GOVERNMENT OF
WESTERN AUSTRALIA

Infant, Child and Adolescent (ICA) System Transformation Implementation Program

Working Group Pre-Reading Pack

Eating Disorders Model of Care

Thank you

We would like to thank you for generously sharing your time, experience and expertise and providing critical advice on the way forward for the mental health system for infants, children and adolescents, their families and carers, and the WA community.

In particular, we would like to recognise the valuable contributions from people with living or lived experience of mental health issues. We recognise their vital contribution at all levels and value the courage of those who share this unique perspective in creating a better future.

Together, this work provides us with the opportunity to deliver a future mental health system for children that is innovative and responsive to needs – a system in which young people, families and carers are treated with dignity, compassion and empathy.

Thank you.

About this document

This is a pre-reading pack to support you in understanding your role as a Working Group participant in co-designing the Model of Care (MoC) for a statewide, stepped care model of care to support children with eating disorders across WA.

The ICA System Transformation Implementation Program requires the development of 12 Models of Care (MoC) and three related documents.

In 2021, a Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years (the ICA Taskforce) was convened to identify the reforms needed in ICA mental health in Western Australia (WA) to better meet the needs of children, their families and/or carers. As part of this work, the ICA Taskforce developed a series of immediate, short, medium, and long-term recommendations to transform the ICA mental health system. This ranged from investment in workforce capacity building in the current system as an immediate priority, to transitioning to a new statewide MoC in the longer-term.

In 2022, the Mental Health Commission (MHC) launched the ICA System Transformation Implementation Program (the Implementation Program) to drive the implementation of all immediate and short-term recommendations, and coordinate the actions of health service providers in transitioning to the future system. The Implementation Program will especially focus on co-designing a range of components that will form part of the future ICA mental health system, including 12 contemporary MoC and three system principles and solutions (outlined in Figure 1[1]).

[1] Please note, Figure 1 summarises how the MoC and other deliverables fit within the future ICA mental health system. It is not intended to accurately or comprehensively describe the future system.

