Bilateral Schedule between the Department for Child Protection and Family Support and Child and Adolescent Health Service, Child and Adolescent Mental Health Services

1. PURPOSE

The purpose of the bilateral schedule is to outline the process for:

- interagency 'consultation-liaison' meetings (referred to as consultation meetings);
- referring allegations of child abuse and neglect to the Department for Child Protection and Family Support (CPFS); 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), including children in the care of the Chief Executive Officer (CEO) of the Department for Child Protection and Family Support (CPFS), referred to as "children in care".

2. LEGISLATIVE BASIS

Children and Community Services Act 2004

The *Children and Community Services Act 2004* provides for the protection and care of children in Western Australia. An important requirement in section 7 is that, in performing a function or exercising a power under the CCS Act, [1] the best interest of the child must be regarded as the paramount consideration. Other provisions relevant to this MOU include:

- Section 22 Cooperation and assistance
- Section 23 CEO etc. may disclose or request relevant information
- Section 24A Power of the CEO to obtain copies of certain reports from CEO (Corrective Services)
- Section 28B Disclosure of information by prescribed authority or authorised entity Section 28 When child is in need of protection
- Section 31 CEO may cause inquiries to be made about child
- Section 32 Further action by CEO
- Section 33 Access to child for purposes of investigation
- Section 33A CEO may cause inquiries to be made before a child is born
- Section 33B CEO's duties if action needed before child born to safeguard etc. child after birth
- Section 129 Protection from liability for giving information

Mental Health Act 2014

The *Mental Health Act 2014* is based around three important principles - fairness for people experiencing mental illness; accountability of mental health clinicians when treating people; and the inclusion of important people in a patient's life (such as families, carers and other people the patient chooses to nominate). The new Mental Health Act 2014[2] removes legal

[1] The *Children and Community Services Act 2004* can be accessed at www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtitle_132_homepage.html
[2] The *Mental Health Act 2014* can be accessed at www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13537_homepage.html

barriers to the inclusion of families and carers; promotes collaborative goal-orientated discharge planning; and gives clinicians greater clarity and certainty.

The main focus of the legislation is the protection of the rights of people experiencing mental illness. This includes treating people with respect and dignity, respecting their right to make decisions about their own lives; and recognising the role and rights of families and carers. The Act outlines a Charter for Mental Health Care Principles which all mental health services must endeavour to meet. The Charter consists of 15 principles which focus on provision of individualised, recovery focussed, culturally sensitive, empowering care.

3. PRACTICE PRINCIPLES

- The best interests of the child must always be regarded as the paramount consideration.
- The parties to this schedule are committed to the principle of professional collaboration to further the best interests of children and young people.
- The parties to this schedule confirm their mutual respect for each other's areas of expertise.

4. PROCEDURES / JOINT PROCESSES

Refer to flowchart - *Referral processes between CPFS and Child and Adolescent Mental Health Services.* (**Appendix 1**).

Interagency 'consultation-liaison' meetings
Consultation meetings aim to develop a collaborative approach to shared cases that is flexible, responsive, accessible and consistent between the two agencies and promote the exchange of relevant information;

The consultation meetings should follow the Terms of Reference as outlined in **Appendix 2**.

In the majority of cases, referrals of children to CPFS or CAMHS will follow the existing processes outlined in the Appendix 1. Complex or contentious matters should be referred to the local interagency 'consultation- liaison' meetings for discussion, but not as an alternative to making timely referrals to the CPFS duty officer or CAMHS Choice Coordinator.

Consultation meetings will be established in every CPFS 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 in **Appendix 2.**

Flexibility should be exercised to enable other Adult Mental Health, Youth Mental Health or CAMHS staff, to participate where relevant.

<u>CAMHS/CPFS portfolio holders</u>

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

For CPFS, 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.

CPCL positions are located in Community CAMHS clinics, and provide a combination of direct clinical work, case management and consultation liaison in relation to child safety matters.

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

Rapid Response and Children in Care Working Group

Rapid Response is an across government framework for prioritising services to help address the complex health, housing, psychological, educational and employment needs of children and young people in care.

Rapid Response targets children and adolescents with more severe and persistent mental health disorders. Rapid Response referrals for children in care are accepted and prioritised by CAMHS according to clinical need.

The Rapid Response and Children in Care Working Group plays an important role in the development, review and implementation of this framework. Both CAMHS and CPFS are represented on this Working Group, and it is one means of addressing policy issues for this group of children and young people as they become apparent.

