Bilateral Schedule between the Department for Child Protection[1] and Child and Adolescent Mental Health Services

1. PURPOSE

The purpose of the Bilateral Schedule is to outline the process for:

- interagency 'consultation-liaison' meetings;
- referring allegations of child abuse and neglect to the Department for Child Protection (DCP); and
- referring children, adolescents and their families experiencing severe, emotional, psychological, behavioural, social and/or mental health problems to the Child and Adolescent Mental Health Services (CAMHS).

2. LEGISLATIVE BASIS

Children and Community Services Act 2004:

- Section 22 Cooperation and assistance
- Section 23 CEO etc. may disclose or request relevant information
- Section 24A Authorities other than the Department may disclose or request information
- Section 31 CEO may cause inquiries to be made about child
- Section 32 Further action by CEO
- Section 33A CEO may cause inquiries to be made before a child is born
- Section 338 CEO's duties if action needed before child born to safeguard etc. child after birth

Mental Health Act 1996:

The objects of the MHA, as stated in s.5, are to ensure that persons having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity to ensure the proper protection of patients as well as the public to minimise the adverse effects of mental illness on family life.

- Part 2 — Administrative provisions
    - Division 1 — Becoming an involuntary patient
    - Division 2 — Detention in authorised hospital
    - Division 3 -Treatment of involuntary patient in the community
- Part 5 — Treatment of patients
- Part 6 — Mental Health Review Board
- Part 7 — Protection of patients' rights
- Part 9 — Council of Official Visitors

3. PRACTICE PRINCIPLES

- The best interests of the child are the paramount consideration.

4. PROCEDURES / JOINT PROCESSES

Flowchart

[1] The bilateral schedule includes the Department for Child Protection's clislricl offices and the Kath French Secure Care Centre.

Referral processes and interagency 'consultation liaison' meetings between the Oeparlment for Child Protection and Child and Adolescent Mental Health Services (Appendix 1).

Interagency 'consultation-liaison' meetings

Interagency 'consultation liaison' meetings aim to:

- develop a collaborative approach that is flexible, responsive, accessible and consistent between the two agencies;
- promote the exchange of information; and
- enhance the skills and knowledge of CAMHS and DCP staff to work with children and their families to better respond and manage mental health issues in the context of abuse and neglect.

Interagency 'consultation-liaison' meetings will allow:

- discussion of complex or contentious issues to determine the most appropriate response;
- clarification of roles and responsibilities and referral threshold for each agency;
- the exchange information where CAMHS have protective concerns and/or DCP have significant concerns about a child or their family's mental health issues;
- discussion about the risks to children of young people who are mental health clients;
- planning for and management of transitions for a child by CAMHS and/or DCP;
- early identification and planning for children or young people who are due for discharge from acute care;
- provision of clear and regularly updated information regarding each agency and staff within CAMHS and DCP; and
- resolution of issues.

In the majority of cases, referrals to DCP and CAMHS will follow the existing processes (blue and orange pathways in the flowchart). Complex or contentious matters should be referred to the local interagency 'consultation-liaison' meetings for discussion, but not as an alternative to making timely referral to the DCP duty officer or CAMHS triage clinician.

'Consultation-liaison' meetings will be established in every DCP metropolitan district, and, where practicable, in regional towns. Country locations should apply a flexible approach to developing a model of interagency 'consultation-liaison' meetings that achieves the aims and objectives stated above.

Flexibility should be exercised to enable other Adult Mental Health or CAMHS staff to participate where relevant to the child and family.

<u>CAMHS/DCP portfolio holders</u>

CAMHS and DCP will appoint a portfolio holder in each respective agency to take responsibility for the management and coordination of interagency 'consultation-liaison' meetings.

For DCP, the portfolio holder will be the District Director or his/her delegate.

For metropolitan CAMHS, the portfolio holder will be the Child Protection Consultation Liaison (CPCL) Officer, who reports to the Director Community CAMHS. When required, liaison will occur with the Director of Acute CAMHS and/or Director Specialised CAMHS or their delegates.

For country regions, the portfolio holder will be the Regional Manager of the Mental Health Services.

Frequency of meetings

Meetings will occur on a regular basis, at a minimum once a month.

Frequency of meetings in country areas can be more flexible and will be determined by local needs.

Attendance and chairperson

Meetings will be attended by CAMHS Child Protection Liaison Consultation Liaison Officers, and DCP portfolio holders, CAMHS Triage Officer and/or Psychiatrist (where available), DCP duty officer, DCP Psychology Services representative and relevant case managers from CAMHS/DCP. The meetings will be chaired by the CAMHS/DCP portfolio holders through rotation.

Arrangements can be more flexible in country areas, dependent on local needs.

Notice of meetings

Meetings should be planned by the portfolio holders 12 months in advance and every effort must be made to promote the commitment to adequate attendance and representation from both agencies.