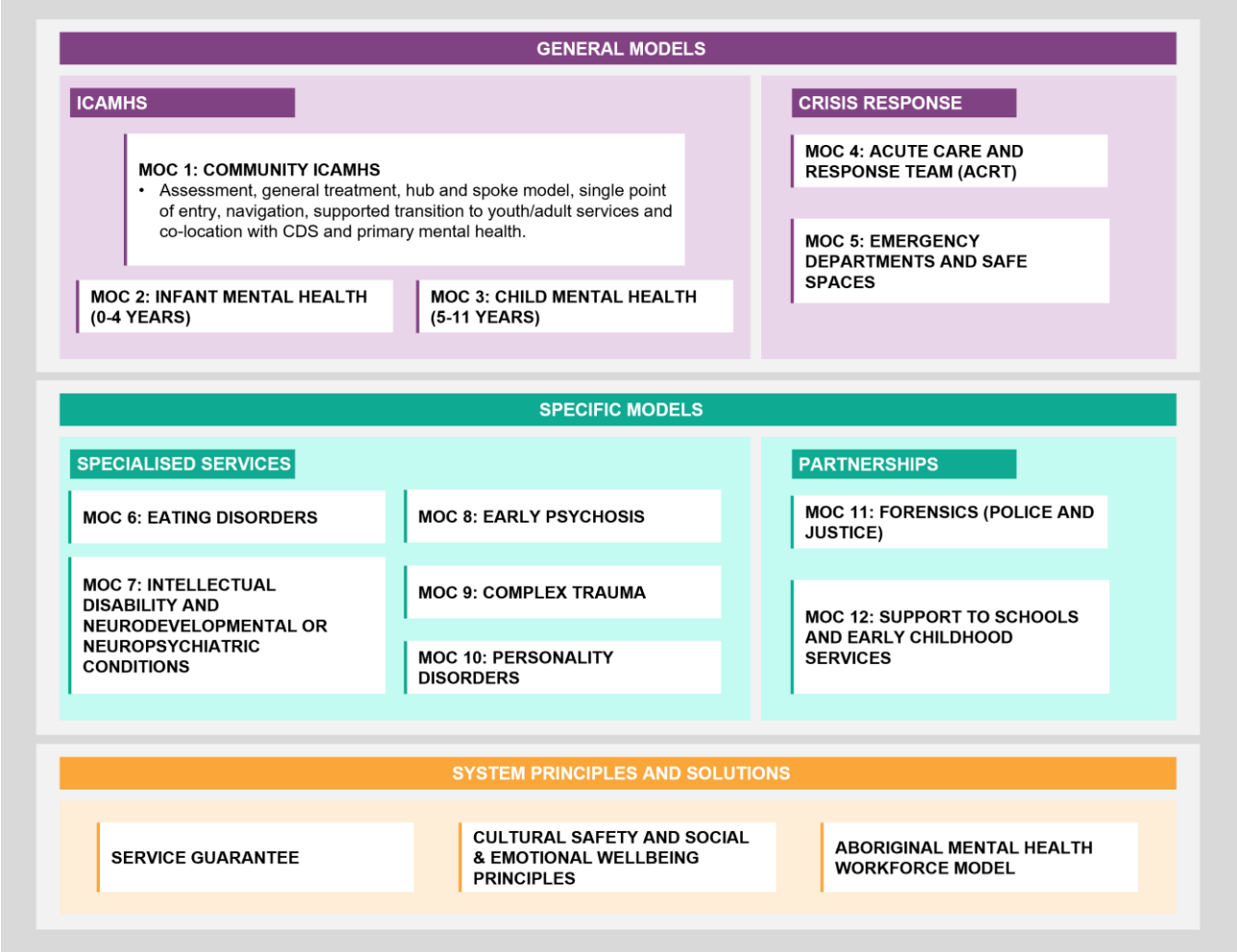

Figure 1 | The Models of Care and related system principles and solutions

Working Groups have been established to support co-design of these components.

A Ministerial Oversight Committee has been established to provide oversight over decisions and implementation regarding the Implementation Program, with an Implementation Working Group responsible for providing direction on the 12 MoC and three system principles and solutions documents.

To co-design each component, the Implementation Working Group has established Working Groups to provide a forum for people with knowledge and experiences of ICA mental health services to share their expertise to define the key features of each component and identify any barriers and/or enablers to its implementation. MoC Working Groups will comprise 20-25 members, with representation from those with lived experience, clinical and non-clinical representatives from Health Service Providers (HSPs), and other stakeholders. Each MoC Working Group will be engaged across **three sessions** to support the co-design of each MoC (see Figure 2 overleaf):

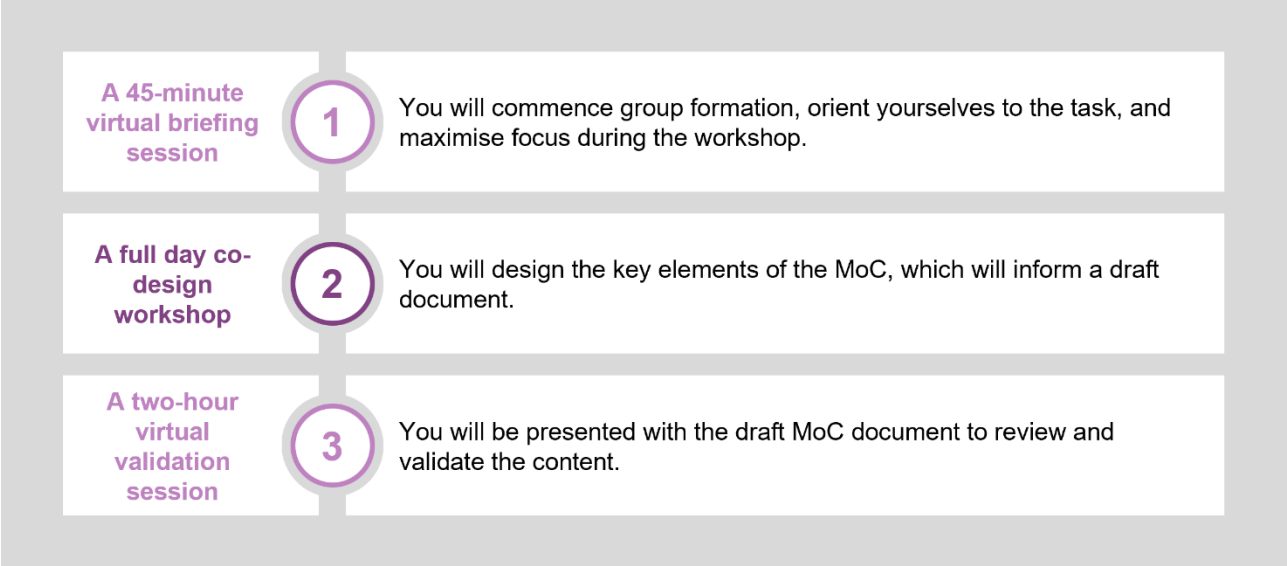

Figure 2 | The Working Group process

Your Working Group is focused on developing Eating Disorders MoC

You have been nominated as part of the Working Group responsible for establishing the MoC for a statewide, stepped care model of care to support children with eating disorders across WA. (MoC 6). Your contributions will be used to define the key components of the MoC, such as what services should be delivered, how they should be delivered, and what barriers and/or enablers to implementation exist.

All Working Group participants are expected to abide by conduct principles and Rules of Engagement developed during Taskforce (outlined in Appendix A) to ensure the safety of those participating; especially of those with lived experience.

Please read the following sections of this document to support your preparation:

- **Section 1 | Background and context.** Outlines relevant findings from the ICA Taskforce, and articulates what the future ICA mental health service system needs to look like.
- **Section 2 | Scope of a MoC**. Provides guidance on what a Model of Care is (and is not), so that you know what to focus your contributions on.
- **Section 3 | Your MoC.** An overview of the service parameters for your Working Group's MoC, which were identified during the ICA Taskforce. This also includes Case Studies and Models of Care from other jurisdictions (nationally and internationally) to support your understanding.
- **Section 4 | Links for further reading.** We encourage you to take the time to undertake further background reading to inform your contributions throughout the process.