Referrals to Department for Child Protection and Family Support

CAMHS referring a concern about abuse or neglect of a child

Section 129 of the Act enables CAMHS to give information to CPFS in good faith about any aspect of the wellbeing of a child. Also, section 23 of the Act enables CAMHS to disclose to CPFS, upon request, information relevant to a child's safety and wellbeing without the consent of the family.

CAMHS staff must refer concerns about the abuse (sexual, physical, or emotional) or neglect of a child to CPFS. Where CAMHS staff are concerned that a child may be suffering abuse or neglect, a referral should be made directly to the CPFS duty officer. Where possible, concerns regarding child abuse or neglect should be raised at the CAMHS Team Clinical Review Meeting prior to referral to CPFS. Referrals may initially be made verbally but as soon as practicable should be followed up in writing to the CPFS district office located nearest to where the child lives. Refer to CPFS 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 CPFS if:

- there are immediate concerns for the child's safety;
- there are any other children in the household;
- the parent/carer is aware of the referral being made; and
- the parent/carer poses a risk to others.
- The type of information that the CPFS duty officer may ask for 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 CPFS Psychology Services; and
- the CAMHS staff member's contact details to obtain further information if required, or to provide feedback.

When making a referral to CPFS, CAMHS should provide any relevant information that it has. It is reasonable for CAMHS to gather relevant information prior to making a referral to CPFS to better determine whether a referral to CPFS is necessary. This can be done under section 28B of the *Children and Community Services Act 2004* (CCS Act). Section 28B enables CAMHS to exchange relevant information with a prescribed public authority, non-government schools and certain non-government providers, provided the information is or is likely to be relevant to the wellbeing of a child or a class or group of children or the safety of a person subjected or exposed to family and domestic violence.

Referrals for medical neglect

CAMHS staff should provide CPFS with any relevant information when referring a concern about a child's physical wellbeing, including:

- information regarding any refusal or failure to seek treatment or give the child required medications;
- information relating to any denial or minimisation of health concerns; and
- Information about the child such as high anxiety levels, disrupted attachment, stress related illness, conditioned trauma response, dissociation, hyperarousal, eating disorders etc.

Referrals for emotional abuse

CAMHS staff should provide CPFS with relevant information when referring a concern about the emotional abuse of a child, including information about:

- Any sustained, repetitive, inappropriate, ill treatment of a child through behaviours including threatening, belittling, teasing, humiliating, bullying, confusing, ignoring or inappropriate encouragement.
- A parent's inability to empathise with and meet their child's needs;
- A parent's inability to identify and prioritise their child's needs ahead of their own;
- The impacts on the child, such as reduced capacity to experience a range of emotions, to express emotion appropriately and to modulate their emotional experience.

<u>Mandatory reporting of child sexual abuse</u>

Refer to WA Health Operational Directive 0344/11.

<u>Feedback after referring an allegation of child abuse and neglect</u>

Refer to the endorsed *Joint guidelines on the mutual exchange of relevant information between WA Health and the CPFS for the purpose of promoting the safety and wellbeing of children* (**Appendix 3**).

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

CPFS' role is to assess if:

- the child has suffered significant harm, or is likely to suffer significant harm as a result of abuse and/or neglect;
- the parents have 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.

CPFS 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 situation 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 CPFS *Signs of Safety Child Protection Practice Framework* the majority of referrals concerning allegations of abuse and neglect are addressed 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 goals and a safety plan.

Signs of Safety Meetings

Where a child is an open case to CPFS, a Signs of Safety meeting can be requested through the caseworker or team leader, with a view to engaging in further case planning.

Where a child is not an open case to CPFS, a request for a Signs of Safety mapping can be discussed at the consultation meeting or through the portfolio holder. The purpose of this meeting is to clarify if each agency has a role.

Role of CPFS Psychology Services

Psychology Services has psychologist positions located in metropolitan and country areas and in residential care. Psychology Services prioritises assisting the therapeutic care needs of children in care. Services may include:

- consultation with child protection workers, residential care workers and others involved in the care planning, reunification and contact;
- consultation at the point of intake;
- assessment of children and adults, with a focus on parenting capacity and intervention, and advice to support foster carers to care for children in their care;
- where possible, attending Interagency Consultation Liaison Meetings;
- limited clinical work with children or adolescents in care; and

- support in key planning areas such as reunification and contact.

Provision of intensive family support

CPFS may provide intensive family support when it has been assessed through the safety and wellbeing assessment:

- 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.