Documentation and reporting

All meetings should be documented, including decisions made.

The DCP portfolio holder should forward copies of the minutes to the District Director.

The CAMHS portfolio holder should forward copies of the minutes to:
- Director / Community CAMHS;
- Executive Director, CAMHS, and
- Local Service Manager, Community CAMHS.

The country CAMHS portfolio holder should forward copies of minutes to the Manager Mental Health Services.

Referrals to the Department for Child Protection

CAMHS referring an allegation of child abuse and neglect

CAMHS staff must refer any concern of child abuse (sexual, physical, psychological or emotional) and neglect to DCP. Referrals may be made verbally, and, thereafter, as soon as practicable in writing to the DCP district office located nearest to where the child lives.

Refer to DCP's website (www.childprotection.wa.gov.au) for details of district offices across the State.

When referring a concern of abuse and neglect, CAMHS staff should advise DCP if:

- there are immediate concerns for the child's safety;
- there are any other children in the household;
- the parenUcarer is aware of the referral being made; and
- the parenUcarer poses a risk to others.

The type of information that the DCP duty officer will gather includes:

- details about the child/young person and family;
- the reasons for the concern;
- the immediate risk to the child;
- the family's previous contact with CAMHS;
- current involvement and ongoing role of CAMHS;
- whether or not the child or family has support;
- what may need to happen to make the child safe;
- details about contact with DCP Psychology Services; and
- the CAMHS staff member's contact details to obtain further information if required, or to provide feedback.

Under section 24A of the *Children and Community SeNices Act 2004* CAMHS can exchange information with a prescribed public authority, provided the information is relevant to the wellbeing of a child or a class or group of children. CAMHS should provide DCP with any relevant information that has been exchanged prior to a referral.

Mandatory reporting of child sexual abuse

Refer to WA Health Operational Directive 0344/11.

Feedback after referring an allegation of child abuse and neglect

Refer to the endorsed *Joint guidelines on the mutual exchange of relevant information between WA Health and the Department for Child Protection for the purpose of promoting the safety and wellbeing of children* (Appendix 2).

Ongoing assessment and case management of allegations of child abuse and neglect

DCP's role is to assess if:

- the child has suffered significant harm, or is likely to suffer harm as a result of abuse and/or neglect;
- the parent's capacity to protect their child/ren;
- a safety plan is required to safeguard the child; and
- the wellbeing concerns are likely to place the child at risk of significant harm if joint work is not undertaken with the family.

DCP uses the *Signs of Safety Child Protection Practice Framework* to determine:

- what supports are needed for families to care for their children;
- whether there is sufficient safety for the child to stay within the family;
- whether the situations is so dangerous that the child must be removed; and
- if the child is in the care of the Chief Executive Officer (CEO), whether there is enough safety for the child to return home.

In accordance with DCP's *Signs of Safety Child Protection Practice Framework* the majority of referrals concerning allegations of abuse and neglect are resolved, without resorting to taking a child into care. This is achieved through effective engagement with families and the provision of services.

Agencies, including CAMHS, may be asked to participate in case planning meetings, for example by attending a Signs of Safety mapping to develop harm and danger statements, safety goal and safety plan.

Role of DCP Psychology Services

Psychology Services consists of 58 psychologist positions located in metropolitan, country areas and residential care. Psychology Services prioritises assisting the therapeutic care needs of children in the care of the DCP's Chief Executive Officer. Services include:

- consultation with Child Protection Workers, residential care workers and others involved in the care planning, reunification and contact;
- assessment of children, adults with a focus on parenting capacity and intervention and advice to support foster carers to care for children in their care;
- clinical work with children or adolescents in care; and
- support in key planning areas such as reunification and contact.

Provision of child centred family support

DCP may provide child centred family support when it has been assessed:

- that a child has suffered significant harm or is like to suffer harm as a result of abuse and neglect; or
- that wellbeing concerns are likely to place the child at risk of significant harm in the future if joint work is not undertaken with the family.

Referrals to Child and Adolescent Mental Health Services

CAMHS provide a range of specialist mental health services in both community and inpatient settings to infants, children, young people, their families and carers. CAMHS provides advocacy for a range of prevention and promotion activities and attempts when possible to facilitate intervention early in the development of a mental illness.

CAMHS in Western Australia are funded to provide services for infants, children and young people with service, complex and persistent mental health disorders. Assessment and treatment are informed by a number of specialist mental health clinicians from multi-disciplinary professions with differing expertise. Community CAMHS responsibilities include:

- provision of community-based acute services;
- assessment, risk assessment and management of complex, persistent and severe mental health disorders;
- provision of some aspects of assessment, intervention and treatment for those with moderate mental health disorders who have not responded to Tier 1 and 2 interventions;
- consultation-liaison regarding the management of mental health issues;
- case management of service provision for clients admitted to CAMHS if required and not provided by other services;

- screening and referral to Tier 4 CAMHS;
- training and consultation with Tier 1 and 2 services; and
- undertaking research, evaluation and development programs.