Section 1 | Background and context

The section below provides an overview of the ICA Taskforce's relevant findings, the intent of the future ICA mental health system, and the scope of the Working Groups.

ICA Taskforce findings and recommendations

The ICA Taskforce delivered their Final Report to Government on 30 November 2021, building on extensive consultation to present a clear vision, purpose and underlying principles for the future ICA public mental health system.

The Final Report defined eight key actions, which step out what needs to happen, and when, to reform the ICA mental health system, in order to realise the vision, purpose and principles. To deliver the eight key actions, ICA Taskforce made 32 recommendations to the WA Government, all of which were accepted by Government and split across four timeframes for implementation.

The scope of the Implementation Program is only on the immediate and short-term steps (shown in Figure 3 below).

Figure 3 | The four phases of implementation for the ICA Taskforce recommendations

The logic of the future ICA mental health system

The purpose of the future ICA mental health system is to ensure that all children, families and carers in WA have timely, enduring and equal access to holistic, integrated and high-quality public mental health care. The new ICA mental health system is based on five pillars, as outlined in Figure 4, and then discussed in more detail below.

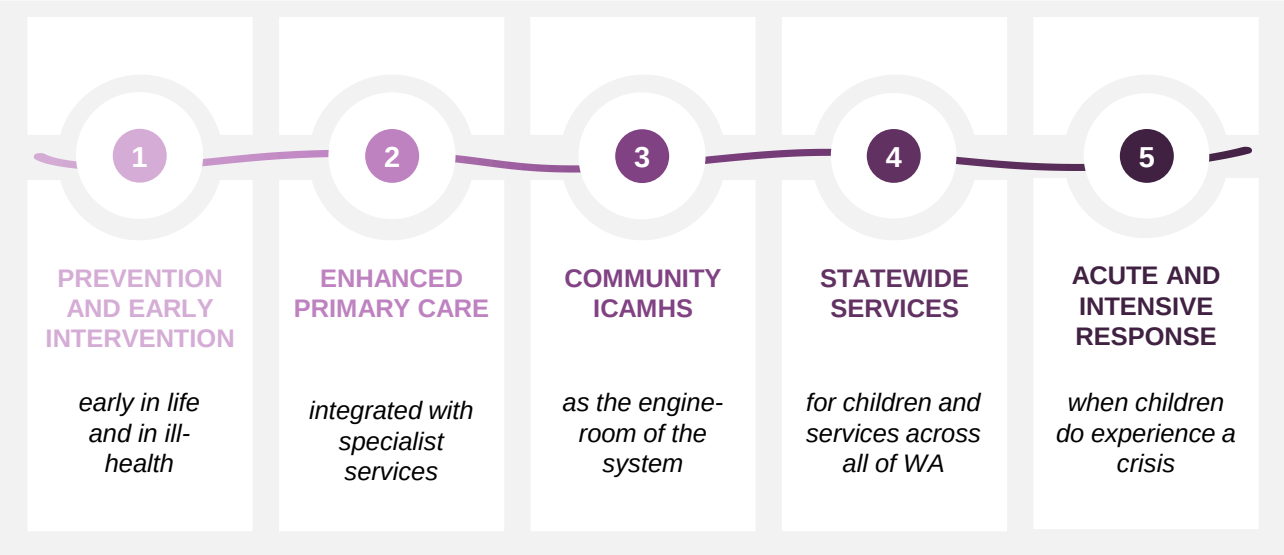

Figure 4 | The five pillars of the future ICA mental health system

1. Prevention and early intervention

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

The system needs a considerable boost to the provision of education and support to assist parents with supporting their child's mental health, and fostering family wellbeing. It will also need to work with children from a young age to build life skills and resilience, significantly expanding the role of early childhood services and schools in supporting the mental health and wellbeing of children in their care.

2. Enhanced primary care

In the future system, primary mental health services need to be partners in care with specialist ICA mental health services and will be enhanced to do more with children, families and carers. Head-to-Health Kids centres and headspace centres will be safe and welcoming 'front-doors' to the ICA mental health system for children and will work in partnership with local GPs, who themselves will be trained to provide more support, coordination and treatment for children, families and carers.

The system needs to have a stronger community-managed and Aboriginal-controlled sector, one that is equipped with the capacity and partnerships to provide culturally safe and responsive care to children and families in their communities.

