Post-Implementation Review: Integration of Acute Response Team (ART) and Acute Community Intervention Team (ACIT) into Community CAMHS

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Table of Contents

Executive Summary........................................................................................................................................... i

Background...................................................................................................................................................... i

The review...................................................................................................................................................... i

Findings and recommendations ........................................................................................................................ ii

Background..................................................................................................................................................... 1

Introduction .................................................................................................................................................... 1

Child and Adolescent Mental Health Services ............................................................................................... 1

Acute and assertive community services ........................................................................................................ 1

Community CAMHS ...................................................................................................................................... 4

The devolution of ACIT and ART services to CAMHS Community directorate ........................................ 5

An environment of change ............................................................................................................................... 5

A new model for ACIT and ART .................................................................................................................... 7

Reviewing the process and outcomes of integration ...................................................................................... 16

Methodology .................................................................................................................................................. 17

Who provided feedback ................................................................................................................................. 20

What people told us ....................................................................................................................................... 22

Limitations ..................................................................................................................................................... 22

What consumers, carers and families told us ................................................................................................. 22

What staff and other stakeholders told us .................................................................................................... 24

The previous model ....................................................................................................................................... 24

The change process ....................................................................................................................................... 25

What’s working well? .................................................................................................................................... 27

The integrated model in practice .................................................................................................................. 29

Further improvements .................................................................................................................................... 31

What the data tells us .................................................................................................................................... 34

Limitations ..................................................................................................................................................... 34

Access times .................................................................................................................................................. 34

Service demand .............................................................................................................................................. 36

Referral outcome ........................................................................................................................................... 38

Geographic access ........................................................................................................................................ 40
Executive Summary

Background

The Acute Community Intervention Team (ACIT) was initially established in 2008 under the governance of Princess Margaret Hospital (PMH), which formed part of the Women’s and Children’s Health Service. It provided six to eight weeks of community-based outreach care for children and adolescents needing urgent follow up and which created an alternative to inpatient admissions for children presenting to the PMH Emergency Department; post discharge support for the PMH mental health inpatient ward; and community based follow up in the least restrictive environment.

In 2011, the Child and Adolescent Mental Health Service (CAMHS) was established as a single service under the governance of Child and Adolescent Health Service (CAHS). During the period 2011 to 2013, there was significant investment in acute and urgent services including the expansion of ACIT and establishment of the Acute Response Team (ART). These services operated as part of the CAMHS Acute directorate, along with other hospital based mental health services.

Following changes to the funding of CAMHS services in the 15/16 and 16/17 financial years, a decision was made by the CAMHS Executive in May 2016 that ACIT and ART services would be integrated into the Community CAMHS directorate. The aim was to ensure the delivery of safe and effective child and family focused services that were financially sustainable. Following consultation with key stakeholders, the Model of Care was endorsed.

A project plan was developed, and an Implementation Steering Committee was established to oversee the integration of ACIT and aspects of ART into the ten Community CAMHS teams. The integration was completed in January 2017. An evaluation was initiated early to mid-2018 and completed later that year.

This document presents the findings of the evaluation and recommendations for further development of acute and urgent services in CAMHS as well as lessons learnt for future change management processes.

The review

The purpose of the review was to evaluate the outcomes of the integration of selected acute services into the Community CAMHS Directorate. Specifically, the project aimed to identify:
1. Whether the required functions of the previous ART and ACIT teams have been integrated into the community teams and implemented effectively; resulting in a high standard of care with improved efficiency?

2. The lessons learned through an assessment of the planning and change process used for the integration project.

3. Learnings for future change management across CAMHS.

4. Opportunities to engage staff in continuous improvement of the model.

The scope of the review does not include a comparison of the models of care pre and post devolution.

A mixed method approach was used with a strong emphasis on qualitative information. Due to the volume of information gathered and a desire to analyse the data using a rigorous approach, a qualitative researcher was employed through the Telethon Kids Institute (TKI).

Comments and feedback were received from a total of 284 individuals/organisations. Information was received through a variety of mechanisms with some people participating in more than one process. This included:

- 27 focus groups, with a total of 101 participants
- 46 interviews, of which 6 were conducted with children and families
- 126 survey responses from children and families
- 17 written submissions

Due to data limitations, quantitative analysis was limited to the following:

- Waiting times to access services
- Referral data including volume, source and outcome
- Geographic location of families who received services

Findings and recommendations

The model in practice

A number of strengths of the current model were identified through this review.