Metropolitan CAMHS provide advocacy for a range of prevention and promotion activities and attempts when possible to facilitate intervention early in the development of a mental illness.

Metropolitan CAMHS provide a range of specialist mental health services in both community and inpatient settings to infants, children, young people, their families and carers. Country CAMHS provide predominantly community based services.

CAMHS also provide education and consultation to Tier 1 and 2 professionals on the management of children and adolescents with less severe mental health problems, and services that provide support to children and adolescents aged zero to 18 years can request such consultation.

Referral to CAMHS

Referrals from DCP should be made to the local community CAMHS closest to where the child resides. Refer to Appendix 3 for contact details.

The referral should include details of relevant assessments or reports, particularly complex trauma histories and contextual factors that can influence an assessment, current interventions and expectation of CAMHS. For young people under 16 years of age, the referral must be accompanied by the child/young person's parent or guardian's consent.

Priority for acceptance into CAMHS is given to infants, children and young people with severe mental disorders who:

- need specialist mental health care;
- cannot be looked after in primary care sector;
- are at risk to self or others secondary to a mental disorder are such that require assertive management from a specialist mental health service;
- on a Community Treatment Order under the *Mental Health Act 1996;*
- discharged from an Inpatient Mental Health facility and assessed as high priority; and
- at high risk due to severity of suicidal ideation and self harming behaviour or psychotic phenomena.

Access to competent, comprehensive, multi-disciplinary mental health services needs to be a priority for children in out-of-home care[2]. Whilst CAMHS prioritises referrals based upon the clinical need for urgency of response and ability to match available staff, it has been agreed that if the clinical need is assessed as equal, the child in the care of DCP's Chief Executive Officer will be prioritised. Refer to the *Bilateral Schedule between the Department for Ghild Protection and WA Health: Health Care Planning for Children in Care.*

[2] The Royal Australian and New Zealand College of Psychiatrist (June 2009). Position Statement 59 – The mental health care needs of children in out-of-home care.

CAMHS is unable to prioritise infants, children or young people with a mental health problem that would be more appropriately managed by another department or agency, for example, those for whom the primary problem is:

- protective or child protection issues;
- sexual assault;
- acquired brain injury/organic difficulties;
- developmental delay;
- relationship discord between parents or parenting difficulties;
- socio-economic or financial difficulties;
- educational and learning difficulties (including school refusal) unless;
  - significant co-morbid severe mental disorder is present;
- primary substance abuse;
- primary intellectual disability; and
- concerns that primarily relate to assessment for family law, pending medico-legal or forensic matters.

Following a referral to CAMHS

A preliminary screening is done to determine immediate risk, severity and complexity of problems. If not accepted into CAMHS, the CAMHS will advise the referrer and where appropriate provide referral to another organisation or provider with advice on management.

- If in need of Tier 3 care, case management, assessment of needs and multidisciplinary treatment are provided.
- Comprehensive assessment of mental health status is undertaken, including (as necessary) talking to parents, other guardian or carers and teachers.
- CAMHS participate in a broader care team for high risk children and young people requiring multiple service responses where appropriate.
- Where necessary, further specialist assessment of specific areas follows (including neuropsychological functioning, physical health, assessment of family, the caring environment and available supports).
- Progress is regularly reviewed using outcome measurement and other recognised clinical tools.
- CAMHS liaise with Tier 1 and 2 services about the referral, management and discharge including those services that will be involved in shared care arrangements.

5. DISPUTE RESOLUTION

Whilst it is expected that disputes are resolved at the local level, when required disputes can be referred to:

- District Director (DCP); and
- Director, Community CAMHS (metropolitan CAMHS); or
- Regional Manager (country CAMHS).

If the issue is unable to be resolved between the Director and Regional Manager, they should be referred to:

- Executive Director, Metropolitan Services (DCP) and Executive Director, CAMHS; or
- Executive Director, Country Services (DCP) and Mental Health Area Director (WA Country Health Services).

6. TIMEFRAME AND REVIEW

The DCP and CAMHS will review this schedule 12 months from date of signing, unless requested earlier in writing by either agency. This agreement will continue to be effective until both parties endorse a revised schedule. Agencies will be consulted and agreement sought for any variation.

7. COSTS

The parties agree to bear their own costs (if any) arising out of this agreement.

8. SUPPORTING DOCUMENTS AND POLICIES

Relevant supporting documents and policies include, but are not limited to, the following:

- Level 1 Strategic Bilateral Memorandum of Understanding between WA Health and Department for Child Protection;
- Flowchart: process for referral and interagency working between Department for Chid Protection and Child and Adolescent Mental Health Services (Appendix 1).
- Joint guidelines on the mutual exchange of relevant information between WA Health and the Department for Child Protection for the purpose of promoting the safety and wellbeing of children (Appendix 2).
- Bilateral Schedule between the Department for Child Protection and WA Health: Health Care Planning for Children in Care.
- Contact list for CAMHS and DCP (Appendix 3).
- Description of CAMHS Tier 1, 2, 3, 4 (Appendix 4).