3. Community ICAMHS

Community ICAMHS are a re-imagined and fully-resourced evolution of the current Community CAMHS services – delivered by the Child and Adolescent Health Service (CAHS) and the WA Country Health Service (WACHS) to provide local, consistent, and integrated care across the state. The Community ICAMHS are the 'engine-room' of the future ICA mental health system. Each Community ICAMHS needs to have a 'hub' located in a regional centre, linked to existing and new local clinics working across each region. Each hub will have:

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

4. Statewide services

In the future ICA mental health system, statewide services represent the reconfigured and enhanced specialised services that are currently Perth-based. These services will aim to support more children, families and carers across the state using a stepped service model. Statewide services and Community ICAMHS will work in partnership to deliver stepped service models, where children can seamlessly 'step up' or 'step down' along a continuum of care based on their needs. This continuum of care is shown below in Figure 5, from least intensive to most intensive care. The least intensive care (level one) is delivered by Community ICAMHS, and the most intensive care (level four) is delivered by statewide services. At level two, Community ICAMHS are supported by consultation liaisons from statewide services. At level three, care is jointly delivered (shared) between Community ICAMHS and statewide services. Many MoC's will need to consider the stepped care model and use it to inform the design of services, specifically the roles of Community ICAMHS and statewide services.

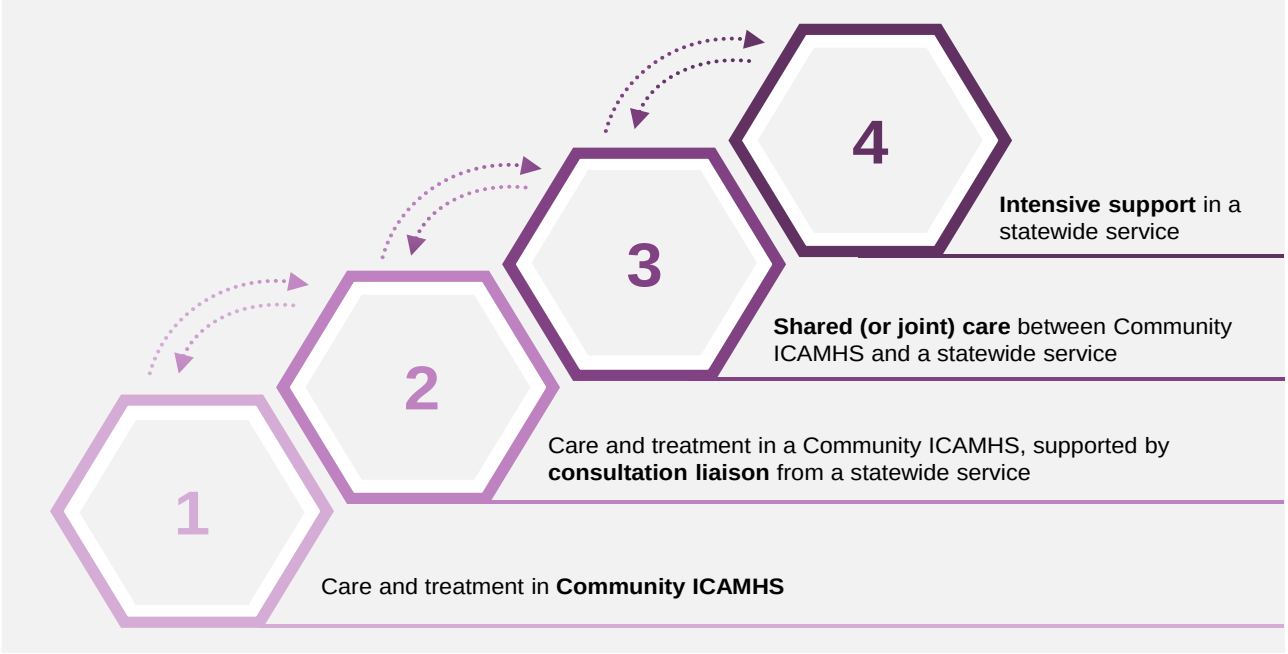

Figure 5 | The Stepped Care Model

5. Acute and intensive response

In addition to the strong focus on community interventions, the future ICA mental health system needs to still have the capability to provide safe and intensive responses to children in crisis. Acute

Care and Response Teams will respond to children in a mental ill-health crisis, or who require highly-intensive support and provide mobile, highly-intensive, and timely care.

Acute and intensive responses in the future system need to be very different to emergency departments. The focus will be on providing children with care that is immediate, delivered in safer, calmer, and in a more child-friendly environment. These 'child safe places' may be new environments, located near emergency departments, that provide an option for respite, assessment, low-intensity treatment, therapeutic counselling, and follow-up support for children who do not need an emergency department, but who need a 'safe haven' to go to.

Models of Care and system principles and solutions

As mentioned above, the Implementation Program requires the development of 12 MoC, which will form a significant part of the future ICA mental health system. In some cases these relate to existing services which will be refined and/or extended, in other cases they may be new services, and in others they may relate to capabilities or processes, rather than discrete services.

There are a number of existing services that form part of the broader ICA system of care that are not subject to design during this phase of work. These include: Gender Diversity Services (GDS), Multi-Systemic Therapy (MST), and the Complex Attention and Hyperactivity Disorders Services (CAHDS). These will be explicitly considered as potential components of other relevant MoC but will not be developed as individual MoC's.

