GOVERNMENT OF
WESTERN AUSTRALIA

Infant, Child and Adolescent (ICA) Taskforce Implementation Program

Child Mental Health: A Model of Care

Version 3.0 | 1 December 2022

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1 Introduction

Across Western Australia (WA), child mental health has historically had a lack of investment and dedicated focus due to a range of factors. This is despite evidence demonstrating that investing more in identification and intervention in a child's early years will support a reduction in the progression of ill-health[1]. To address these challenges, the Mental Health Commission (MHC) has developed this **Child Mental Health Model of Care**[2], which defines how child mental health care will be delivered in WA's future infant, child, and adolescent (ICA) mental health system.

Under this Model of Care, children aged 5-to-12 years of age with mental health issues will have access to a range of person-centred and evidence based supports. To achieve this:

- **Community Infant, Child and Adolescent Mental Health Service (ICAMHS) will provide the majority of care to children, families and carers.** Community ICAMHS Hubs will have dedicated child mental health workers who will provide direct supports and care coordination, and support other ICAMHS clinicians to deliver supports.
- **Pathways will provide specialised and intensive supports to children, families and carers**. This includes working in partnership with Community ICAMHS and other services, such as the Child Development Service (CDS), to provide case-by-case advice, joint care, training, and clinical supervision.
- **Community ICAMHS and Pathways will contribute to building the system's capacity** and capacity to respond to and manage child mental health issues.

This Model of Care was developed through the establishment of a Working Group that was responsible for designing the key features of the Child Mental Health Model of Care, with support from relevant good practice models in other jurisdictions. The Working Group provided a forum for people with knowledge and experience of ICA mental health services to share their expertise to inform the design of this Model of Care. It included a broad range of voices including families and carers with lived and/or living experience of mental health issues, clinicians, and other system leaders. To ensure a broad reach, a survey was subsequently designed and shared with a cross-section of stakeholders across the ICA 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 (refer to page 5). These principles apply to

[1] Mental Health Commission. (2021). Final Report - Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0 – 18 years in WA. Western Australia Government.
[2] A Model of Care broadly defines the way health care is delivered. 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.

all ICA mental health services and are intended to guide how all models of care, including the Child Mental Health 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 children, families, and carers across all ICA mental health services, including this Model of Care. A summary of the ICA Culturally Safe Care Principles are provided in Figure 2 (refer to page 6).

Purpose of this document

The purpose of this document is to describe how child mental health care will be delivered across the ICA mental health system. It 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. For these communities, this Model of Care provides an overarching framework that can be adapted to address local needs. It is recognised that this Model of Care is a living document; it will evolve over time to reflect new research, and findings from monitoring and evaluation activities.

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, families and carers** have been used and is inclusive of all children, family, carers, supporters, and community members who have an experience of a child mental health issue. 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.

Figure 1 | Service Guarantee Principles

Figure 2 | ICA Culturally Safe Principles

2 Background: Case for change

This section provides a summary of child mental health and the key reasons why change in this space is needed within the ICA mental health system.

2.1 Child mental health

Children require positive mental health for both their physical and emotional development. Children who are experiencing mental health issues often find it difficult to regulate their emotions, engage in play, and may have intense struggles with their behaviours, learning and relationships. Similarly, they might find it challenging to be separated from a parent or carer, or have issues with sleeping, eating, excessive crying and engaging in their school environment[3]. Social, economic, and physical environments factors can also influence children's mental health. The presence, severity and impact of these factors will depend on each child, family and carer's circumstances[4].

There can be limitations with diagnosing mental health issues among children, as often the symptoms of mental ill-health and developmental delays overlap. Regardless, early identification and intervention of both is important in supporting positive physical and mental health later in a child's life.

2.2 Case for change

The prevalence of mental health issues among children aged 5-12 years of age is increasing

The Chief Psychiatrist's *Targeted Review*, conducted in 2020, reported a 403 per cent increase in the number of infants, children and adolescents under 13 years of age presenting to the emergency department (ED) in Perth for self-harm or suicide-related reasons[5]. Similarly, there has been a 39 per cent rise in the number of children aged 5-11 referred to the Child and Adolescent Health Service (CAHS) Child and Adolescent Mental Health Service (CAMHS) between 2015-2019.

[3] Emerging Minds. (2022). What is infant and child mental health (and why is it important)?. https://emergingminds.com.au/resources/what-is-infant-and-child-mental-health-and-why-is-it-important/
[4]Australian Institute of Health and Welfare. (2022). Children with mental illness. Australian Government. https://www.aihw.gov.au/reports/children-youth/australias-children/contents/health/children-mental-illness
[5] Chief Psychiatrist of Western Australia (2020) Targeted Review: Chief Psychiatrist's Review into the Treatment of Ms Kate Savage by Child and Adolescent Mental Health Services, Western Australia.

Presentations of mental ill-health in childhood can be predictive of future mental health needs

Children aged 5–12 years of age have increasingly experienced difficulties accessing WA's public mental health services, due to being perceived as 'lower risk'. This is despite research indicating that children experience mental health issues at increasingly earlier ages, and that if not addressed, mental health issues amongst children can result in future mental health disorders and long-term needs[6]. For the system, this can result in greater demand for crisis and bed-based services.

Current services are focused on older children, creating a critical gap in mental health services for those aged 5-12 years old

At present, younger children have relatively limited access to existing CAMHS services, as these services have typically prioritised supporting older children and adolescents. Limited accessibility to services is particularly felt in regional and remote areas of WA.

The existing Pathways [7] is currently dedicated to supporting the 6-12 year old age cohort, however, it is limited to supporting a very small number of children that are very 'high risk' and have unusual, very severe, complex or persistent disorders, that are often complicated by risk factors. As such, children who tend to be earlier in their course of mental illness are often unable to access the care they need[8].

The current ICA mental health system is designed to focus on supporting older children, and children with highly complex needs, rather than on early identification and intervention. Greater investment in the latter will reduce demand on the system, particularly demand on crisis and bed-based services, and support a long-term reduction in the prevalence of mental ill-health in children.

[6] Chief Psychiatrist of Western Australia (2020) Targeted Review: Chief Psychiatrist's Review into the Treatment of Ms Kate Savage by Child and Adolescent Mental Health Services, Western Australia.
[7] Pathways is a WA statewide service providing assessment, treatment and support for children aged 6 to 12 years with complex and longstanding mental health difficulties.
[8] Commissioner for Children and Young People Western Australia (2015) Our Children Can't Wait (Review of the implementation of recommendations of the 2011 Report of the Inquiry into the mental health and wellbeing of children and young people in WA), Western Australia.

3 Overview of the Child Mental Health Model of Care

This section provides an overview of the Child Mental Health Model of Care, including its objectives, limitations, and its intended outcomes for children, families, carers, and staff within the ICA mental health system, and the broader WA community.