Feedback from CAHS staff as well as other government and non-government service providers highlighted the following:

- The Community CAMHS teams that have the capacity to respond quickly are viewed favourably.
- Under the current model, Community teams have the flexibility to adapt to the different needs of families that come to the service.
• That Community CAMHS are seeing more complex cases.
• The service is more accessible for consumers and families.
• That services with acute teams embedded within them are seen and experienced as working well.

From a consumer and carer perspective, their experience of the current model was reported to be very positive with feedback highlighting the following strengths:
• Services are easy to access.
• That CAMHS is providing a helpful, high quality service that meets their needs.
• Patients and families feel heard and listened to.
• That CAMHS staff are friendly and non-judgemental.
• That CAMHS is liaising with other providers such as schools, which is seen as very helpful.
• That patients and families are being provided with additional resources and support to as required.

One of the challenges identified was the increase in demand for community CAMHS services following the devolution of ACIT and ART. An analysis of data revealed that there has been a 32% increase in referrals to Community CAMHS when comparing 18-month periods prior to and post devolution of ACIT and ART with the size of the increase varying across teams. Participants reported that this has resulted in increase pressure on staff, that services are at capacity and that there are concerns about staff burnout.

With regards to access to services, the Model of Care includes a Key Performance (KPI) Indicator that children and families are offered an appointment within 2 working days of referral. Over the 18-month period 1 January 2017 to 30 June 2018, there was a median waiting time of 6 days across all Community CAMHS teams with considerable variation across teams.

The variability observed in terms of demand and access times across teams would suggest the need to review current resource allocations and/or catchment areas across CAMHS to ensure that there is an equitable allocation of resources.

**Recommendation 1**

That CAMHS undertake a review of optimal resources to meet demand across the metropolitan area.

In addition to the increased demand for Community CAMHS, participants also highlighted a number of other challenges with specific reference to the concerns about the sustainability of the model for smaller teams including being able to cover unplanned leave.
A prominent theme was that the current system is not integrated with inconsistencies and gaps in service provision. The most significant gap identified is that there is very limited capacity to provide in-reach and outreach services or after-hours support, which results in unnecessary ED presentations and hospital admissions and ultimately much poorer patient outcomes. This was raised by all stakeholder groups and was identified as a concern with the existing model as well as the most significant area for improvement. It was recognised that there is limited capacity to deliver these services given the current demand and the resources available.

**Recommendation 2**

That CAMHS seek additional funding to enable delivery of an intensive and assertive assessment and intervention service, including after-hours support for those children and young people who need more care than it is usually possible to provide within the CAMHS settings.

At the time of integration, a number of risks were identified that related to the impact of the proposed model on acute workers. A review of the qualitative data reveals that these risks were not sufficiently mitigated for all staff with a number of participants stating that they experienced feelings of loss and grief at the dismantling of their team; significant levels of stress and anxiety as a result of the way the change was handled as well as the sudden loss of acute leadership roles; and poor communication resulting in confusion about the reason for the change. This issue is discussed in more under the change process section.

While the change clearly had a significant impact on a number of the acute workers, a positive aspect of the process was that they felt very welcomed by the Community CAMHS teams.

**The change process**

Effective change management is central to successful implementation of any project. In simple terms project management focuses on the tasks required to complete the project deliverables; while change management focuses on the people impacted by the change.

A rigorous project management framework was adopted as part of the integration project in 2016. This included various project documentation, establishment of committees and working groups; stakeholder consultations; a variety of communication strategies and process; development of a HR plan; financial and activity data analysis; and regular reporting.

Despite the level of project governance, some staff were dissatisfied with the process. The following issues were highlighted to varying degrees by all CAMHS staffing groups, including the senior leadership team:

- a lack of consultation
- poor communication
- lack of clarity regarding the reason for the change
• staff unhappiness and uncertainty
• a lack of transparency regarding the allocation of staff to Community teams
• the impact of staff leaving the service, particularly the suddenness of the departure of staff who accepted a voluntary severance
• a lack of training and support for the ACIT and ART staff

There are a number of factors that were outside the scope of the review that may have contributed to staff dissatisfaction including:
• The devolution occurred at a time of significant change and reform across CAHS.
• Staff were originally asked to participate in a performance check for ACIT and ART as part of the preparation for the planned move to the new Perth Children’s Hospital; this process was commenced but not completed due the decision to devolve services into Community CAMHS. Further, there was no close out process for the performance check.
• The Service Design Team had a very short timeframe of six weeks to complete the task of identifying a preferred model; this may have resulted in additional stress and anxiety for staff.