9. STATUS OF SCHEDULE

Child and Adolescent Mental Health Services and Department for Child Protection agree that this Bilateral Schedule is not intended to, and does not create any legally binding obligation between the parties.

10. SIGNATURE OF RESPECTIVE CEOs

This Bilateral Schedule is signed by:

TERRY MURPHY
DIRECTOR GENERAL

DEPARTMENT FOR
CHILD PROTECTION

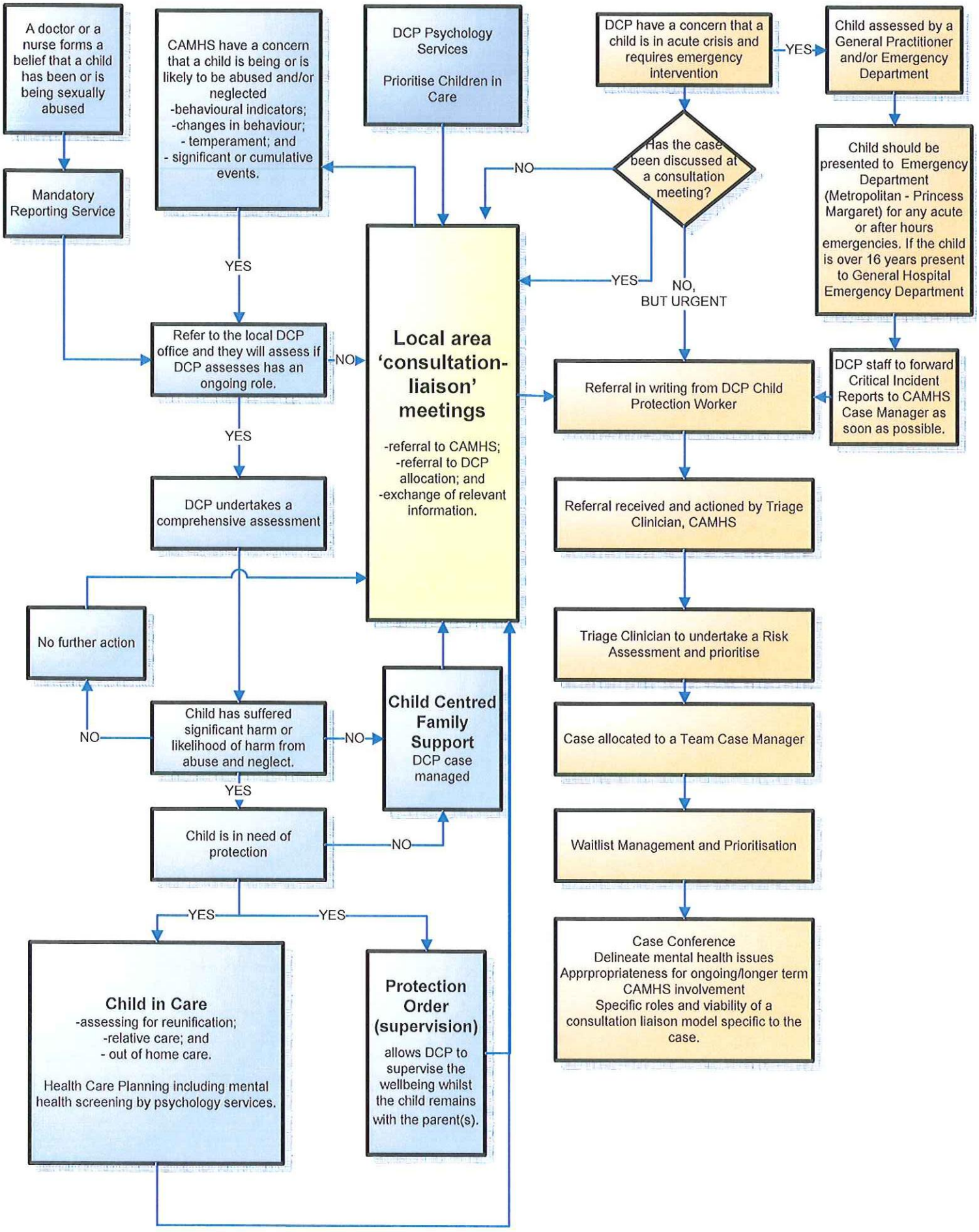
DATE: 17/5/12

KIM SNOWBALL
DIRECTOR GENERAL

WA HEALTH

DATE: 23/6/12

PROCESS FOR REFERRAL AND INTERAGENCY WORKING BETWEEN DEPARTMENT FOR CHILD PROTECTION (DCP) AND CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)



Appendix 2

Department for Child Protection
Department of Health

Joint guidelines on the mutual exchange of relevant information between WA Health (incorporating the Department of Health, Metropolitan Health, WA Country Health Services and Peel Health Service) and the Department for Child Protection for the purpose of promoting the wellbeing[1] of children

Rationale

- The protection of children under 18 years of age is the paramount consideration for all professionals who work with parents and/or their children.
- Reviews have consistently identified the importance of improved information sharing between government agencies to prevent negative outcomes including child death.
- The provision of integrated and seamless support to children and families with complex needs is enhanced through effective information sharing practices.
- Legislation supports the mutual exchange of information about the wellbeing of a child between the Department for Child Protection and WA Health.