3.1 What is a Child Mental Health Model of Care?

The Child Mental Health Model of Care describes how care Community ICAMHS and Pathways will provide care to children aged 5-12 years of age, using a stepped approach. More specifically, this Model of Care outlines how:

- Community ICAMHS will provide care for children, families and carers, including providing early intervention and support. At times, this will be with support from Pathways (via Community ICAMHS seeking case by case advice).
- Community ICAMHS and Pathways will provide joint care for children, families and carers, using an evidence-based and person-centred approach.
- Community ICAMHS and Pathways will provide care in partnership with other services, such as the CDS, general practitioners (GP), primary care services, Child Protection and Forensic Service, hospitals (e.g. Perth Children Hospital's [PCH]).
- Community ICAMHS and Pathways will contribute to building the capability of the broader system to identify and respond to child mental health needs.

As this is the Child Mental Health Model of Care, the focus is on describing the role, responsibilities and capabilities of Community ICAMHS and Pathways in regard to child mental health care. Further information on how Community ICAMHS delivers care can be found in the Community ICAMHS Model of Care document.

3.1.1 Objectives

The objectives of the Child Mental Health Model of Care are to:

- Outline how children, families and carers will **access and receive child mental health care** within the ICA mental health system.
- Outline the **high-level workforce, infrastructure and delivery considerations** to implement this Model of Care.
- Guide the **future operational design of services** that will deliver child mental health care.

3.1.2 Limitations

This Model of Care is intended to provide a framework that broadly defines how care will be provided. As such, it is not intended to:

- **Define specific treatments, supports, therapies or interventions, or clinical guidelines**. These decisions are subject to an individual's needs, their agency as a child receiving care, 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**. Future service providers will tailor this Model of Care 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 this Model of Care**. This will be the focus of future streams of work involving the MHC and other partners of the WA Government.

3.2 Model of Care's outcomes

The Child Mental Health Model of Care is intended to deliver a range of outcomes, outlined in Table 1 below.

Table 1 | Child Mental Health Model of Care intended outcomes

Outcomes that child mental health care is seeking to achieve for…	
 **Children, families and carers**	Children can **access care in their early years of life**, reducing the severity, complexity, and progression of ill-health.
	Care provided to children, carers and families leads to **improved mental health and wellbeing**, both now and into the future.
	Children's **thoughts and feelings are understood, recognised, and taken into consideration,** regardless of their age.
	Children, families and carers receive care in **environments that enable them to feel safe and comfortable.**
	The care provided builds the **family and carer's capacity** to support children, family and carers, and **helps family members and carers identify and address their own needs**.
 **Staff working in child mental health**	Staff feel **supported, optimistic, and empowered** to deliver safe and high-quality care, and work within an environment where they **can speak up and raise concerns without fear**.
	Staff are **highly skilled in child mental health** and provide care that is informed by **best practice**.

Outcomes that child mental health care is seeking to achieve for…	
 **The broader ICA mental health system**	The broader child mental health system can **easily access specialised advice, supports and information** to support how it delivers care to children, families and carers.
	The system is united by **shared outcomes** and has the means to **work collaboratively together** to support children, families, and carers across WA.

3.3 Considerations for different communities and populations

It is recognised that there are historical barriers to accessing mental health care for different communities and populations, and that care is often not catered specifically to their unique social, cultural or other needs. This Model of Care is designed to be inclusive, accessible and of benefit to different communities and populations across the state. These include, but are not limited to:

- regional, rural and remote children, families and carers
- Aboriginal and Torres Strait Islander children, families and carers
- ethnoculturally and linguistically diverse (ELD) children, families and carers
- LGBTQIA+ children.

It is recognised that as part of implementing this Model of Care, there will need to be a level of adaption to ensure that the care delivered meets the needs of different communities and populations.

4 Child Mental Health Model of Care in practice

This section describes the Child Mental Health Model of Care in detail. It focuses on providing information around: who this Model of Care is for; who will provide child mental health care; how care will be provided; and where care will be provided.

4.1 Who is this Model of Care for?

This Model of Care is primarily for children aged 5-12 years across WA with mental health needs. These children may present with the following types of needs:

- experience mental health needs, and developmental delays and neurodiversity[9]
- experience atypical behaviours, and difficulties with sleeping, eating, learning and relationships
- experience difficulties in regulating emotions, moods and behaviours
- find it challenging to be separated from a parent or carer (i.e. attachment difficulties or caregiver-child relationship difficulties)
- have challenging family dynamics or poor family functioning, including trauma symptoms and related attachment difficulties
- have experienced trauma and experiencing mental health difficulties as a result of trauma
- find it difficult to engage in their school environment or refusing to attend school
- demonstrate evidence of self-harm and/or harm to others.

Within the above profile of need, there may be variation in terms of the scale or complexity of needs. Accordingly, this Model of Care seeks to provide care to children with mental health needs that may vary in complexity. Further, there should also be some flexibility in the 5-12 years of age cohort. For example, Community ICAMHS and Pathways should be empowered to consider children aged 4 or 13 years of age who present with needs that would benefit from child mental health supports.

Aboriginal and Torres Strait Islander children, families and carers

It is recognised that the child mental health care provided to Aboriginal and Torres Strait Islander children, families and carers needs to address their physical, mental and social health and wellbeing in a cultural context. Care provided needs to be culturally appropriate and

[9] Please note, a separate model of care for intellectual disabilities, neurodevelopment disorders and neuropsychiatric conditions has been developed.

respectful of Aboriginal and Torres Strait Islander communities' traditional healing and medicine practices.

ELD children, families and carers

It is acknowledged that the child mental health care provided to ELD children, families and carers needs to be accessible and respectful of the cultural, linguistic, religious and spiritual needs of ELD communities. It also should consider the specific needs of ELD children, families and carers (e.g. their refuge and/or migrant experience, potential impact of trauma from their journey, etc.).

Regional and remote children, families and carers

It is recognised that all levels of child mental health care need to be accessible to regional and remote children, families and carers across WA, and be tailored to local communities' context and needs. To do this, future implementation planning and service design needs to involve stakeholders from within regional and remote areas of WA.

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

Community ICAMHS, and Pathways will provide specialised child mental health care, using a stepped care approach. This will involve specially trained child mental health workers in Community ICAMHS and Pathways providing care to children, families and carers, subject to their needs. These clinicians will be trained in evidence-based and child-focused assessments and therapies.

It is recognised that providing mental health care to children is the responsibility of a broad range of health and social care services, including CDS, other ICA services, primary care and community services. As such, this Model of Care aims to describes how Community ICAMHS, and Pathways may work with these services. Table 2 provides an overview of how these services will deliver child mental health care. Further detail is provided thereafter.

Table 2 | Overview of how child mental health care will be delivered in the future ICA mental health system

Service	Description
Community ICAMHS	Community ICAMHS Hubs will have child mental health workers who will be trained in child mental health specific assessments and therapies. These child mental health workers will conduct assessments and deliver therapies to children with complex needs. They will also support other Community ICAMHS clinicians to provide treatments to children with less complex needs, and provide case by case advice to primary care providers. Community ICAMHS clinicians will provide care coordination, and in some circumstances the child mental health worker may act as the care coordinator, particularly when needs are more complex. In addition, Community ICAMHS will provide peer support options to the child, family and carers.