The project management methodology did not include a close-out report. This would have provided staff with an objective summary of the project process and outcomes as well as immediate reflections for the organisation. Importantly, it may have provided some staff with a sense of closure.

**Recommendation 3**
That future project documentation includes completion of a project close-out report.

While there were various communication strategies utilised, many relied on information being cascaded down through the organisation, which can lead to gaps in communication and information flow.

**Recommendation 4**
That CAMHS consider using additional evidence-based strategies and processes or frameworks published in the implementation (or de-implementation) science literature in conjunction with a cascading model of communication for significant change processes. This could include more accountability for staff that are responsible for cascading the information, for example, requiring staff to provide evidence of how the information has been shared and ensuring that all feedback is documented and confirmed with the team prior to circulation.
A key communication issue that emerged from the feedback from previous ACIT and ART workers and the community clinicians was that they felt there was a lack of transparency about key decisions and that at times, the consultation was tokenistic. These comments may suggest a lack of trust between some staff and the CAMHS leadership team at the time. The involvement of external representative/s including consumers and carers on the Steering Committee may have been a useful strategy to ensure that there was an appropriate level of independence and objectivity in the project; and that this was perceived to be the case.

**Recommendation 5**

That CAMHS consider including external representation on Steering Committees for projects as appropriate.

There was a strong theme regarding the impact of the voluntary severances. Under the voluntary severance scheme (VSS), staff were offered an incentive payment if they resigned immediately following acceptance of the severance. This often resulted in staff leaving within a very short time frame with little if any time for handover. It is noted that the VSS was a WA State Government program and as such, the terms of the VSS were outside the control of CAMHS.

The review did not identify evidence of any specific change management approach or methodology used. A review of the CAHS website revealed a number of project management tools and templates (particularly through the Project Management Officer); however, no change management framework or strategy to guide change within the Health Service.

**Recommendation 6**

That a CAHS change management framework/strategy is developed to ensure consistent and transparent approach to change across the health service.

While the ACIT and ART staff commented that they felt very welcomed by the Community CAMHS team, they also stated that they did not receive the appropriate training and support to undertake their new role. This was reiterated by Heads of Service and Service Managers who stated that they did not have enough time to plan for the staff coming to their teams. Given the scale of the change, and the fact that many of the acute workers had very little, if any experience in community based services, it would have been beneficial to provide additional resources to support the implementation phase. This could have included the roll out of a training package as well as a more structured approach to implementation across the ten teams.
Recommendation 7
That CAMHS consider the resources required at the local level to support implementation of change including development of appropriate education/training packages.

Further improvements to the model
The importance of assertive outreach and in-reach services for children with acute and urgent mental health issues was highlighted by all groups consulted. There is currently limited capacity to provide these services with only a small number of teams providing these services.

Inconsistencies across the teams were noted and while some participants viewed this as a positive aspect of the model, it has also resulted in inequities for consumer and families. There is always a tension between enabling local innovation to respond to the community’s needs whilst also ensuring that services do not end up being a ‘postcode lottery’ with families having access to different services depending on where they live. Given that it is not more than two years since the services were devolved to Community CAMHS, it is timely to review and refine the model to ensure the best possible outcomes for children and families.

Recommendation 8
That CAMHS clearly identify which aspects of the model are essential to ensure a minimum standard across the ten teams. Consideration should be given to ensuring outreach and in-reach services are built into the model across the metropolitan area. This could include increased use of telehealth within the metropolitan area.

Documentation
Information for this review was accessed from multiple locations, which was time consuming and possibly resulted in some information being overlooked.

Recommendation 9
That CAMHS progress implementation of RM (the CAHS Records Management system) as a priority.
Background

Introduction

The governance and funding of urgent and acute child and adolescent mental health services in metropolitan Perth has undergone several iterations in recent history.