Legislation

- Section 23 of the *Children and Community Se!Vices Act 2004* (CCSA) enables the exchange of relevant info mation[2] relating to the wellbeing of a child or group of children between the Department for Child Protection and WA Health.
- The 'best interests of the child' is the paramount principle for information sharing practices.
- Operating under the *Health Act 1911* is not an impediment to sharing information with the Department for Child Protection.
- The *CCSA* allows for information to be shared with agencies operating under other State laws, provided that the information is relevant, provided in good faith and to promote the wellbeing of children or in compliance with a request made by the Department for Child Protection.
- The *CCSA* allows for the protection of children to be the paramount consideration and overrides client confidentiality.
- Section 33 of the *CCSA* allows for an authorised officer, without informing the child's parents, to have access to a child at a hospital for the purpose of an investigation.

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[1] Wellbeing of a child includes the care, development, health and safety of the child.

[2] Relevant information means information that, in the opinion of the CEO of the Department for Child Protection, is, or is likely to be, relevant to (a) the wellbeing of a child or a class or group of children; or (b) the performance of a function under the *Children and Community Services Act 2004* (section 23). This includes concerns for a child's safety or wellbeing.

- New provisions came into effect on 31 January 2011, that enable the Department for Child Protection to make inquiries before a child is born to determine whether action should be taken to safeguard or promote the child's wellbeing after the child is born.

Context

Mutual exchange of information is a two way process, of both giving and receiving relevant, client specific information. The information needs to be relevant to the care, health, safety, stability and development of a child.

Effective mutual exchange of information can support ongoing WA Health assessments and service provision alongside any assessment and investigation undertaken by the Department for Child Protection.

When agencies share relevant information, more holistic assessments and integrated provision of services can be provided to families with complex needs. Coordinated service delivery is particularly critical when families receive services from more than one agency. In most cases, providers will be in agreement about the value of exchanging information.

Client's consent prior to the release of information

While it is not a requirement, consent should be obtained prior to sharing the individual's information, unless there are good reasons not to do so. Both agencies will need to know whether the individual has given consent to the sharing of their information.

Gaining a client's consent may not be possible or appropriate in the following circumstances:

- the child may be placed at further risk or harm;
- reasonable efforts to obtain consent have failed;
- unable to contact the parents;
- clear from previous contact that consent would not be given;
- the child poses a risk to themselves or is a risk to others; or
- the referrer may or would be at serious risk or imminent threat to their health or safety.

Agencies need to document the reasons why consent has not been obtained or why the agency was unable to obtain consent. This information may be relevant to the referral agency.

Information exchange between WA Health and the Department for Child Protection

Information can be exchanged between WA Health and the Department for Child Protection when there is a legitimate purpose to do so, which could include:

- protecting a child from being abused or neglected;
- protecting groups of children from potential harm;
- diverting a child from harming himself/herself;

- helping a professional to provide more effective services;
- avoiding duplication or compromising of services;
- assisting with a child protection investigation;
- contributing to decisions about the placement of, or planning for, a child;
- ensuring appropriate services for a child in the care of the Chief Executive Officer (CEO), or providing case-specific information about a child in the CEO's care;
- providing positive feedback on a child or family; and
- discussing concerns for the wellbeing of a child.

What is relevant information can be reviewed through ongoing discussions between both agencies. The discussion should reflect on whether the changing circumstances of the child and their family have led to the need to share information that has not been exchanged previously.

When WA Health requests relevant information from the Department for Child Protection, the following information should be discussed to ascertain what can be shared:

- WA Health to confirm if the client has provided consent for the exchange of information.
- The Department for Child Protection's current or previous level of involvement with the family, as well as the health professional's role and current involvement.
- Prior to releasing information, the Department for Child Protection has to ensure the validity of the information provided.

When the Department for Child Protection requests relevant information from WA Health they should provide information to assist the agency in determining what is relevant information including:

- the Department for Child Protection to confirm if the client has provided consent for the exchange of information;
- the nature of the Department for Child Protection's involvement (for example assessing concern, level of harm or planning reunification);
- the Department for Child Protection's role with the child and family; and
- the type of information that the Department for Child Protection needs.