Service	Description
Pathways	The existing Pathways Service will expand its scope of practice to work in partnership with Community ICAMHS. This will involve Pathways providing case-by-case advice, joint care, training, clinical supervision, educational resources to Community ICAMHS' child mental health workers and clinicians. Pathways will also provide specialised and intensive supports to children, families and carers who have been referred to Pathways by Community ICAMHS. This will include providing care in hospital-based settings, where required. Pathways' research and excellence function will support the system to build its capability and capacity to identify and manage child mental health issues.
Other ICA services	Other ICA services may be involved in supporting a child, family, and carer. Depending on the child's needs this may be in addition to Pathways or instead of Pathways. These ICA services may include the new statewide Complex Trauma Service, the new statewide Intellectual Disabilities, Neurodevelopment Disorders and Neuropsychiatric Conditions service, Touchstone, Complex Attention and Hyperactivity Disorders Service, and other services that support children aged 5 – 12 years of age.
Child Development Service (CDS)	CDS provides a range of assessment, early intervention, and treatment services to children with a developmental delay or difficulty that impacts their function, participation and/or parent/carer-child relationship[10]. Community ICAMHS and Pathways will work in partnership with CDS to deliver care to children with a developmental delay or difficulty. This may involve the services working together in a shared care arrangement (e.g. Community ICAMHS and CDS may conduct joint assessments or deliver supports together), or Community ICAMHS, Pathways or CDS sharing expertise with each other to support the delivery of care to a child, family, and carer (e.g. through providing case by case advice).
Primary care and community services	Community ICAMHS and Pathways will work with primary care and community services, including not for profits, Aboriginal community-controlled health organisations (ACCHOs) and other services. This will involve Community ICAMHS and Pathways providing case by case advice to enable these services to respond to and better support a child with a mental health issue, and their families and carers; and working in partnership with these services to support a child with a mental health issue. Community ICAMHS and Pathways will also contribute to building the capability of these services to support children, families, and carers with mental health issues.

4.2.1 Community ICAMHS

Community ICAMHS Hubs will have specialised child mental health workers to support children, parents and carers in community-based settings. These child mental health workers will be

[10] Child Adolescent Health Service. (2022). Child Development Service. https://cahs.health.wa.gov.au/Our-services/Community-Health/Child-Development-Service

trained in specific skills and capabilities related to child mental health, and will sit within the Community ICAMHS Hubs and provide outreach support to the Community ICAMHS local clinics. This includes periodically visiting the local clinics across all regions of WA, to conduct assessments and appointments, and provide support to clinicians. Alongside the child mental health workers, the Community ICAMHS Hubs and local clinics will have clinicians who have some expertise in child mental health. These clinicians will provide care coordination and deliver supports to children with less complex needs.

Role of Community ICAMHS' child mental health workers

The level of support that a child mental health worker provides to each child, family and carer may vary. For example, if a child's needs are less complex, another Community ICAMHS clinician will provide care coordination and supports, and draw on the child mental health worker's expertise as required. However, if a child's needs are highly complex, then a child mental health worker will deliver supports, while another Community ICAMHS clinician acts as the child, family and carer's care coordinator. Table 3 below provides a summary of the child mental health worker's key responsibilities.

Table 3 | Child mental health worker's key responsibilities

No.	Child mental health worker's key responsibilities
1.	Support the Community ICAMHS intake team to triage referrals.
2.	Conduct child mental health specific assessments and deliver child mental health therapies, particularly to those children with more complex needs.
3.	Provide support to other Community ICAMHS clinicians who are working with children, families and carers with less complex needs. For example, the child mental health workers may provide case by case advice to an ICAMHS clinician supporting a child with less complex needs.
4.	If required, carry out care coordination. However, for the most part, it is anticipated that other Community ICAMHS clinicians will be a child's care coordinator.
5.	Provide case by case advice and shared care with CDS, primary care and other community service providers, as needed.
6.	Draw on Pathways to provide case by case advice that supports child mental health workers to provide specialised and intensive supports to children, families and carers.
7.	In severe and complex cases, work with IMHS to deliver specialised and intensive supports, using a shared care approach. In these shared care arrangements, Community ICAMHS will lead care provision.

4.2.2 Pathways

Pathways currently supports children aged 6-to-12 years of age with complex, high-risk, and longstanding mental health issues. However, in the future, its role will be expanded to include supporting those aged 5-to-12 years of age and providing the following:

- Case by case advice to the Community ICAMHS Hubs and other key partners (e.g. CDS, General practitioners [GPs], paediatricians, etc.).
- Care alongside Community ICAMHS' child mental health workers and clinicians, CDS, primary care and other services. This may involve Community ICAMHS, Pathways and other services individually delivering supports simultaneously, and/or services delivering supports together through co-facilitating programs, or jointly conducting one-on-one consultations and group sessions.
- Intensive and specialised therapies and recovery-based programs to children, families and carers, in the community, outreach and inpatient care (e.g. Perth Children's Hospital [PCH]) settings. When this occurs and a child fully transitions to Pathways, a clinician within Pathways will provide care coordination. However, the Community ICAMHS' care coordinator will sustain contact with the family, but with less frequency, and become an ancillary member of Pathways' multidisciplinary care team.
- Care in regional and remote areas via telehealth and regularly conducting clinics/circuits in country areas. This includes Pathways clinicians undertaking set visits to regional and remote Community ICAMHS Hubs and local clinics each year. For example, a mobile team of Pathways clinicians could travel to a different region each school term to provide expertise and support to children, families and carers, and clinicians.

Pathways' research and excellence function

Pathways will establish a research and excellence function to support Community ICAMHS and the broader system increase their capacity and capability to identify and manage child mental health issues. Table 4 outlines the supports the research and excellence function will provide to Community ICAMHS and the broader system.

Table 4 | Overview of what Pathways' research and excellence function will provide to ICAMHS and the system

What supports will Pathways' research and excellence function provide to Community ICAMHS?	What supports will Pathways' research and excellence function provide to the system?
Training and professional development programs to child mental health workers and others within Community ICAMHS' Hubs and local clinics. Training will cover multiple topics, including how to undertake assessments and deliver generalised child mental health supports. Training programs may involve classroom learning (e.g. lectures / workshops via in-person, virtual, or hybrid settings) and job placements in Pathways.	**Education and training** to increase early childhood services, schools, community organisations and primary care providers' capacity and capability for early intervention, and early identification and management of child mental health issues.
Clinical supervision and mentoring to child mental health workers and others within Community ICAMHS, where required. Supervision will incorporate reflective practices and be provided in one-on-one and group settings.	**Research related to child mental health**. These research activities should inform the therapies delivered and the development of the Pathways' training and education programs and resources. As part of undertaking research, Pathways should

What supports will Pathways' research and excellence function provide to Community ICAMHS?	What supports will Pathways' research and excellence function provide to the system?
	form partnerships with researchers, such as tertiary education institutions and research institutes.
Educational resources (e.g. articles, FAQs, etc.) for Community ICAMHS to guide safe community management of children, and their families and carers.	**Child and parent/carer friendly resources on child mental health** (e.g. information booklets, handbooks, etc.). These resources should include general information about child mental health and self-help strategies for children, parents and carers to use, particularly when waiting for care. These resources can be shared with children, parents and carers via Community ICAMHS Hubs and clinics, community services, primary care, CDS, schools, and others within the system.
	Forums or communities of practice to facilitate system-wide collaboration. This could include hosting events and workshops that bring various parts of the system together to share knowledge and experiences, and design solutions to current challenges.