The Acute Community Intervention Team (ACIT) was initially established in 2008 under the governance of Princess Margaret Hospital (PMH), which formed part of the Women’s and Children’s Health Service. In 2011, the Child and Adolescent Mental Health Service (CAMHS) was established as a single service under the governance of Child and Adolescent Health Service (CAHS). During the period 2011 to 2013, there was significant investment in acute and urgent services; initially through funding from the WA Mental Health Commission (WA MHC) and then in 2013 through a Commonwealth Government investment as part of the National Partnership Agreement Supporting National Mental Health Reform (NPA).

In May 2016, a decision was made by the CAMHS Executive and communicated to staff that ACIT and ART services were being integrated into the CAMHS Community directorate. A Service Design Team and Steering Committee were established to oversee the process. The integration was completed in January 2017. An evaluation was initiated early to mid-2018 and completed later that year.

This document presents the findings of the evaluation and recommendations for further development of acute and urgent services in CAMHS as well as lessons learnt for future change management processes.

Child and Adolescent Mental Health Services

The CAMHS structure currently consists of three directorates: Community, Specialised and Acute. Prior to the integration with Community CAMHS, ACIT and Acute Response Team (ART) services were functionally aligned within the Acute directorate.

Acute and assertive community services

ACIT was developed in the context of difficulties in accessing community child and adolescent mental health services, as the district-based teams in South Metropolitan and North Metropolitan Area Health Services had lengthy waitlists for services. The team was established as a centralised model with office space at 70 Hay Street and clinics in PMH combined with outreach services. During the same period a Psychiatric Liaison Service (senior
registered nurse) was provided in the PMH Emergency Department (ED) between 8:00am and 10:30pm daily.

Initially, the ACIT service consisted of six clinical FTE and it provided six to eight weeks of community-based outreach care during business hours to children and adolescents needing urgent follow up and which created:

- an alternative to inpatient admission for children under 16 years who presented to PMH ED;
- support post-discharge from Ward 4H at PMH (a non-authorised mental health ward), if no other community mental health service and supports were in place, for improved mental health bed flow and community follow-up; and
- community based follow up in the least restrictive environment.

There was significant investment into acute and urgent services over the period 2011 to 2013 with funding from various sources. A detailed examination of the funding and recruitment of staff to these services was outside the scope of this review; however, a summary of the evolution of these services within CAHS is provided below.

In August 2011, soon after the establishment of CAMHS as a single service, the WA MHC and CAHS agreed to expand the ACIT service through the Emergency Department Mental Health Diversion Program. At this time ACIT grew to a total of 12 FTE to address the inclusion of the Bentley Adolescent Unit (BAU) in CAMHS and in order to provide a service to children up to age 18; as well covering a larger geographic area through accepting referrals from all metropolitan EDs.

In 2011-12, the MHC invested $1.6 million to develop the Acute Response Team (ART). The investment resulted in:

- additional staff being employed in the PMH ED;
- increased coverage to provide a service 24/7;
- expanded capacity for an emergency response in the community and to other metropolitan hospital EDs;
- provision of consultation advice to rural and remote areas; and
- provision of a 24-hour telephone line (1800 number) to provide advice and information about services for consumers, carers and professional staff.

At this time, ART had a total clinical FTE of 14.6.

By April 2012, all States and Territories had signed the five-year National Partnership Agreement Supporting National Mental Health Reform (NPA), which aimed to “deliver improved health, social, economic and housing outcomes for people with severe and persistent mental illness by addressing service gaps and preventing ongoing cycling through

The *Mental Health Assertive Community Intervention (ACI) initiative* was one of the programs funded under the NPA and in February 2013, a Service Agreement was signed between the MHC and CAHS enabling the funds to be used to enhance and develop services within the Acute CAMHS directorate over four financial years; 2012-13 to 2015-16.

Under the ACI Initiative, the following services were pilot funded within the Acute CAMHS directorate with a staged implementation as follows:

1. March 2013 - expansion of the ART by additional 4.5 FTE;
2. April 2013 - expansion of the ACIT to provide a weekend service through the addition of 2 FTE;
3. October 2013 - establishment of a new team, ACI North-East (ACI-NE) consisting of 4 clinical FTE and 0.5 Consultant Psychiatry; and
4. A partnership with Mission Australia and their new specifically established team, the Children and Family Support Service (CAFSS).

The additional funding increased the ART clinical FTE to a total of 19.1, of which 16.25 were permanent and 3.5 were fixed term contracts. This enabled the service to function as a multidisciplinary team providing a 24-hour, 7 day a week service with telephone information and support, acute assessments in metropolitan EDs and state-wide mental health bed flow coordination for children under 18 years of age. ART also provided, when possible, community based acute mental health assessments in the metropolitan area as an ED diversionary program; this was delivered through the CAHS budget allocation. The ART clinicians were supervised by the on-call CAMHS psychiatrist.