The recently released *Building Safe and Strong Families: Earlier Intervention and Family Support Strategy* (the Strategy) recognises the importance of earlier and more intensive engagement and intervention for positive outcomes for children and families.

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. Country CAMHS provide predominantly community based services.

CAMHS in Western Australia are funded to provide services for infants, children and young people with severe, 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.

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. Services that provide support to children and adolescents aged zero to 18 years can request such consultation.

Referral to CAMHS

Referrals from CPFS should be made to the local community CAMHS closest to where the child resides. Refer to **Appendix 4** for contact details. Where appropriate, CPFS can

continue to refer directly to Specialised CAMHS programmes, such as Pathways and Multisystemic Therapy (MST). Refer to **Appendix 5** for Tier information.

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.

The CPFS case manager should contact the relevant service for more information on referral processes.

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 such that they require assertive management from a specialist mental health service;
- are on a Community Treatment Order under the Mental Health Act 2014;
- are 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[3]. 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, a child in care will be prioritised. Refer to the *Bilateral Schedule between the Department for Child Protection and Family Support and WA Health: Health Care Planning for Children in 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.

<u>If either party closes the case (with either no further action or referral to social services)</u>

[3] 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.

The agency closing the case will advise the other agency of the decision to close the case and the rationale where appropriate. CPFS and CAMHS will also discuss:

- whether either party has an ongoing role with the family; and
- whether any additional services are required for the family and the steps that each agency will take to link the child and family into these services.

Both parties will consult with one another if they have any further concerns for the child.

Following a referral to Community CAMHS

The child and family will be invited to make an appointment for an initial face to face appointment (Choice Meeting). If the child is not a child in care, parental consent can be sought for CPFS staff involved in their care to attend this meeting. A preliminary assessment is done to determine immediate risk, severity and complexity of problems. Where the needs of the child can be addressed, the decisions regarding the future plans are jointly decided between the family and CAMHS Clinician, and the family is provided with a time for a Partnership Appointment.

- If in need of Tier 3 care, case management, assessment of needs and multidisciplinary treatment are provided.
- At the Partnership Appointment, 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.
- If not requiring Tier 3 mental health services, the family is provided with information about appropriate alternative services. The referrer is provided with feedback about the outcome. This can be shared with other service providers, with parental consent.

5. DISPUTE RESOLUTION

Disputes should be resolved at the local level through Team Leaders and Service Managers; however, if necessary disputes can be referred to:

- District Director (CPFS);
- Director and Head of Department, Community CAMHS (metropolitan CAMHS) or the Regional Manager (country CAMHS).

Disputes which are unable to be resolved by the District Director and Regional Manager should be referred to:

- Executive Director, Metropolitan Services (CPFS) and Executive Director, CAMHS; or

Executive Director, Country Services (CPFS) and Mental Health Area Director (WA Country Health Services).

6. TIMEFRAME AND REVIEW

CPFS and CAMHS will review this schedule two to three years from date of signing, unless requested earlier in writing by either agency. This MOU 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 MOU.

8. APPENDICES AND SUPPORTING DOCUMENTS

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

- **Appendix 1** – Referral processes and interagency 'consultation liaison' meetings between the Department for CPFSS and Adolescent Mental Health Services.
- **Appendix 2** - CAMHS/CPFS Joint Liaison Meetings Terms of Reference
- **Appendix 3** - Joint guidelines on the mutual exchange of relevant information between WA Health and the Department for Child Protection and Family Support.
- **Appendix 4** - Contact list for Child and Adolescent Mental Health Services and CPFS
- **Appendix 5** - Description of CAMHS Tier 1, 2, 3, 4

Supporting Documents:

- CAMHS Entry Protocol
- CAMHS Access Policy
- CAMHS Shared Care Guidelines

9. STATUS OF SCHEDULE

CAMHS and CPFS agree that this Bilateral Schedule is not intended to, and does not, create any legally binding obligation between the parties.