4.2.3 Child Development Service (CDS)

CDS supports children experiencing significant developmental delays or difficulties that may impact on function, participation and/or parent/carer-child relationships. Depending on the child, family and carers' needs, Community ICAMHS' child mental health workers, Pathways and CDS may work together to support a child, and their families and carers. This may involve the services providing case by case advice to each other, or working together in a shared care arrangement. For example, if Community ICAMHS receives a referral that indicates s child has a significant developmental delay, it may request CDS to support the assessment given CDS' expertise in this area.

Community ICAMHS and CDS

There will be occasions where Community ICAMHS and CDS will work together to support a child, family and carer. To enable this, Community ICAMHS and CDS will need to develop processes for referrals, case by case advice, shared care, care coordination, and case conferencing between the two services.

4.2.4 Primary care and community services

Primary care and community services may be involved in care provision for a child with a mental health issue. Community ICAMHS and Pathways will work with GPs and other community-based health services (including ACCHOs). This will involve Community ICAMHS and Pathways:

- Providing case-by-case advice to primary and community health services to enable them to respond to and better support the needs of children with mental health issues, and their families and carers.
- Providing shared care with primary care and community services, so that holistic supports that meet the needs of the child, family and carers can be delivered.
- Helping to build and strengthen the capacity and capability of primary care and community services to support children with mental health issues, and their families and carers.

4.2.5 Stepped model of care

Community ICAMHS and Pathways will use a stepped model of care to deliver child mental health supports. A stepped care approach involves providing supports that are matched to a child, family and carer's needs and preferences. For example, if a child has highly complex needs, the support provided will likely be more intensive.

How does the stepped model of care approach work?

Community ICAMHS Hubs' child mental health workers will be responsible for supporting children, families and carers 'step up' and/or 'step down' the intensity of their care, including supporting the transition to and from Pathways, where required. It is recognised that the stepped care approach may look different for each child, family and carer. The following provides some examples to illustrate how the stepped model of care may work between Community ICAMHS and Pathways.

Example 1: A child presents with highly complex needs upon entry into the Community ICAMHS. The decision from the Community ICAMHS' child mental health worker is to refer the child immediately to Pathways for care. However, an ICAMHS care coordinator is assigned, to remain connected to the family. Intensive care is provided to the child and their family for 3-6 months. After receiving care from Pathways, the child, family and carers agree to 'step down' into Community ICAMHS to receive ongoing support from the child mental health worker, before they transition to their primary care provider.

Example 2: A child presents with needs that are moderate in complexity upon entry into Community ICAMHS. Community ICAMHS' child mental health worker decides to work with Pathways to provide joint sessions. After some time, Community ICAMHS and Pathways, with agreement from the child, family and carers, decide the child can 'step down' the intensity of

their care. Community ICAMHS continues to provide care, with Pathways providing case by case advice.

Example 3: A child presents with low to moderate complex needs upon entry into Community ICAMHS. The decision from the Community ICAMHS' child mental health worker is for an ICAMHS clinician to provide therapies with support from the child mental health worker. After treatment commences, the child mental health worker recognises that the child's needs are more complex than originally thought. The child mental health worker refers the child to Pathways for more intensive care (i.e. the child 'steps up' in the intensity of care they receive). Pathways then provides care to the child. When Pathways and the child, family, and carer determine the child is ready to transition back to Community ICAMHS, Pathways works with Community ICAMHS to enable this 'step down' in care. Subsequent to the child 'stepping down', the child mental health worker within Community ICAMHS provides ongoing care to the child, family and carer, before supporting them to transition out to their primary care provider.

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

The following section describes how a child, family and carer may access and receive care from Community ICAMHS and Pathways, across three broad stages: **access; support; and transition**.

4.3.1 Access

Community ICAMHS will receive referrals to provide care to a child with a mental health issue, and their family and carers, and manage their intake and assessment process. The following describes the key activities Community ICAMHS, and Pathways will undertake within this stage.

Referral

All referrals for child mental health issues will come through to the Community ICAMHS Hubs from various sources and channels (e.g. online, in-person, over the phone etc.), including, but not limited to:

- a child, family and carer (self-referral)
- CDS
- community health nurses
- paediatricians
- GPs
- ACCHOs / Aboriginal Medical Services (AMS)
- schools (e.g. school nurses, school counsellors, psychologists and teachers)
- childcare services
- child protection services

- other services / organisations involved in a child, family and carer's network.

Any referrals that Pathways and Community ICAMHS' local clinics receive will be directed to the Community ICAMHS Hubs.

Pathways' referral processes

Pathways will direct any referrals it may receive to Community ICAMHS. Ideally, Pathways should only receive referrals from Community ICAMHS, after an assessment within Community ICAMHS has been undertaken.

Triage and intake

Community ICAMHS Hubs will have an intake team who is responsible for triaging and assessing the referrals it receives against intake criteria. As required, they will seek input from the child mental health workers to support the triage process. If the referral indicates that a child's needs are highly complex, the child mental health worker may reach out to Pathways for general advice, and/or request they are involved in the assessment. The intake team within the Community ICAMHS Hubs will ensure that all children are receiving some immediate support. Once the referral has been reviewed and triaged, the intake team will assign the child, family and carer a care coordinator from a Community ICAMHS Hub or clinic.

Pathways' triage processes

Community ICAMHS will be responsible for triaging all referrals for child mental health in the first instance. When Pathways receives referrals from Community ICAMHS, it will review them on a weekly basis. Following the initial review, Pathways will arrange a videoconference with the Community ICAMHS' child mental health worker, care coordinator and other clinicians (where relevant) to discuss intervention goals, timeframes of admission, and commencement of assessment and intervention.

Support and information provision

At the first point of engagement with Community ICAMHS, the intake team will offer the child, family and carers the option to have access to a peer support worker. It will be the child, family and carer's decision if they choose to access this support. At this time, Community ICAMHS will also provide information and educational resources to children, families and carers, including guidance on self-help strategies they can use while waiting for care, and information on how they can access the 24/7 crisis line, if needed.

Pathways' role in supporting information provision and support

Pathways' research and excellence function will be responsible for developing child mental health information and educational resources (e.g. handbooks, guides, etc.), and distributing these to Community ICAMHS and other key services to share with children, parents and carers.