In addition to these, **three system principles and solutions documents** are being developed: including Cultural Safety and SEWB Principles; an Aboriginal Mental Health Workforce Model; and a Service Guarantee. These will be developed early, so they can inform and support the development of each of the MoC, and embedded into the design of the future ICA mental health system. As a baseline, these three system principles and solutions act as a guide for how services should be delivered or configured across all areas of the system, and will therefore be critical inputs into all service delivery components.

As part of the Implementation Program the components in Table 1 will be developed, with an overview of each provided for baseline context.

Models of Care		
1	**Community ICAMHS**	Community ICAMHS will provide local, consistent, and integrated mental health care for children of all ages who have moderate and/or severe needs through a hub-and-spoke model that ensures access across WA. 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.
2	**Infant mental health (0-4 years)**	A new statewide service which is able to work intensively with infants and young children aged 0-4, whose social, emotional, or developmental wellbeing is at risk and support the work of others, including Community ICAMHS, in meeting the needs of this population.

3	**Child mental health (5-11 years)**	This new MoC will improve the quality of mental health services delivered to children aged 5-11. It is intended to operate within the ICAMHS hub-and-spoke model, with capability embedded within the ICAMHS hub, in addition to providing statewide consultation and liaison capabilities.
4	**Acute Care and Response Team (ACRT)**	A statewide mobile, intensive and timely service to support children and adolescents that are in a mental ill-health crisis or who require intensive support.
5	**Emergency Departments and Child Safe Spaces**	A MoC for ICA-specific mental health emergency department presentations, and child safe places in the community.
6	**Eating disorders**	This MoC will extend 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.
7	**Intellectual Disability and Neurodevelopmental or Neuropsychiatric conditions**	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.
8	**Early psychosis**	This MoC is for a statewide stepped care model for children and adolescents presenting with symptoms of early psychosis and at risk of future psychiatric conditions.
9	**Complex trauma**	This MoC will be a statewide, stepped care model of care to support children and adolescents with complex trauma.
10	**Personality disorders**	This MoC will extend the existing Touchstone service through the development of a statewide, stepped care model of care to support adolescents with personality disorders.
11	**Forensics (Police and Justice)**	A new forensic child and adolescent mental health service for vulnerable and at-risk children, families and carers who are in contact with the police and justice system.
12	**Support to schools and early childhood services**	A MoC for schools and early childhood services that increases their capability to address mental health and wellbeing.
System principles and solutions		
13	**Service guarantee**	A document that outlines what all children, families and carers should expect to experience in all interactions with the ICA mental health system.
14	**Cultural safety and SEWB principles**	A set of principles intended to guide and underpin the delivery of quality, culturally safe, responsive health care to Aboriginal and Torres Strait Islander peoples across the ICA mental health system.
15	**Aboriginal Mental Health Workforce Model**	A contemporary workforce model that will inform the roles, responsibilities, and career pathways of Aboriginal mental health workers in the ICA mental health system.

Table 1 | An overview of the MoC and related documents being developed

The MoC and related documents will be an input into the work of the Implementation Program, including supporting the development of business cases and detailed workforce planning. The MoC are intended to support system planning, and are therefore high-level blueprints for the mental health service system, rather than providing clinical direction.

Section 2 | An introduction to Models of Care

The section below articulates what a Model of Care is (and is not), and what key questions you as a Working Group will be required to answer during the design workshop.

What is a MoC?

A "Model of Care" broadly defines the way a specific health service is delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition or event. The following definition of a Model of Care can be used:

> *An overarching design for the provision of a particular type of health service that is shaped by a theoretical basis, evidence-based practice and defined standards.*[2]

What are the objectives of a MoC?

Within the context of the ICA System Transformation Implementation Program, **each MoC has three key objectives**:

1. Articulate the **principles and elements** that should apply to the provision of mental health care.
2. Outline the **future care pathway** and the **capabilities required** to deliver on these.
3. As a document, **inform and guide decision-making** in the development of future plans.

What are the limitations of a MoC?

In light of the above definition and objectives of a Model of Care, it is critical to note the limitations of the scope of all Models of Care. Given its broad nature, a Model of Care **does not**:

- **Define specific interventions** within each stage of the care pathway, or clinical guidelines for the delivery of these specific interventions. It is understood that these decisions are subject to an individual's needs, their agency as a consumer, the clinical judgment of a health worker, and the input of a parent or carer.
- Provide guidance on future service provision for specific **regions, districts, or communities**. It is understood that future service providers will tailor models to the respective needs of the communities they serve and the unique context in which they operate.
- Provide specific **workforce, infrastructure, or other requirements** to deliver the Model of Care. This will be the focus of future streams of work involving the MHC and other partners of the WA Government.

[2] NSW Agency for Clinical Innovation, (2013), Understanding the process to develop a Model of Care. An ACI Framework, Sydney, 2013.

Framework for developing a Model of Care

As you know, 12 MoC have been prioritised for development. The ICA Taskforce has identified a high-level blueprint for future services, based on a stepped model of care, which all MoC will need to be based upon. This includes overarching principles for service delivery and the relationships between specialist statewide services and services delivered locally by the Community ICAMHS service. The purpose of each detailed MoC developed as part of this project will be unique based on the various complexities listed above to best meet the needs of children, families, and carers. However, there is a need for a consistent scope of these MoC outputs, so to reflect a whole of system, whole of community approach to recovery oriented, person centred community-based care.