When WA Health workers or workers from the Department for Child Protection seek relevant information, both agencies need to:

- make contact verbally or in writing to discuss the case and the information required;
- explain how the request for information relates to the wellbeing and/or risk of harm for the child or young person;
- identify the subject of the information request and (if it is not the child or young person) identify the client's relationship to the child or young person;
- provide any particular identifying information so that agencies can be sure they are talking about the same person;
- negotiate a timeframe that is suitable to enable client consent to be sought to disclose the information if this is appropriate;

- provide information verbally or in writing, however, all verbal information should be followed up in writing; and
- specify the time period for which the information is sought (for example for the last three years), the type of information sought and when it is required.

Verifying the identity of the WA Health worker or departmental worker's name and role can be done, for example, by contacting the relevant office.

When WA Health requests feedback after making a mandated report or reporting a concern for a child:

- Wherever possible and appropriate, the Department for Child Protection will provide a reporter with feedback on its planned actions.
- The level and details provided will be guided by the nature of the relationship of the reporter with the child and family and the reporter's ongoing involvement with the case, including case planning.
- If the reporter does not receive feedback they should contact the worker from the Department for Child Protection who they reported the concern to or who originally requested the information.

Confidentiality and protection

WA Health employees are protected under the *Children and Community Services Act 2004,* for giving information or making a report or notification. Employees do not incur any civil or criminal liability providing the information is provided in good faith. The disclosure is not regarded as a breach of professional ethics, standards or any principles of conduct applicable to the person's employment or as unprofessional conduct.

The identity of the notifier or reporter should not be disclosed without consent, except in exceptional circumstances. It is possible that an application made by the Department for Child Protection will proceed to a hearing and the reporter or notifier may be subpoenaed to give evidence.

Contact list for Child and Adolescent Mental Health Services (CAMHS) and Department for Child Protection district offices (DCP)

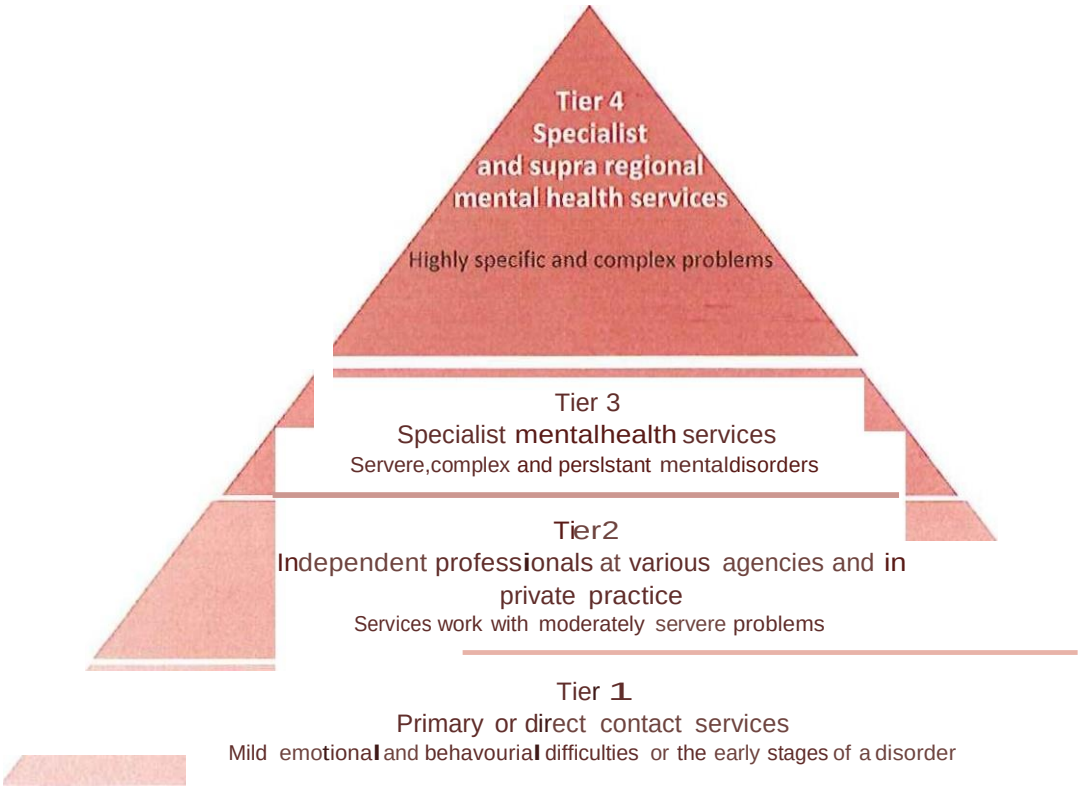
CAMHS	DCP
COMMUNITY CAMHS	
ARMADALE CAMHS House, Ecko Road Armadale WA 6992 (08) 9391 2455	Armadale Goline 145 Jull Street Armadale WA 6112 (08) 9497 6555
BENTLEY FAMILY CLINIC 18-56 Mill Street Bentley WA 6982 (08) 9334 3900	Cannington Corner Grose and Lake Street Cannington WA 6107 (08) 9351 0888
FREMANTLE CAMHS 1 Stirling Street Fremantle WA 6160 (08) 9336 3099	Fremantle 25 Adelaide Street Fremantle WA 6160 (08) 9431 8800
PEEL CAMHS Peel Health Campus 110 Lakes Road Mandurah WA 6210 (08) 9531 8080	Peel Corner Sutton & Tuckey Streets Mandurah WA 6210 (08) 9583 6688
ROCKINGHAM CAMHS Clifton & Ameer Street Rockingham WA 6968 (08) 9528 0555	Rockingham Corner 8 Leghorn St Rockingham WA 6168 (08) 9527 0100
HILLARYS CAMHS Endeavour Business Centre Unit 2/3, Level D 32 Endeavour Road HILLARYS WA 6025 (08) 9403 1999	Joondalup Joondalup House, 8 Davidson Terrace Joondalup WA 6027 (08) 9301 3600
CLARKSON CAMHS 77 Renshaw Boulevard CLARKSON WA 6030 (08) 9304 6200	Joondalup Joondalup House, 8 Davidson Terrace Joondalup WA 6027 (08) 9301 3600
WARWICK CAMHS 316 Erindale Road WARWICK WA 6024 (08) 9448 5544	Mirrabooka 8 Sudbury Road Mirrabooka WA 6061 (08) 9344 9666
SHENTON CAMHS 227 Stubbs Terrace SHENTON PARK WA 6008 (08) 9382 0773	Perth 190 Stirling Street Perth WA 6000 (08) 9214 2444 Mirrabooka 8 Sudbury Road Mirrabooka WA 6061 (08) 9344 9666