ACI-NE operated under the centralised governance arrangements but was specifically targeted at Community CAMHS services that had experienced significant increased demand; namely Clarkson, Hillarys and Swan. This focus assisted in the management of priority waitlists at these sites and provided brief crisis intervention to patients who were active with Community CAMHS. The aim was to provide intensive community intervention, more than could be provided by Community CAMHS, over a period of 1-2 weeks in order to avoid hospital admissions. This location specific referral pathway existed until ACIT and ACI-NE were integrated into Community CAMHS in 2017.

As a result of this additional investment, resources for the combined ACIT/ACI-NE service increased to a total of 18 clinical FTE with a staffing profile that consisted of a consultant psychiatrist, senior registered and clinical nurses, senior social workers, senior clinical psychologists, senior occupational therapist, teacher support with School of Special Education
Needs (SSEN) Hospital School Services (funded by the Department of Education) and a culturally and linguistically diverse mental health worker.

Appendix 1 provides a summary of the functions of the ACIT and ART teams over time.

**Community CAMHS**

Community CAMHS services are delivered out of ten (10) community clinics spread across the greater Perth metropolitan area. Community CAMHS provide services for children and adolescents (up to their 18th birthday) with severe and/or complex emotional and mental health wellbeing concerns, who are experiencing substantial impairment in functioning because of these concerns on a continuous or intermittent basis.

Community CAMHS offer assessment, case coordination, case management and multidisciplinary evidence-based individual, family and group interventions and operate Monday to Friday during business hours (9.00am-5.00pm, excluding public holidays). Interagency consultation and liaison is an important part of case management.

**Choice and Partnership Approach (CAPA)**

At the time of CAMHS coming together under a single governance structure, there were significant variations in service delivery and lengthy waiting lists across the metropolitan area.

The challenges with accessing services was highlighted in a number of reports including the MHC *Towards 2020 Consultation Paper*, which stated that children were “waiting up to 6-8 months for non-urgent referrals and several months for priority referrals” (MHC, 2010 p111); and the Commissioner for Children and Young People Western Australia’s *Report in the Inquiry into the mental health and wellbeing of children and young people in Western Australia*, which received oral and written evidence from a range of individuals and organisations about long waiting lists for CAMHS services (Commissioner for Children and Young People Western Australia, 2011).

In 2012, the CAMHS Executive decided to review and redesign its Community CAMHS clinics to ensure children and their families would receive the best possible and most timely care and treatment within existing resources. CAMHS’s goal was to ensure services were as consistent, ‘lean’ and consumer focused as possible in order to minimise waste and support the child’s treatment and recovery.

The Choice and Partnership Approach (CAPA) (York and Kingsbury, 2013), which is based on demand and capacity theory and was developed specifically for CAMHS services, was identified as the service reform model to be implemented across CAMHS. Following a pilot in one site, CAPA was fully implemented across all ten services by July 2015.
An overview of CAPA can be found in Appendix 2.

The devolution of ACIT and ART services to CAMHS Community directorate

An environment of change

The devolution of ACIT and ART occurred in a live environment and during a time of significant change within CAHS and the broader health system including:

- The expiration of the five-year National Partnership Agreement Supporting National Mental Health Reform and funding for States and Territories associated with that;
- The expiration of the Service Agreement between CAHS and the MHC that provided funding for the pilot ACI initiative;
- Changes to Activity Based Funding (ABF) with a reduction in the Specialist Psychiatric Age Adjustment (weighting for inpatient episode) from a 30% loading in 2013/2014 and 2014/15 to 9% for the 2015/16 FY;
- Finalisation of funding negotiations for 2016/17 in May 2016, which resulted in an overall shortfall of $4.1m for the 2016/17 FY;
- The implementation of the WA Health Services Act (2016) and the establishment of CAHS as a Health Service Provider with an independent statutory Board that came into effect on 1 July 2016;
- The planned move to the new Perth Children’s Hospital (PCH) and the large scale service reforms (including performance checks for all hospital based services) and commissioning activities (including the commissioning of the new authorised inpatient mental health unit at PCH) associated with that; and
- Changes to mental health service provision for children aged 16 and 17 year olds. This included the decision to align the CAMHS inpatient unit (IPU) criteria with the hospital’s as part of the transition to PCH, resulting in CAMHS IPU accepting children up to 16 years of age at PCH rather than 18, which had been the case at BAU (the community CAMHS age criterial has remained up to 18); and the opening of inpatient and community based services at Fiona Stanley Hospital for 16-24 year olds. The commissioning of a new East Metropolitan Health inpatient unit (EMyU) for 16-24 year olds, occurred in 2018.