Assessment

The assessment process will be multidisciplinary and involve identifying the specific needs of a child, and their families and carers. Community ICAMHS' child mental health workers will be responsible for conducting the assessments. This may involve the child's care coordinator and other disciplines within Community ICAMHS (e.g. occupational therapists, speech therapists, etc.), and in some cases involve Pathways and/or CDS supporting or co-facilitating the assessment (either in-person or virtually). For children with developmental delays and difficulties, and emotional dysregulation difficulties, it would be helpful for CDS and Community ICAMHS to undertake a joint assessment[11].

Assessments will take place in settings that are most appropriate for the child, family and carers. These may include: Community ICAMHS Hubs or clinics; the child, family and carer's GP practice, home, a nearby community centre, library or via telehealth. The assessment will cover multiple emotional, behavioural, social, and environmental contexts. The types of assessments undertaken may involve observations in multiple settings (such as those described above), psychometric assessments or allied mental health assessments (e.g. speech and occupational therapy assessments, etc.).

Pathways' role in the assessment process

Upon request, Pathways may co-facilitate assessments with Community ICAMHS' child mental health workers, or lead the assessment, with the Community ICAMHS' child mental health worker present. This will typically occur in situations where the Community ICAMHS' intake team has identified from the d triage process that the child may have highly complex needs.

When a child is referred to Pathways, the service may conduct an additional assessment, to help inform what intensive and specialised supports Pathways should provide. These assessments will be comprehensive and modular and may involve:

- extended observations (e.g. observation over multiple settings and / or at different times)
- psychometrics (e.g. intelligence testing, cognitive profiling)
- psychiatry assessments (e.g. diagnostic clarification, medication review, second opinions)
- allied mental health assessments (e.g. speech and occupational therapy assessments, exercise physiology assessments).

[11] Please note, a separate model of care for intellectual disabilities, neurodevelopment disorders and neuropsychiatric conditions has been developed.

4.3.2 Support

Children with mental health issues, and their family and carers, can receive a broad range of evidence-based therapeutic supports that meets their needs, preferences and goals. The following outlines the key activities that Community ICAMHS and Pathways will undertake during this stage.

Care plans

Before supports are provided, the Community ICAMHS' child mental health worker and/or care coordinator will develop care plans, in partnership with the child, families and carers, and other relevant stakeholders. Depending on the child's needs, Pathways may also provide expert advice to support the development of a care plan. The assessment and the child, family and carer's needs (e.g. physical, psychosocial, educational and cultural needs), goals, circumstances and preferences, will inform the care plan.

Safety plans

Depending on the circumstances, safety plans may also need to be developed. These need to be developed with the child, family and carer, so that they feel empowered to action the plan, should they need to. Safety plans should be tailored for children so that they can understand them and use them to monitor their emotions and risks. This may include the use of simple language and visual tools (e.g. pictures, symbols, etc.). The plans should be focused on supporting a child, family and carer to prevent or manage a crisis situation.

Similar to care plans, the child mental health worker and/or care coordinator within Community ICAMHS will develop safety plans and draw on Pathways' expertise, as required. Where possible, safety plans should be shared with the child, family and carers' GPs and be accessible to other services supporting the child, family and carers.

Pathways' role in care plans and safety plans

Pathways may provide advice to Community ICAMHS to support the development of care plans and safety plans, upon request from the child mental health worker.
In situations where a child is referred to Pathways, Community ICAMHS will provide Pathways clinicians with the existing care plan. Pathways will then update the care plan to reflect the supports that Pathways will provide and share this with the Community ICAMHS care coordinator.

Supports and treatment

Supports and treatments will be provided to a child, family and carer that are trauma-informed, evidence-based, person-centred, holistic; address child psychological development and physiological and psychosocial needs; and improve a child's wellbeing and mental health. Community ICAMHS will provide moderate to intensive supports, while Pathways will provide

more intensive, specialised supports. The following outlines examples of the types of supports that Community ICAMHS and Pathways may provide.

Community ICAMHS' supports and treatments

Community ICAMHS may provide the following types of supports to children, families and carers:

- psychoeducation for children, families and carers
- individual counselling, psychotherapy and play therapy
- attachment based and family therapies
- group mindfulness programs for children
- physical therapy and exercise
- home visits, focused on developing positive parenting/carer practices
- social and emotional support for children, families and carers, via peer support workers
- parent/carer group therapy, education and support (group programs could be co-facilitated with local and community services)
- access to evidence-based online programs for children, carers and parents
- access and connection to existing community supports
- other non-clinical supports, such as facilitating access to financial, legal and social supports.

Where possible, Community ICAMHS' group programs should be designed and facilitated in collaboration with relevant community and local services, to enable partnerships across the system, and greater community involvement.

Pathways' supports and treatments

Pathways will provide supports and treatments in Community ICAMHS Hubs and local clinics, in the home, via telehealth, and in hospital-based settings. They may provide the following types of supports and treatments in the form of day programs, one-on-one consultations, group sessions, or holiday/group programs:

- individual evidence based psychotherapies
- group therapy for children, parents and siblings
- family therapy and dyadic (interactive) parent and child therapy
- physical therapy, exercise and mindfulness
- exercise programs/physical literacy
- social skills training
- schooling (provided by Department of Education School of Special Educational Needs: Medical and Mental Health (SSEN:MMH))
- liaison with schools, including providing advice regarding learning plans and behavioural management.

Pathways' role in providing supports and treatment

During the support stage, Pathways may support the delivery of care in three ways, including:

- providing case by case advice to Community ICAMHS and other services, such as CDS
- providing joint care with Community ICAMHS and other services, such as CDS
- providing intensive and specialised directly care to children, families and carers.

Care coordination

During the support stage, the Community ICAMHS care coordinator will regularly communicate with the child, family and carers through various ways (e.g. in-person, email communications, or virtual options, such as videoconferencing). They will also play an important role in navigating and coordinating the child, family and carer's experience, supports and appointments, and ensuring information is appropriately shared among services. To facilitate this, the care coordinator may use the following approaches:

- **Hold multidisciplinary team meetings** to enable collaboration and shared decision-making across all teams/individuals involved in care provision. Care plans and treatments should be discussed and evaluated in these meetings. Where appropriate, these meetings may include the child, family and carers.
- **Have regular touchpoints between the Community ICAMHS child mental health worker, care coordinator, and Pathways** when the child has transitioned to Pathways for care. These touchpoints will help to enable the 'step down' in care from Pathways to Community ICAMHS when the time is right. If appropriate, these meeting should include the child, family and carers.
- **Hold interagency meetings**, where required, to facilitate information sharing about ongoing care and management, and discuss any new, emerging needs.
- **Regularly communicate with the child's GP and/or paediatrician** to share information and discuss care planning, treatment and management. Where appropriate, these meetings may include the child, family and carers.
- **Regularly liaise with schools** to enable them to best support the child at school including provide guidance regarding education plans and behaviour management. Children, family and carers should be invited to these meetings as appropriate.