SWAN VALLEY CAMHS 36 Railway Parade MIDLAND WA 6936 (08) 9250 5777	Midland 281 Great Eastern Highway Midland WA 6056 (08) 9274 9411
ACUTE CAMHS	
The Triage / Patient Flow is operational between the hours of Bam to 4pm Monday to Friday, this positions manages all admission to PMH 4H and Bentley Adolescent Unit (BAU), contact MB: 0478 474 956. Afterhours enquires for PMH, please contact the Psychiatric Liaison Nurse at PMH through the PMH hospital switch on 9340 8222. Afterhours enquiries for the Bentley Adolescent Unit, please contact the shift coordinator on 9334 3689.	All
SPECIALISED CAMHS	
Complex ADHD Service Murdoch University Campus (08) 9360 1650	All
Eating Disorders Team Princess Margaret Hospital (08) 9340 7012	All
Families at Work (residential program for children with significant behavioural and emotional disorders)- Bentley (08) 9334 3851	All
Family Pathways (day program for children with significant behavioural and emotional disorders)- Shenton Park (08) 9382 0730	All
MST or Multi-systemic therapy. (Intensive home & community based program for children & adolescents with severe and enduring behavioural disorders. Services cover Joondalup area and Rockingham area). MST Administration (08) 9431 3781 MST Northern suburbs (08) 9403 1200 MST Southern suburbs (08) 9528 0537	North Team- Joondalup District Office South Team- Rockingham and Peel District Offices
YOUTHLINK 223 James Street NORTHBRIDGE WA 6003 (08) 9227 4301	District offices north of the river
YOUTH REACH SOUTH L2 Cockburn Youth Centre 25 Wentworth Parade Success WA 6964 (08) 9499 4274	District offices south of the river

COUNTRY CAMHS	
BUNBURY MENTAL HEALTH SERVICE South West Health Campus, Robertson Drive, Bunbury WA 6230 (08) 9722 1300	South West (Bunbury) 80 Spencer Street Bunbury WA 6230 (08) 9722 5000
CENTRAL WEST MENTAL HEALTH SERVICE Shenton Street GERALDTON WA 6530 (08) 9956 1999	Murchison (Geraldton) 45 Cathedral Avenue Geraldton WA 6530 (08) 9965 9500
GREAT SOUTHERN MENTAL HEALTH SERVICES -ALBANY Hardie Road ALBANY WA 6330 (08) 9892 2440	Great Southern (Albany) 25 Duke Street Albany WA 6330 (08) 9841 0777
KALGOORLIE BOULDER COMMUNITY MENTAL HEALTH CHMS, The Brick Quarters Cnr Maritana and Piccadilly Streets KALGOORLIE WA 6430 (08) 9088 6200	Goldfields (Kalgoorlie) Cnr Boulder Road and Cheetham Street Kalgoorlie WA 6430 (08) 9022 0700
KIMBERLEY MENTAL HEALTH AND DRUG SERVICE cnr Anne & Robinson Streets BROOME WA 6725 (08) 9194 2640	West Kimberley (Broome) 19 Coghlan Street Broome WA 6725 (08) 9192 1317
PILBARA MENTAL HEALTH AND DRUG SERVICE Colebatch Way SOUTH HEDLAND WA 6722 (08) 9174 1240	Pilbara (South Hedland) Cnr Brand and Tonkin Streets South Hedland WA 6722 (08) 9160 2400
WHEATBELT MENTAL HEALTH SERVICE 10/210 Fitzgerald Street NORTHAM WA 6401 (08) 9621 0999	Wheatbelt (Northam) Cnr Fitzgerald and Gairdner Streets Northam WA 6401 (08) 9621 0400