Given the scope of change and reform, it is possible that CAMHS staff were impacted by a number of these changes; however, the scope of this review was limited to evaluating the outcomes of the integration of ACIT and ART services including staff’s experience of the change process.
Two of the above issues featured prominently in the events leading up to the decision to devolve ACIT and ART to the Community CAMHS directorate; the performance check that was commenced but not completed, and the change in funding for CAMHS.

**Service performance check for ACIT and ART**

In late 2015, the Chief Executive of CAHS indicated that all services transitioning to PCH needed to undertake some form of service improvement process. The purpose was to ensure that CAHS was using contemporary models of care that considered the design, layout and new technologies at PCH; and that services were financially sustainable.

In February 2016, CAMHS commenced a performance check of ACIT and ART and a Service Improvement Team (SIT), led by a senior project officer, was established. The SIT included representation from Acute CAMHS, inclusive of ART and ACIT staff; as well as Specialised and Community CAMHS directorates. The process included analysis of data, service mapping, review of evidence-based models of care, surveys of stakeholders, review of Experience of Survey Questionnaire (ESQ) results and a focus group with young people.

The performance check was originally scheduled to occur between February and July 2016; however, following a reduction in funding of CAMHS services, a decision was made at the end of May 2016 to integrate ACIT and components of ART into the Community CAMHS Directorate. A Service Design Team (SDT) was established to develop the model of care and a Steering Committee and related working groups subsequently established to oversee implementation of the new model (further details are provided in the section titled ‘A new model for ACIT and ART’). The SDT also considered the data and information obtained through the stakeholder consultation as part of the performance check.

**Funding for CAMHS services**

There were significant changes to the funding arrangements for CAMHS services during the 2015/16 and 2016/17 FYs. These issues were outlined in Briefing Notes to the CAHS CE dated 8 June, 17 June and 8 July 2016 as follows:

- A reduction in the Specialist Psychiatric Age Adjustment, down from 30% in 2013/14 and 2014/15 to 9% in 2015/16 and the resulting reduction in the allocation of Weighted Activity Units (WAUs) and therefore funding for inpatient services;
- The cessation of the NPA funding of $1.9m, which was offset by a MHC allocation of $800K resulting in a shortfall of $1.1m;
- A total funding shortfall of $4.1m for CAMHS in 2016/17, which was only confirmed on 16 May 2016 and following extensive negotiations with the MHC and the Department of Health;
It was noted that the additional funding had previously been used to partially offset enhanced service delivery across the ART, ACIT and Paediatric Consultation Liaison (PCL) Team\(^1\), which all provide bed sparing services.

A new model for ACIT and ART

Identifying the preferred model

Given the imperative to develop a financially sustainable model for the delivery of urgent, community based mental health care, a decision was made to integrate ACIT and components of ART into the Community CAMHS directorate so that assertive acute community intervention could be provided within the available financial envelope. The Head of Department Community CAMHS was the Executive Sponsor for the integration project.

Figure 1 provides a timeline of events surrounding the decision to integrate services and implementation of the model.

The CAMHS Executive communicated its decision at a meeting with ACIT and ART staff on 31 May 2016 and advised that a SDT would be formed. The aim of the SDT was to identify a safe, effective, family focused service with a financially sustainable model by 27 July 2016.

The SDT was established with representation from Community, Specialised and Acute directorates, including ACIT and ART staff on 14 June 2016, which resulted in a timeframe of six weeks to identify the preferred model.

The objective of the reform was to provide a sustainable acute community service within the reduced financial envelope. The model needed to provide a response:

1. that was closer to home
2. with fewer transitions between services
3. with reduced duplications of assessments (within and between services)
4. where patients would be seen within an acceptable timeframe
5. that provided equity of service across the metropolitan area.