Pathways' role in care coordination

When a child is in the primary care of Community ICAMHS, depending on the circumstances, Pathways clinicians may attend multidisciplinary team meetings and provide advice to the child mental health worker.

When a child 'steps up' and fully transitions to Pathways for care, care coordination will be transitioned as well. The child's care coordinator from Community ICAMHS will maintain contact with the children, family and carers, but with less frequency. To support continuity of care for the child, the Community ICAMHS care coordinator should become an ancillary member of the Pathways multidisciplinary care team and attend meetings.

4.3.3 Transition

When it is safe and suitable to do so, children with mental health issues and their families and carers, will be supported to transition into other settings, ensuring continuity of care. The following describes the key activities that Community ICAMHS and Pathways will undertake in this stage.

The transition stage involves a child, family and carer transitioning their care from Community ICAMHS to a primary care and/or community service provider. Transition in this context does not refer to the transition or 'step down' from Pathways to Community ICAMHS. All children will only transition out to the community for care via Community ICAMHS (see commentary below which describes the transition from Pathways to Community ICAMHS).

Transition from Pathways to Community ICAMHS

Where a child is referred to Pathways for care, they will always transition back to Community ICAMHS after receiving care and before transitioning out to the community. The transition between Pathways and Community ICAMHS will be conducted with proper handovers and communication between the services.

Pre-transition

Before the transition, the Community ICAMHS' child mental health worker and/or care coordinator, the child, family and carers, and others supporting the child, family and carers (including those inside and outside of Community ICAMHS) will begin discussions on when it may be appropriate to transition care out to a primary care or community service provider. Progress on the family's goals/milestones should also be considered during these conversations. Before the transition commences, the individuals/team supporting the child may begin to gradually reduce the intensity of support, as a way to prepare the child, family and carer for the transition.

During transition

During the transition, the child mental health worker and/or care coordinator will engage with relevant support services and organisations to conduct warm handovers and discuss the ongoing support needs. This may involve having meetings with all services present, or one-on-one meetings with Community ICAMHS, the service/organisation, and where appropriate, the child, family and carer. At this point, the child mental health worker and/or care coordinator will provide educational support and resources to support the family and carers provide ongoing care. Resources may include: information about what they could expect in the coming weeks, months or years; strategies that the child, family and carer could use if they are struggling; and a list of services they could reach out to for support and advice. If required, the child mental health worker and/or care coordinator may develop or refine a safety plan for the child, families and carers.

Post transition

Post transition, the Community ICAMHS' care coordinator will maintain contact and communication with the child, family and carers for some time. As part of these touchpoints, the care coordinator will check-in on how the child, family and carers are going, and discuss whether current supports are appropriate.

4.4 Where will care be provided to children, families and carers?

Community ICAMHS and Pathways will provide care to children, families and carers in a range of settings and locations. Most importantly, services will be delivered in settings that make children feel safe and comfortable, and are easily accessible for children, families and carers. Community ICAMHS may provide care in Community ICAMHS Hubs and local clinics; CDS clinics, GP practices, AMS/ACCHO centres, home, at community centres and libraries, public outdoor spaces (e.g. parks, playgrounds or skate parks) or via telehealth. Pathways may provide care in the settings listed above, as well as in Pathways clinic(s) and in hospital-based settings.

4.5 What might a consumer journey look like?

Children, families and carers' journeys will be unique. The consumer journey examples overleaf show how a child, family and carer may access child mental health care. The examples provided are for illustrative purposes only, and does not present all children, families and carers' situations.