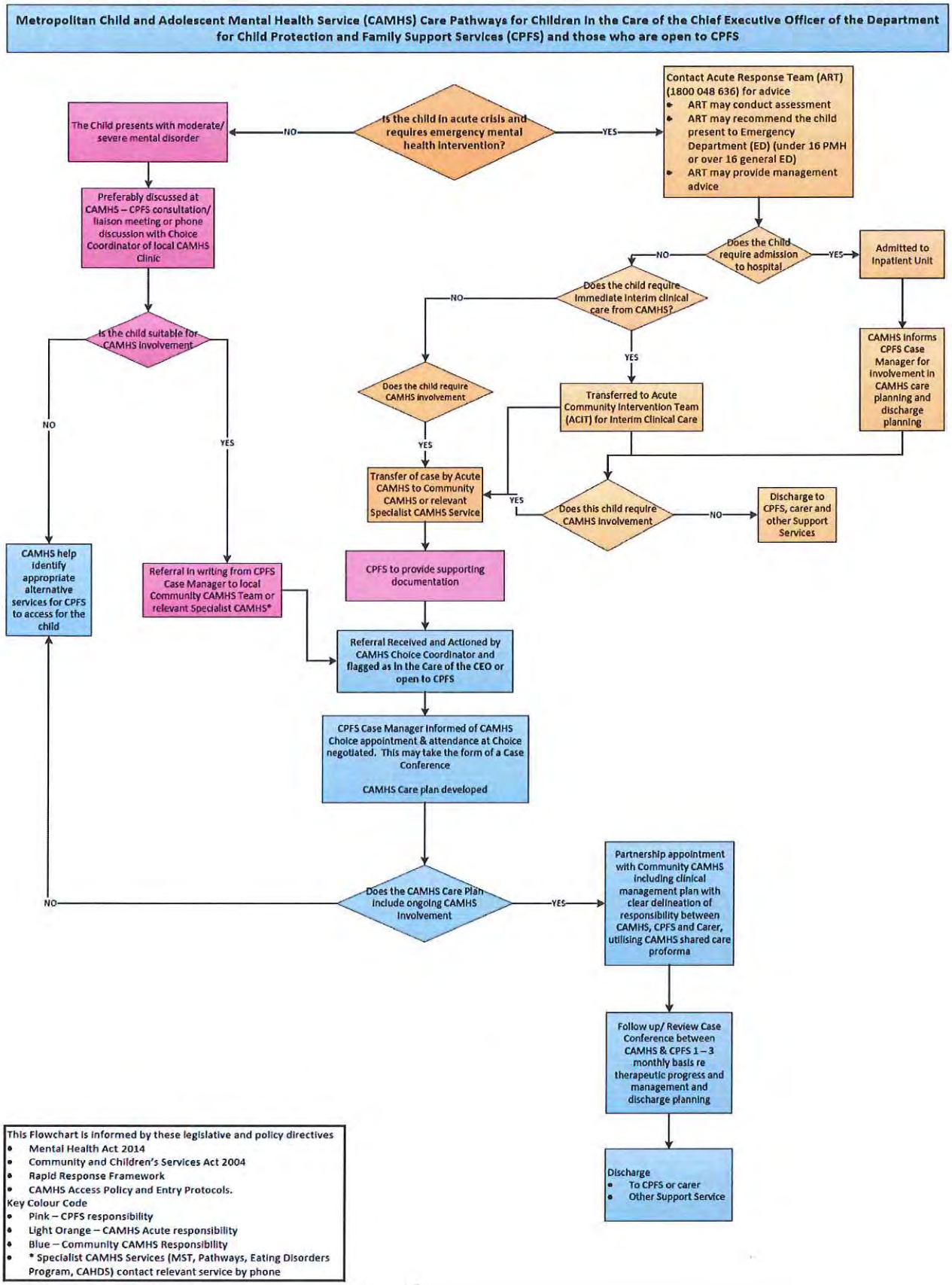
10. SIGNATURE OF RESPECTIVE CEOs

This bilateral schedule is signed by:

EMMA WHITE DIRECTOR GENERAL	PROF FRANK DALY CHIEF EXECUTIVE	JEFF MOFFATT CHIEF EXECUTIVE
DEPARTMENT FOR CHILD PROTECTION AND FAMILY SUPPORT	CHILD AND ADOLESCENT HEALTH SERVICE	WA COUNTRY HEALTH SERVICE
DATE: 25-05-2017	DATE: 31/5/17	DATE

Appendix 1

Referral processes between Department for Child Protection and Family Support and Child and Adolescent Mental Health Services



Appendix 2

CAMHS/CPFS Interagency Consultation Liaison Meetings - Terms of Reference

Background

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

Complex or contentious matters can be referred to the consultation meetings for discussion, but these meetings should not be used as an alternative to making timely referral to the CPFS duty officer or CAMHS triage clinician.