While the broad parameters for your MoC have been set (see Section 3), your Working Group will be responsible for addressing a series of questions that will explain how the model will be applied in practice (as illustrated in Figure 6 below). This includes understanding:

- **the parameters of the service** – what type of Model it is, and who it is intended for;
- **what will be delivered** – the care pathway and systems of care;
- **how services will be** delivered – including workforce capabilities, infrastructure, service developments or service enhancements, and technology; and
- other considerations including **principles of care, system integration and outcomes**.

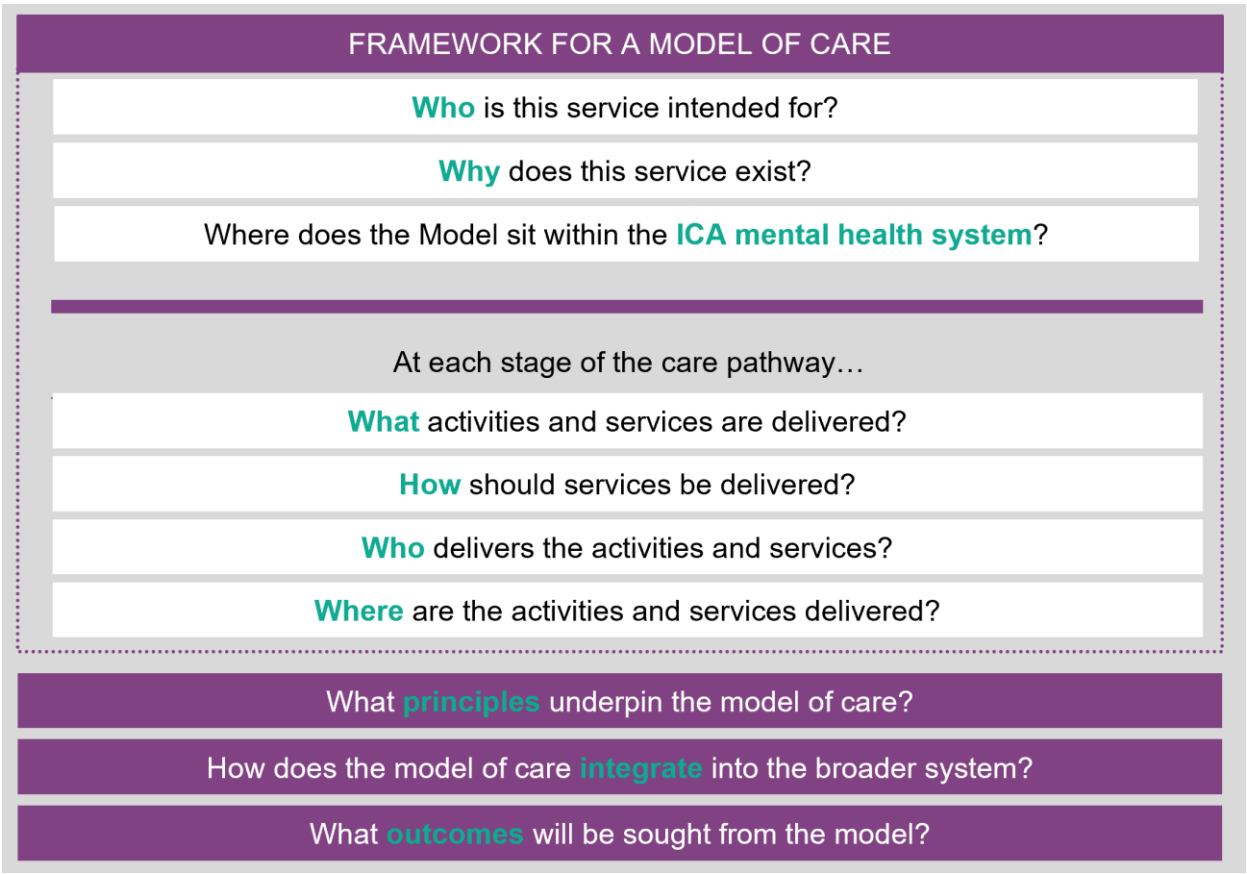

Figure 6 | Key questions you will be required to discuss when developing the Model of Care

How will this guide your efforts as a working Group?

As a result, the focus of the full-day design workshop with your Working Group will be on developing the core components of the MoC document, aligned to the questions outlined in Figure 6 above. For example:

- **'Who is this service intended for?'.** While the broad parameters are set, your Working Group will focus on clarifying the target population and profile, and indicative inclusion criteria.
- **'What activities and services are delivered?'.** In the workshop, your Working Group will look to develop the future state care pathway, from intake to discharge, including the options that consumers and clinicians should consider when developing treatment plans.
- **'How does the MoC integrate into the broader system?'.** In the workshop, your Working Group will define the systems of care (how shared care might look in this context, the required partnerships, and transition between settings).