Figure 3 | Consumer journey map 1

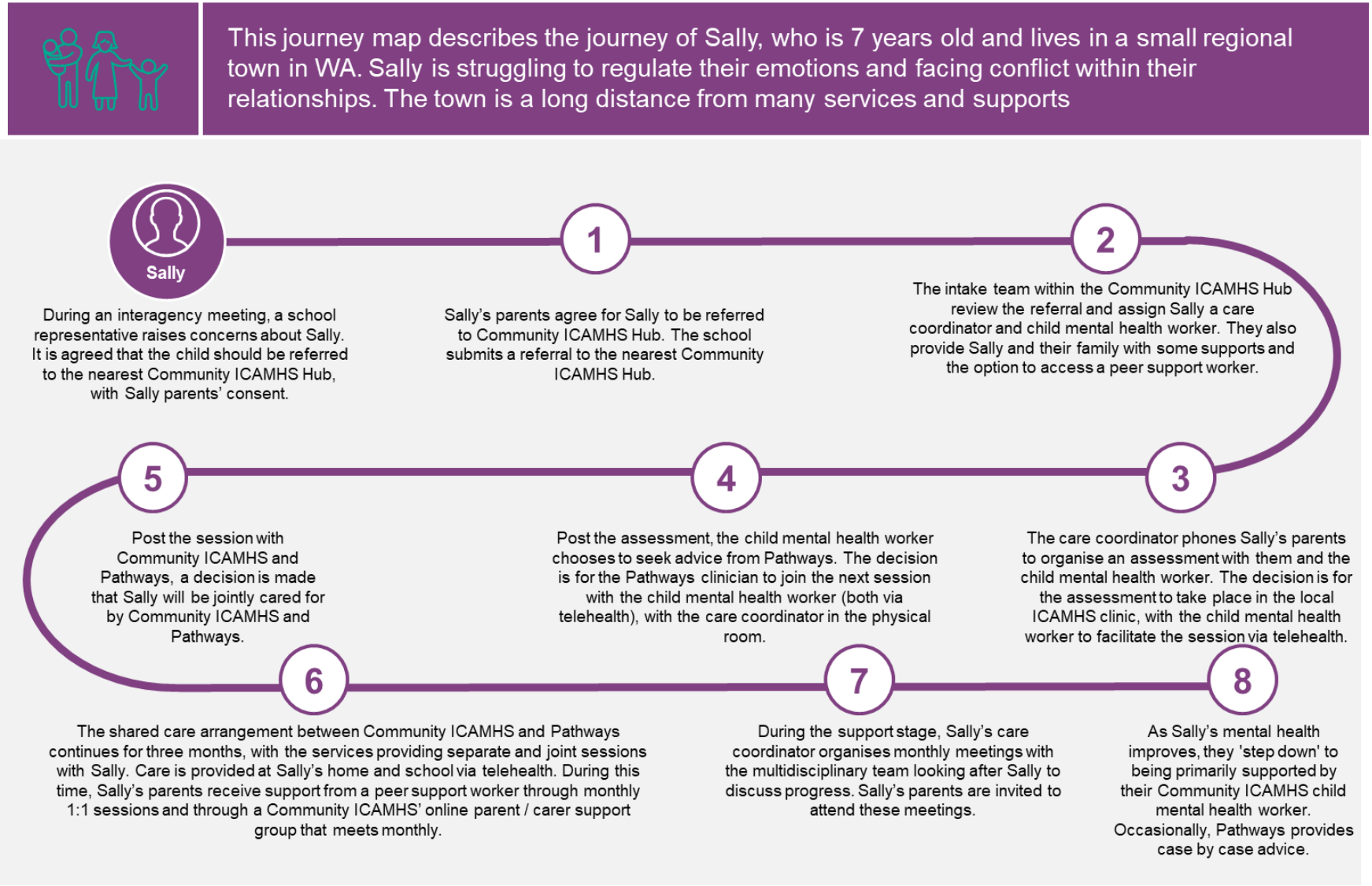
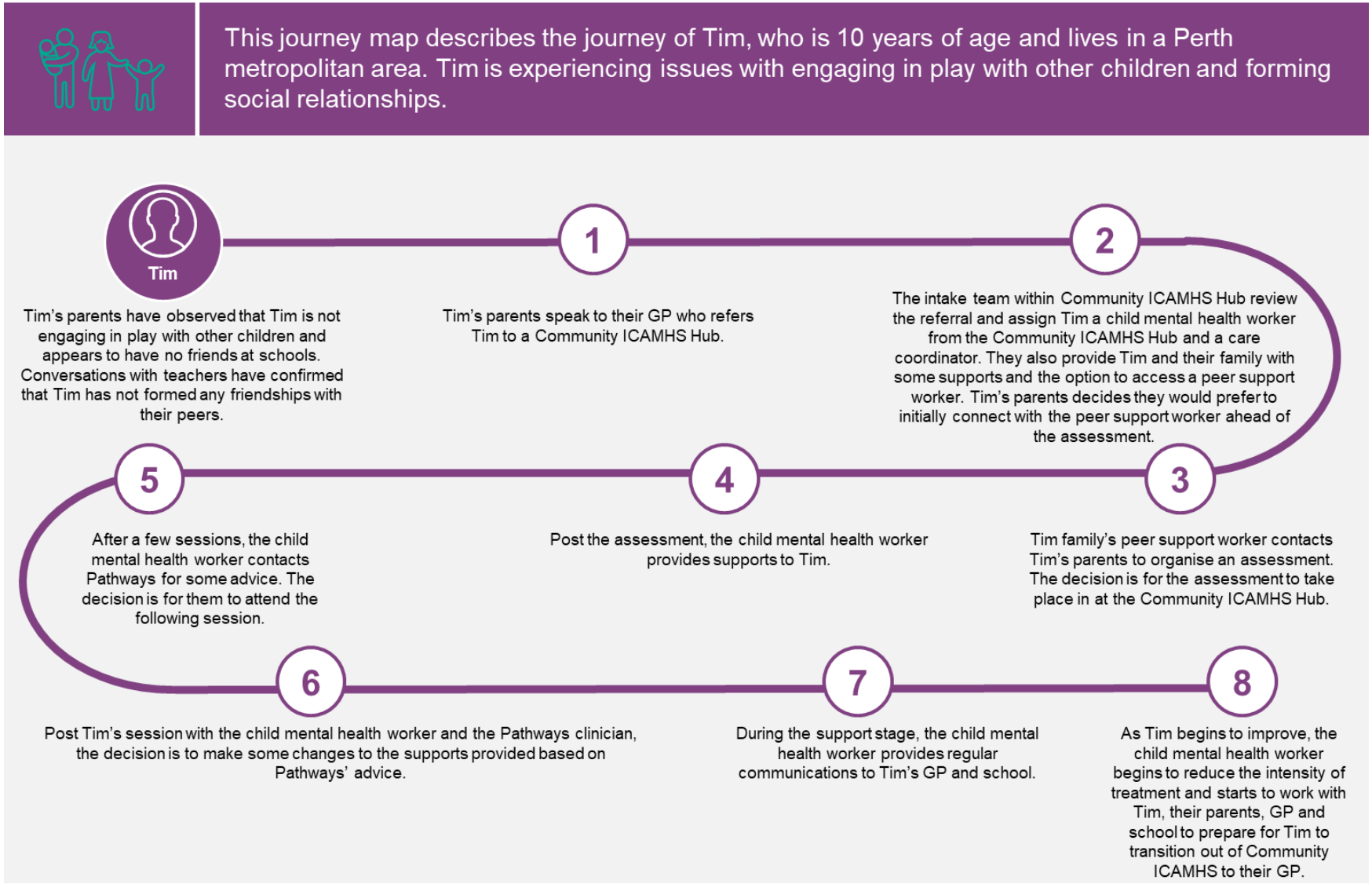


Figure 4 | Consumer journey map 2



5 Delivering the Child Mental Health Model of Care

There are various considerations that need be taken into account to operationalise the Child Mental Health Model of Care. These considerations have been outlined in this section using the following categories: adaptation of Pathways; key relationships and partnerships; workforce; infrastructure; and other delivery considerations.

5.1 Adaptation of Pathways

To deliver this Model of Care, the existing Pathways Service will need to be expanded and adapted to accommodate the new and formalised responsibilities. This is likely to include increasing the current size and scale of the Pathways team to enable them to support an increased number of children, and ensure access in regional WA. As a result, a detailed service and operations design and change management process will be required to support this. Further, a rapid review or assessment of Pathways' current functionality would be beneficial, so that existing opportunities for improvement of the service can be considered in the plan to transition to the future, enhanced service.

5.2 Key relationships and partnerships

It is recognised that there a critical relationship between Community ICAMHS Hubs and clinics, and between Community ICAMHS and Pathways to deliver child mental health. As such, strong partnerships, underpinned by appropriate processes, infrastructure and agreed working practices, will be important in supporting the services to communicate, collaborate and share information in relation to a child, family and carer's care. Other services, outside of Community ICAMHS and Pathways, will at times need to be involved. The types of services and organisations involved will differ for each child, family and carer. Some of these services and organisations may include *(listed in alphabetical order):*

- CDS
- Child Protection and Family Support services
- community health and social care services (e.g. Headspace)
- early childhood services
- Gender Diversity Service (GDS)
- paediatricians
- primary care (e.g. GPs, ACCHOs, AMS)

- schools and School of Special Educational Needs: Medical and Mental Health (SSEN:MMH).

5.3 Community ICAMHS' workforce

Community ICAMHS Hubs will have a multidisciplinary team to support the delivery of child mental health care. Multidisciplinary team members will come from a range of professional backgrounds, including but not limited to, psychologists, social workers, nurses, Aboriginal Mental Health Workers and peer support workers. The Community ICAMHS Model of Care provides further detail on the multidisciplinary team, and other teams within Community ICAMHS that will provide care.