Appendix 4

Description of Child and Adolescent Mental Health Services Tier 1, 2, 3 and 4



Source: Mental Health Division, Department of Health 2001, Infancy to Young Adulthood: A Mental Health Policy for Western Australia.

TIER ONE – PRIMARY/UNIVERSAL SERVICE PROVIDERS

In this tier, services work effectively with children who manifest mild emotional and behavioural difficulties or the early stages of a disorder.

Personnel in this tier have a unique opportunity to engage with children and families in early identification and management of mental health problems. Some have acquired specialist training and expertise and work regularly and closely with specialist services.

Tier 1 services make a valuable contribution in that they are not perceived as stigmatising by parents or young people. Workers in these services often know a good deal about the children's families and their wider situation.

Service providers must operate with a level of skill necessary to identify and refer children with mental health problems who are likely to need ongoing and more skilled attention.

Services at this level are provided by non-mental health specialists who are in a position to:

- provide developmental opportunities that promote mental health and wellbeing
- initiate prevention strategies
- identify mental health problems and disorders early
- refer children with symptoms of mental health problems and disorders for assessment
- offer general advice
- in certain cases provide treatment
- manage cases.

Services at this level work with children and young people who have moderately severe problems that will need attention by professionals trained in children's mental health.

Conditions will tend not to be complicated by comorbidity or serious risk factors.

TIER TWO- INDEPENDENT PROFESSIONALS AT VARIOUS AGENCIES AND IN PRIVATE PRACTICE

Tier 2 is a level of service provided by professionals who relate to others through a network (rather than within a team). Personnel often identify mental health problems and disorders in children who are presenting with problems. They can provide assessment for cases that are not complicated by comorbidity or severe risk factors and can be mitigated by health and mental health professionals with the relevant skills and experience from any one of a number of disciplines. More complex mental health disorders will often need to be assessed by a third tier team, although management may occur in tiers 1 and 2. Key roles and responsibilities can include:

- identification of children with mental health problems and disorders
- assessment of less complex, severe and persistent cases provision of treatment for problems not complicated by comorbidity or serious risk factors
- case management
- training and secondary consultation to tier 1 personnel
- outreach services to identify severe or complex needs which require more specialist interventions but where specialist services are not accessible
- counselling, liaison and advocacy
- Screening and referral to tier 3 and 4 services.

Types of services and service providers can include:

- paediatricians
- mental health practitioners
- educational services
- adult mental health services
- general practitioners with specific skills
- Department for Child Protection
- Disability Services Commission
- Juvenile justice services.

TIER THREE- SPECIALIST MENTAL HEALTH SERVICES

Children and young people with more severe, complex and persistent disorders.

Assessment and treatment are informed by a number of specialists with differing expertise who may be working as a team or close network. Treatment may be by one specialist but all specialists involved may monitor the progress of the child.
Key roles and responsibilities can include:

- provision of emergency services
- assessment and provision of some aspects of treatment for complex, persistent and more severe cases
- case management of multi-modal service provision
- screening and referral to tier 4
- training and consultation with personnel in tier 1and 2 services
- undertaking research and development programs.

Types of services and service providers can include:

- a multidisciplinary team working in a community clinic or outpatient service
- Child and Adolescent Mental Health Services
- specialised paediatric services
- educational psychological services
- emergency services
- adult mental health services
- other specialists as required.

TIER FOUR- SPECIALIST AND SUPRA REGIONAL MENTAL HEALTH SERVICES

Children and young people with the most severe and persistent disorders.

Tier 4 services are often provided in particular settings such as inpatient units or specialist outpatient clinics for children who have unusual, very severe, complex or persistent disorders, almost always complicated by risk factors. This tier also includes tertiary services that are supra regional as not all regions can expect to offer this level of service.

Key roles and responsibilities can include:

- complex assessment
- treatment of the most complex, persistent or severe cases
- contribution to services, training and consultation at tiers 1, 2 and 3
- undertaking research and development programs.

Types of services can include:

- highly specialised outpatient teams
- specialist treatment programs
- inpatient services for older children and young people who are severely ill or suicidal.

Source: Proceedings from the Metropolitan and Rural/Remote and Adolescent Mental Health Service Mapping Exercise (1999) and Kurtz, Thomas and Wolkind (1995)