Initially, seven potential models were identified, with three being assessed as sustainable. The three models were presented to the design team on 16 June 2016. The design team met five times between 16 June and 30 June 2016. Following an analysis of data and an assessment of financial sustainability, the models were further narrowed down to two: the cluster model; and the integration model.

On 1 July 2016 a decision was made to retain the 1800 number at PMH/ PCH.

\(^1\) While the briefing notes state that ACIT, ART and PCL all provided bed sparing services, it has subsequently been confirmed that PCL did not fulfil this role.
On 5 July 2016 the design team presented the two models of care to the CAMHS Executive including an analysis of the FTE required for each model in order to meet current demand. Details of the models are provided below.

**Model 1: The Cluster Model - 2 teams; one North and one South**
- Governance would sit with a dedicated Service Manager and Psychiatrist split across both hubs.
- Estimated that 12 FTE would be retained with 5 FTE located in the South and 7 FTE in the North.
- Two (2) facility hubs and five (5) vehicles required.
- Core business hours would remain the same (Monday – Friday 8.30am-4.30pm).

**Model 2: The Integration Model**
- Governance would sit with each of the ten (10) Community CAMHS teams.
- Estimated that 17-19 FTE would be retained.
- Acute clinician/s would work in collaboration with the Choice Coordinator and the CAMHS team.
- The Head of Service and Service Manager of the local Community CAMHS teams would be responsible for meeting the demand of the local community.
- Core business hours would remain the same (Monday –Friday 8.30am – 4.30pm).

Following discussion and analysis of the efficiency, effectiveness and risks of both models, a number of potential benefits of the integration model were identified including:
- The ability to maximise limited resources available through utilisation of existing facilities and avoiding additional costs associated with lease, administration, overheads and management costs;
- It provided care closer to home resulting in increased convenience for families and decreased travel time for clinicians and families;
- Decreased service transitions for children and families;
- Improved access to children and families in outer suburbs;
- Improved district based knowledge of community resources;
- Up-skilled Community CAMHS clinicians in acute intervention;
- Access to wider team based skills.

Potential risks in the integration model were also identified and included:
- Potential for increase in access to Community CAMHS leading to increased waiting times for services;
- Loss of ACIT team identity;
- Concerns regarding the sustainability of an integrated model in the smaller teams;
• Potential for acute staff burnout, isolation and loss of skills;
• Difficulties in catering to variation in demand across community sites;
• Difficulties in covering planned and unplanned leave of acute staff;
• Concern regarding a shift to crisis management rather than acute intervention;
• Increased distance to CAMHS IPU, limiting face to face access.

Consultation sessions were held with staff to further explore the models including:

- An information session with ACIT and ART on 7 July;
- A meeting with ACIT and ART staff on 11 July including Human Resource (HR) and Union representatives;
- The Medical Advisory Committee (MAC) on 12 July;
- Two (2) forums on 13 and 14 July attended with a request for a representative from each Community CAMHS team to attend at least one of the forums with an expectation that staff attending the forums would be responsible for consulting within their own teams and providing feedback to the project team;
- Meetings with affected ACIT/ ART consultants on 25 July;
- A meeting with not-for-profit organisations was held on 25 July.

A total of 97 CAMHS staff attended these consultation meetings.

Staff could also provide feedback via email to the Project Lead. In addition, Community CAMHS teams were asked to develop a log of unique issues and risks for their service in the context of the devolution of ACIT and ART.

On 27 July 2016 a decision was made to proceed with the integration model. The decision was communicated to ACIT and ART staff and union representatives at a meeting on 29 July with the rationale for the decision being:

- Risks were mitigated more easily with the integrated model
- Maximises the clinical capacity
- Minimises the risk of re-deployment of staff/ redundancy
- Provides local acute response
- Seamless patient journey
- Capacity for further upskilling of community CAMHS in acute intervention
- Improved district based knowledge of community resources.

As part of this process, three FTE leadership positions were abolished, and the staff accepted voluntary severances.

Community CAMHS teams were advised of the decision by email on 4 August 2016.
Information regarding the governance and the implementation process are provided below.

**Implementation of the integrated model**

A Project Plan was developed with the objective of safely integrating the functions of ACIT and aspects of ART into the Community CAMHS directorate. The project methodology included consultation with internal and external stakeholders, further analysis of demand, identification of process changes required within Community CAMHS teams and execution of risk mitigation strategies. The deliverables were identified as:

- an endorsed Model of Care outlining services to be delivered, Key Performance Indicators (KPIs) and a patient pathway;
- a HR plan; and
- a communications’ plan.