Section 3 | Your Model of Care

Your Working Group is focused on co-designing the Eating Disorders MoC.

The section below provides an overview of the service parameters that have been identified for your MoC based on findings from the ICA Taskforce. This is intended to provide you with an introductory or 'baseline' understanding of what the MoC should be. This will be the basis for designing the detailed components of the MoC during our design workshop. Please refer to the case study for ideas as to what this MoC could look like in practice and feel free to seek out other models and ideas as part of your personal workshop preparation.

MoC definition

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

Rationale

The prevalence of eating disorders for children and adolescents in WA is increasing rapidly with the Child and Adolescent Health Services' EDS recording a 47.9 per cent single year increase in 2020 and the CAHS inpatient unit at Perth Children's Hospital recording a 168 per cent increase in eating disorder admissions between 2017 to 2020. Regional hospitals have experienced a similar trend in admission rates.

Furthermore, continuity of care between community and generalist mental health services and the EDS remains fragmented. This requires a greater focus on collaboration and coherence of care between mental health and physical health clinicians, and clearer transitions of care from the child to the adult mental health system, which has significantly less capacity.

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.

What we know about this MoC from ICA Taskforce

Overview

As stated by the ICA Taskforce, this service will be a reconfiguration of the EDS as a stepped eating disorders MoC for children, both in the community and in hospital settings. This service should provide consultation liaison, shared care and intensive treatment, to increase the accessibility of eating disorders support within the community as much as possible, yet provide intensive tertiary treatment if required. It will impart expertise to enhance the core capabilities of all services in their treatment of children and adolescents presenting with eating disorders, including

Community ICAMHS, while also being responsible for joint or sole service provision based on an individual's level of acuity and need.

Objectives

1. This service will improve access to appropriate treatment and support for children and adolescents with eating disorders, and their families and carers, across WA.
2. This service will enhance capability of mental health professionals in responding to the treatment needs of children and adolescents with eating disorders.

Where does it sit in the ICA mental health system?

This statewide service is intended to operate within a hub-and-spoke model and ensure a stepped-care approach to eating disorders, with eating disorder capabilities embedding in all Community ICAMHS so they can operate as a hub for eating disorders capabilities across the state. The statewide EDS will provide advice (i.e. consultation liaison) to and share care with the Community ICAMHS. Further the EDS will continue to provide intensive treatment where required, including for metro and regional children.

Good practice case studies

There is growing evidence for the stepped care approach to eating disorder treatment, with services driving better outcomes for the adolescent and their families, as compared with intensive, longer-term inpatient treatment. These case studies, described in more detail below, demonstrate a stepped care approach, where inpatient care is immediately followed with outpatient care or in-home care, which could inform the Eating Disorders MoC.

HYBRID INPATIENT AND OUTPATIENT CARE
GERMANY

Description

In Germany, a specialist Eating Disorder Unit (EDU) has integrated inpatient and outpatient care, providing inpatient care over three weeks (the stabilisation period), followed by a stepped day patient treatment for adolescents with anorexia nervosa. All patients had received multi-disciplinary treatment and individual and family components of care.

Another example of a hybrid approach is a stepped care model with an immediate day program following inpatient care in Germany. This approach involved early discharge of children and adolescents in mental health inpatient units, followed by 12 weeks of intensive support at home, and a follow up eight months later.

QUEENSLAND CYMHS – EATING DISORDER GUIDELINES
QUEENSLAND

Description

Queensland Health has developed a guideline (similar to a model of care) to assist staff within its Child and Youth Mental Health Services (CYMHS), Departments of Emergency Medicine, inpatient mental health units and paediatric medical wards when assessing a child or adolescent with a possible eating disorder, and deciding the most appropriate placement, treatment and care.

The guideline is not intended to be a prescriptive model of care. Rather, it includes guidance on assessment; examination; treatment and management. The overarching principle guiding the model of care is that treatment of children and adolescents with eating disorders have a right to access

medical and mental health services across the continuum of care, including inpatient, outpatient and specialist services.

CARE PROCESS MODEL FOR EATING DISORDERS
USA

Description

Intermountain Healthcare in the USA has developed a Care Process Model for eating disorders. The model includes guidance on diagnosis, treatment, management and the composition and roles of the multidisciplinary team supporting the child or adolescent.

The model is based on the approach of treating individuals on a continuum. For instance, the treatment intensity increases, if disease severity increases, and similarly, treatment intensity decreases as an individual's condition improves. After the condition has resolved, individuals receive ongoing support through primary care services.

The model includes psychotherapy strategies, dietitian strategies, medical strategies and criteria for diagnosis, treatment, admission and discharge.

FUTURE DIRECTIONS FOR EATING DISORDERS SERVICES
NEW ZEALAND

Description

New Zealand has developed a proposed model of care for eating disorders services for adults, children and young people. The model comprises of three service levels: primary, secondary and tertiary. To ensure seamless service delivery and easy transitions between services and continuity of care, the proposed model also involves establishing eating disorders liaison roles and providing each service user referred to a secondary service with a care coordinator.

