early intervention are missed**. Much of this has been because of the **difficulty and/or hesitation of services to diagnose personality disorders** in early adolescence. However, a lack of intervention or treatment commonly leads to **serious psychosocial consequences** in later adolescence and during the next 10-20 years of the young person's life. There is only **one child-specific specialised personality disorders service, Touchstone**, in WA. Touchstone is a metropolitan service, providing a structured day program for children aged 12-17 with **emerging Borderline Personality Disorder,** who have struggled with **complex mental health issues for an extended period of time.** The service offers an evidence-based intervention called Mentalisation Based Therapy (MBT).

OVERVIEW

This MoC will be a **review of the existing Touchstone service** through the development of a **statewide, stepped care model of care** to support adolescents with **personality disorders**.

SOME KEY FEATURES

1. This **statewide service is intended to operate within a hub-and-spoke model**, with the ICAMHS operating as the hub. This statewide service will **provide advice to or share care with the Community ICAMHS**. It should also be linked with complex trauma.
2. This service should provide **consultation liaison, shared care and intensive treatment**. It will impart expertise to enhance the core capabilities of all services in their treatment of adolescents presenting with personality disorders.

Defining shared care and stepped care

MoC design workshop | Objectives

8 hours	*20 – 25 participants*	*Hybrid workshops*

1. **Affirm the future requirements** of the MoC, based on the background and rationale for the MoC (i.e. the design criteria)

2. **Validate the service parameters** and **define the principles** for the MoC (i.e. the non-negotiables)

3. **Define the key components** of the MoC (i.e. populate the content of the MoC framework)

4. Explore **considerations for implementation, monitoring, evaluation**, and **system integration**

MoC design workshop | considerations

The **45-minute virtual briefing** for each Working Group will **commence group formation** and **orient members on the task** to maximise focus during the workshop. Framing of invites is that everyone comes prepared.

It will be made clear to Working Groups that their **role is to support development** of the draft MoC, which means that **consensus is not always necessary** during the workshop.

Given that it is expected that a **significant proportion of Working Group members will participate virtually**, the workshop will cater to providing **virtual participants with an active voice in discussions** (such as being able to contribute to virtual whiteboards, vote in polls, contribute in smaller breakout groups, etc).

There will be **some flexibility** in timing allocated to **developing various components of the MoC** based on the level of discussion required. However, there remains a need to be conscious of time by **blocking out sessions to develop the key components of the MoC.** This is to ensure equal quality discussion across all components of the MoC.

Session	Key content	Timing
1. Welcome and introductions	• Welcome, Acknowledgement of Country, and Acknowledgement of Lived Experience • Overview of workshop (agenda/objectives), introductions and overview of working safely together	0900 (15 mins)
2. Introductions to Models of Care	• Present and clarify what the Model of Care is and is not, and set the expectation for what the MOC document will deliver versus what it will inform, and how today's workshop will develop the components of the document.	0915 (5 mins)
3. Model of Care XYZ	• Present Model of Care service parameters (set by IWG) for validation, summarise the case for change/rationale, reintroduce good practice inspiration, define the future requirements for the MoC and explain how the MoC fits within the system.	0920 (20 mins)

4. Key components of the MoC (Part 1)	• Present and review Principles of Care. Slido and group discussion:
	  • Who is the service for (i.e. cohorts and inclusion criteria)?
	  • Where will the service be delivered?
	  • What outcomes will be sought from the model?
		0940 (60 mins)

Morning tea (15 mins)		1040 (15 mins)

5. Key components of the MoC (Part 2) – Future Care Pathway	• Session framing and individual thinking/development of ideal future care pathway: (15 mins)
	  • What care/services should be delivered?
	  • How should it be delivered (options and considerations for delivery)?
	  • Applying these considerations to the stages of the future care pathway
	• Breakout groups (3-4) to develop a proposition for the future approach to care for this MoC. (45 mins)
	• Whole Working Group come together and discuss options for care, and summary (35 mins)
		1055 (95 mins)

Lunch & Wellbeing (45 mins)		1230 (45 mins)

6. Key components of the MoC (Part 3) – Systems of Care	• Self-care and group wellbeing activity (5 mins)
	• Recap of aggregate MOC – what we are agree and what is subject to further development (5 mins)
	• Breakout group activities to provide guidance regarding (40 mins)
	  • Provision of care between public and other services
	  • Staged care within the public system
	• Breakout group to provide guidance regarding provision of care for priority and at-risk cohorts (40 mins)
		1315 (90 mins)

Afternoon tea (15 mins)		1445 (15 mins)
7. Key components of the MoC (Part 4)	• How will services be provided? (30 mins) • Who will deliver the services, including key capabilities? (30 mins) • Key considerations for implementation (including barriers and enablers), system integration and/or transition (30 mins)	1500 (90 mins)
9. Next steps and close	• Summary of workshop outcomes, summary of key issues/questions, IWG reflections.	1630 (15 mins)

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Mental Health Commission

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The information contained in the document is considered to be true and correct at the date of publication however, changes in circumstances after the time of publication may impact upon the accuracy of the data. The databases are active databases and therefore the data may change without notice. Changes may relate to a number of issues, including amendments made to the databases and variations in syntax used to perform the individual queries. The Mental Health Commission is not in any way liable for the accuracy or repeat reliability of any information.

Additional key performance indicators may be developed over the life of the Strategy as needed that focus on priority groups, drugs of concern and emerging issues.