Child mental health workers

There will be dedicated child mental health workers within Community ICAMHS Hub who have specialised child mental health expertise. These workers will be responsible for conducing assessments, supporting other clinicians to provide treatments, and delivering treatments to children with highly complex needs. While child mental health workers are part of Community ICAMHS Hubs, they will receive training, education, clinical supervision and mentoring from Pathways' clinicians. Some of the core competences child mental health workers will have include, but are not limited to[12]:

- Specialised knowledge of child mental health issues, including an understanding of developmental delays and difficulties, and human growth and development (this may include an understanding of normal biological, cognitive, and psychosexual development, including sociocultural factors.
- An ability to provide non-judgemental support when interacting with children who are exhibiting challenging behaviours.
- An ability to actively listen to and support children in a vulnerable state to identify what their most critical and immediate needs are.
- An ability to remain calm when interacting with children in a heightened state.
- An ability to work cross culturally.
- An ability to assess and address environmental factors, including school and home environments, and recognise and address trauma.
- An ability to work with children, families and carers to foster emotion regulation.
- An understanding of how to undertake holistic, multidisciplinary assessments for children aged 5-12 years of age.
- An ability to deliver a range of trauma-informed, child-focused and evidence-based interventions, including individual, group, and family therapies.
- An ability to integrate psychotherapies into multimodal treatments, including biological, family, educational, and sociocultural interventions.
- An ability to support family and carers increase their capacity to support children in their care.

[12] Competencies – Infant/Early Childhood Mental Health Commission. (2022). National Centre of on Health. https://www.ecmhc.org/documents/ECMHC_Competencies_508%20(5).pdf

5.4 Pathways' workforce

Pathways will have a multidisciplinary team to provide intensive treatments, and an expert team within its research and excellence function. Roles within this team may include (listed in alphabetical order):

- Child health nurse and/or nurse practitioner
- Exercise physiologist
- Occupational therapist
- Child psychiatrist
- Child psychologist
- Peer support worker
- Social worker
- Speech therapist
- Teacher from SSEN:MMH

Research and excellence function

The research and excellence function will need to be staffed with individuals who are skilled in child mental health. The roles within this team may include research, training, and administrative staff. The team may also receive ongoing input from the Pathways multidisciplinary team, particularly to ensure the resources and advice they produce reflect ongoing practice.

This team will focus on education, training and research in child mental health practices and therapies. This includes conducting research for the purposes of: improving service delivery models, clinical pathways and care transitions; developing an enhanced understanding of the causes, prevention and treatment of mental illness in children, families and carers; and improving the experiences, clinical outcomes, and the recovery of children and families and carers. To support research activities, Pathways' research and excellence function should develop partnerships with tertiary education institutions and research institutes, and identify funding opportunities that could be leveraged.

5.5 Infrastructure

Physical and digital infrastructure is critical in enabling the delivering of child mental health care. The following describes the key infrastructure requirements.

5.5.1 Physical infrastructure

Facilities

Spaces within Community ICAMHS Hubs and clinics, and Pathways, need to be child friendly, welcoming and culturally safe. To support the delivery of child mental health, Community ICAMHS' Hubs should have large playrooms (with suitable toys and sensory/tactile tools), calming spaces, (e.g. quiet zones/chill out spaces with items such as beanbags, Wi-Fi access, televisions, etc), and spaces to allow art therapy (e.g. rooms stocked with art supplies and

equipped with storage space, a tap and sink, and spacious enough to enable individual and group sessions) and other therapies.

Like Community ICAMHS Hubs, Pathways should have spaces that enable individual and group sessions and child mental health therapies to be easily conducted (e.g. playrooms, quite zones, spaces for individual consultations, etc.). It should also have a training room and a designated office space for Pathways' research and excellence function. To accommodate the physical infrastructure requirements, Pathways' existing space may need to be adapted and/or expanded.

Resources to support outreach child mental health care

Resources are required to support Community ICAMHS, and Pathways staff deliver care – including mobile outreach care and home visits. These resources may include access to transportation (e.g. motor vehicles) and accommodation.

5.5.2 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 digitally. Community ICAMHS Hubs and clinics will provide staff with the necessary digital infrastructure. This may include: portable devices, such as laptops, i-Pads and smart mobile phones, with reliable internet connectivity / Wi-Fi; high-quality cameras to enable videoconferencing and telehealth; and a centralised data system that all individuals involved in a child, family and carer's care (including those outside of Community ICAMHS and the child, family and carer themselves) can access to view the child's care plan, appointments, digital medical records, and their contact details and preferences (Figure 5).

Figure 5 | Centralised data system for the ICA mental health system

A recommended feature of the future ICA mental health system is that care plans, and other critical information relating to an infant/young child's care, will be in a centralised location and accessible to GPs and other service providers, via a system-wide information management system. This is to enable a seamless care experience for children, families and carers.

5.6 Other delivery considerations

There are other various considerations to support delivery of child mental health care, such as:

- **Community ICAMHS Hubs and local clinics could be co-located with integral services, such as CDS**. Given the linkages between CDS and Community ICAMHS, it would be beneficial to have these services co-located, where possible.
- **Pathways focusing on creating equitable access to children, families and carers in regional and remote areas**. This could be achieved through the application of suitable

targets (i.e. a proportion of Pathways' caseload will be children residing in regional and remote areas).

- **Pathways' research and excellence function could be made up of staff from multiple Health Service Providers (HSP)**, including WA Country Health Service (WACHS) and CAHS, who work together from multiple locations.
- **Pathways and other statewide services, such as Touchstone and CDS, could establish networks** to support research and the delivery of integrated care.
- **If funded, HSPs should work with the WA Primary Health Alliance and other primary care stakeholders** to consider optimal approaches for GPs and other services to work with Community ICAMHS and Pathways.
- **Memorandums of Understanding** could be established among services and organisations to facilitate information sharing and care coordination.
- **Changing the language that is used when providing care** to children, families and carers to more inclusive, safe and accessible (i.e. less clinical).
- **Reviewing and evaluating service delivery regularly** to improve how care is provided to children, families and carers.

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
AMS	Aboriginal Medical Service
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Service
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.
ED	Emergency Department
ELD	Ethnoculturally and linguistically diverse
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.
GDS	Gender Diversity Service
GP	General practitioner
HSP	Health Service Provider
ICA	Infant, child and adolescent

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.
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.
Pathways	Pathways Service is a statewide service providing assessment, treatment and support for children aged 6 to 12 years with complex and longstanding mental health difficulties. All children who come to Pathways have had problems in experiencing overwhelming emotions and intense emotional distress. Some of the issues they may present with include post-traumatic stress disorder, attachment difficulties, anxiety, depression, refusing to go to school, self-harm, learning difficulties, developmental issues and family stress and conflict.
PCH	Perth Children Hospital
Peer support worker	A peer support worker is someone with lived experience who is there to support the child, families and carers. They may provide emotional and psychological supports; be in attendance at appointments; or be an advocate and/or champion 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.
Shared care	Shared care involves two or more services working together to deliver coordinated care to children, families and carers.
SSEN:MMH	School of Special Educational Needs: Medical and Mental Health. This School sits within the Department of Education.
Staff	People who work within the ICA mental health system.
Touchstone	Touchstone is a structured day programme for young people aged 12-17 years who are struggling to cope with relationships, mood difficulties and impulsive self-harming behaviours.
WACHS	WA Country Health Service

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