The model of care provide advice on assessment, treatment and management, as well as specific guidelines for children and young people. The guidelines also emphasise the importance of family involvement, particularly given family members play a crucial role in treatment and recovery. As an example, therapy involving family should include educating the family about the disorder and strengthening the parental subsystem and the roles of family members. In addition, family should have access to psychological support, should they need it.

Section 4 | Links for further reading

This section provides direct links to relevant ICA Taskforce reports, and examples of relevant case studies. We encourage you to explore this content prior to the design workshop to inform your contributions.

- ICA Taskforce Final Report
- Emerging Directions Report
- Case Study 1 – Germany hybrid care
- Case Study 2 – Queensland CYMHS
- Case Study 3 – USA Care process model
- Case Study 4 – New Zealand Future Directions

Appendix A | Working Group conduct

Members will abide by conduct principles outlined below and the Rules of Engagement developed by ICA Taskforce (outlined in Figure 7) to ensure the safety of those participating; especially of those with lived experience.

1. All members are equal and will work towards consensus wherever possible, treat each other with respect and maintain confidentiality.
2. All members will operate in a trauma informed manner, that is where one's conduct reflects an understanding that trustworthiness and transparency, peer support, collaboration and mutuality, empowerment of voice and choice, and cultural, historical and gender issues are essential to facilitate participation and collaboration and that members behaviours reflect and demonstrate this understanding in their conduct and behaviour in each interaction.
3. Members will be required to declare any potential, perceived and actual conflicts of interest. These conflicts, and the way in which they will be addressed, will be maintained in a register. Report conflicts of interest to ICAImplementation@mhc.wa.gov.au.
4. Information shared and information generated in the sessions is not to be shared, distributed or used external to the purposes in which it was generated. It is therefore expected that members or persons attending the session do not share content, do not use content or duplicate content for reasons outside of the intended purpose outlined in item 2, for the Infant, Child and Adolescent Implementation Program.

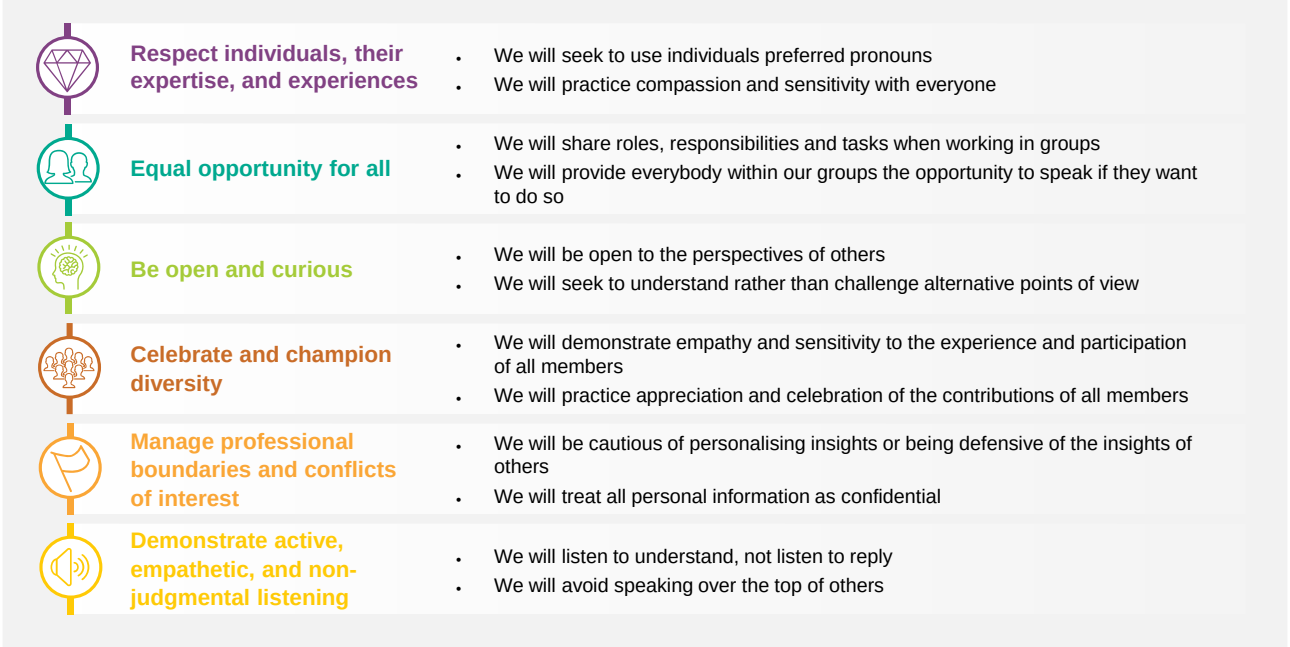

Figure 7 | Rules of Engagement for Working Group members

GPO Box X2299, Perth
Business Centre WA 6847

Level 1, 1 Nash Street
Perth WA 6000

T (08) 6553 0600