Flexibility should be exercised to enable other adult or youth mental health providers or CAMHS staff to participate where relevant to the child and family. Where possible CPFS district psychologists should attend the consultation meetings.

Consultation meetings aim to:

- develop a collaborative approach that is flexible, responsive, accessible and consistent between the two agencies;
- promote the exchange of relevant information;
- enhance the skills and knowledge of CAMHS and DCPFS staff to work with children and their families to better respond and manage mental health issues in the context of abuse and neglect: and
- improve the health and wellbeing outcomes for children, including those in the care of CPFS.

Consultation meetings will allow:

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

Both services will acknowledge that the core business of each service is different and, as such, flexibility with case discussions will be required. The table below outlines the core differences that are of particular note.

	CAMHS	CPFS
Core Business	CAMHS provides episodic mental health care to children and adolescents in a recovery orientated framework.	CPFS provides a statutory child protection service to children who have experienced, or are likely to experience, abuse or neglect.
Prioritisation of Services	CAMHS prioritises services based on actual risk to self and others, as well as developmental risk.	CPFS prioritises responses on the basis of the urgency to assess if the child is at risk and what actions are required to protect the child.

It is acknowledged that the consultation meetings are not to take the place of timely referrals between the two agencies, and consultations to support this process can take place outside of the interagency consultation meetings.

CAMHS/CPFS portfolio holders

CAMHS and CPFS will appoint a portfolio holder in each respective agency to take responsibility for the management and coordination of consultation meetings.

For CPFS, 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.

The CPCL positions are located in Community CAMHS clinics, and provide a combination of direct clinical work, case management and consultation liaison in relation to child safety matters.

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

Frequency of meetings

Regular meetings are to be negotiated and agreed to by the CAMHS and CPFS teams, with a *minimum* of four meetings per year recommended.

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

Administration

Administrative duties will be shared by the members of the consultation meeting. Agenda's will be disseminated no later than 2 working days prior to meetings and minutes no later than 2 weeks after a meeting.

Attendance and chairperson

Meetings will be attended by CAMHS Child Protection Consultation Liaison Officers, and CPFS portfolio holders, CAMHS Choice Coordinator and/or Psychiatrist (where available), CPFS duty officer, CPFS Psychology Services representative and relevant case managers from CAMHS/CPFS. The meetings will be chaired by the CAMHS/CPFS 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 CPFS portfolio holder should forward copies of the minutes to the district director.

The CAMHS portfolio holder should forward copies of the minutes to the Local Service Manager, Community CAMHS.

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

District specificity
These Terms of Reference may be added to, but not changed substantively, to reflect the particular arrangements within each district.

Review of terms of reference
These Terms of Reference will be reviewed as deemed necessary by the parties involved.

Appendix 3

GOVERNMENT OF WESTERN AUSTRALIA

Department for **Child Protection** and **Family Support**

Department of **Health**

Joint guidelines on the 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 and Family Support (CPFS) for the purpose of promoting the wellbeing[4] 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 CPFS and WA Health.

Legislation

- Section 23 of the *Children and Community Services Act 2004* (CCSA) enables the exchange of 'relevant information' [5] relating to the wellbeing of a child or group of children between CPFS and WA Health.
- The 'best interests of the child' must be the paramount consideration when information sharing under the CCSA.
- Operating under the *Health Act 1911* is not an impediment to sharing information with CPFS.
- The CCSA enables information sharing between CPFS and agencies operating under other State laws, provided the information is relevant information disclosed in good faith or in compliance with a request by CPFS.
- The CCSA allows for the protection of children to be the paramount consideration and overrides client confidentiality.
- Section 33 of the CCSA enables an authorised officer, without informing the child's parents, to have access to a child at a hospital for the purpose of an investigation.
- Section 33A enables CPFS 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, and 33B identifies the actions CPFS may take if necessary, including an investigation into the likelihood the child will be in need of protection after the child is born.

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

[5] Relevant information means information that, in the opinion of the CEO of the Department for Child Protection and Family Support, is, or is likely to be, relevant to (i) the wellbeing of a child or a class or group of children; or (ii) the wellbeing of a person who is eligible for leaving care services under section 96; (iii) the safety of a person who has been subject or exposed to family and domestic violence or (iv) the performance of a function under the *Children and Community Services Act 2004* (section 23).

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 CPFS.

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 and Family Support (CPFS)
Information can be exchanged between WA Health and CPFS 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 CPFS, 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.
- CPFS'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, CPFS has to ensure the validity of the information provided.

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

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

When WA Health workers or workers from CPFS 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, CPFS 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 CPFS who they reported the concern to or who originally requested the information.

Confidentiality and protection

WA Health employees are protected under the CCSA for giving information or making a report or notification. Employees do not incur any civil or criminal liability providing the information is disclosed in good faith or in compliance with a request from CPFS. 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 as allowed by the CCSA. It is possible that an application made by CPFS will proceed to a hearing and the reporter or notifier may be subpoenaed to give evidence.

Appendix 4

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

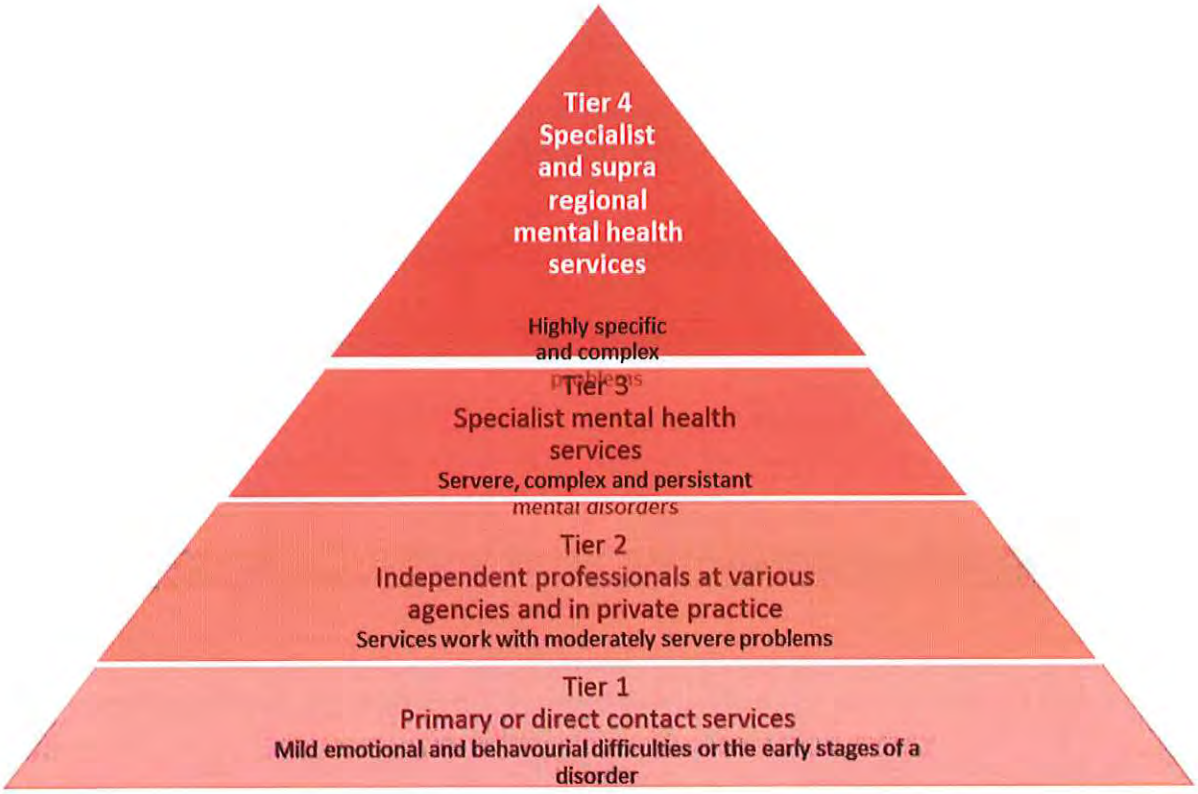
CAMHS	CPFS
COMMUNITY CAMHS	
ARMADALE CAMHS Goline House, Ecko Road Armadale WA 6992 (08) 9391 2455	Armadale 145 Jull Street Armadale WA 6112 (08) 9497 6555
BENTLEY FAMILY CLINIC 18-56 Mill Street Bentley WA 6982 (08) 9334 3900	Cannington Corner Grose and Lake Street Cannington WA 6107 (08) 9351 0888
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 Corner Clifton & Ameer Street Rockingham WA 6968 (08) 9528 0555	Rockingham 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 8am 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-based program for 11 - 16 year olds with enduring and severe behavioural disorders. 2 clinical teams cover Hillarys to Two Rocks, and Cockburn, Rockingham & Peel areas). MST Administration (08) 9431 3787 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 5

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 and Family Support**
- **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)