The original intention was for the new model to be implemented in October 2016 to coincide with the planned move to the new Perth Children’s Hospital in November. Due to a number of delays in the commissioning of PCH and given that a number of ACIT and ART staff had left the service, a decision was made to commence the new model in January 2017 despite the fact that PCH would not be open. This also coincided with the school holidays, which is traditionally a clinically quieter period, thereby ensuring a smoother transition of services. Figure 1 provides a timeline of events.

Project governance included the appointment of a Project Manager who was seconded from a Service Manager role within Community CAMHS; establishment of the CAMHS Community Acute Intervention Services Implementation Steering Committee, chaired by the Director Community CAMHS and with representation from community, acute and specialised directorates including managers and clinicians; a clinical planning officer; and allocation of a data analyst and project officers. The purpose of the Steering Committee was to work collaboratively with services across all CAMHS directorates to ensure the safe transition of the staff and services for delivery from Community CAMHS teams. The Committee was tasked with being a central point for communication of all related activity within CAMHS. The Committee reported to the CAMHS Executive Committee on a monthly basis.

Specific responsibilities of the Steering Committee included:

- Safe implementation including model of care, and allocation of physical and human resources
- Identification of education and training needs
- Consideration of Information and Communication Technology (ICT)
- Risk mitigation
- Communication and stakeholder engagement
- Evaluation framework
Two working groups were also established under the Steering Committee:

- The HR working group, which was responsible for developing an overarching HR plan, and in conjunction with CAHS HR, establishing and reassigning acute staff into the community CAMHS directorate.
- The clinical model working group, which was responsible for developing a clinical model implementation and transition plan, following consultation with key stakeholders.

A comprehensive HR Change Plan was developed which outlined the following key principles:

- CAHS was committed to assisting all employees during the period of change.
- The principle of procedural fairness underpinned equitable effective human resource management.
- Once the model was approved, positions would be transitioned.
- Wherever possible permanent CAHS employees would be transferred to a position with equivalent classification.
- Where this was not possible, employees would be CAHS redeployees and provided with gainful employment until a suitable alternative position was identified.
- The relocation and deployment of staff was to be undertaken in accordance with government policy in relation to security of employment (WA Health Operational Directive OD 0372/12).

The HR Change Plan detailed the process for consulting with affected staff and unions and for allocating staff to their new positions. On 9 September 2016, affected staff received a written invitation to participate in a preference process and to complete a Preference Registration Form (PRF) indicating their preferred work location. They also received a copy of the PowerPoint presentation that had been provided to staff at the meeting held on 27 July and a set of Frequently Asked Questions (FAQs) about the preference process.

A panel was formed to assess the preferences and to assign staff across the Community CAMHS teams. The panel was comprised of the Directors of Acute and Community, a representative from the HR Steering Group, the Project Lead and a CAHS HR Consultant. A selection report was completed outlining the decisions and rationale for staff allocation. Staff were notified of their workplace location via letter on 7 October 2016 with information regarding who to contact if staff had concerns about the process and/or decisions made. Staff were encouraged to spend some time with their new team to plan their transition prior to formal commencement in the role in January 2017; a number of staff took up this opportunity.

The Final Draft Model of Care and Urgent Pathway flowchart was tabled at CAMHS Executive on 19 October 2016 for feedback, which was subsequently collected, and the documents endorsed. The endorsed Model of Care for the Urgent Pathway across Community CAMHS was distributed by the Director Community CAMHS to Service Managers and Heads of Service on 17 December 2016, to commence from 3 January 2017. Within the same
correspondence, a notice to stakeholders, signed by the Executive Director Mental Health, was provided for Community CAMHS leadership teams to distribute to local stakeholders including the Department of Child Protection and Family Services, non-government agencies, WA Police, Schools and Emergency Departments. The Director Community CAMHS provided the stakeholder notice to the Principal of the School of Special Educational Needs (SSEN) for distribution to public, independent and catholic education networks, including school psychologists.

Once the announcement had been made, plans for the ramping down of ART and ACIT were enacted. This included the movement of staff into Community CAMHS teams and the transition of existing clients to Community teams from 3 January 2017.

Immediately prior to devolution, there were a total of 32.1 permanent FTE employed across ACIT (15.9) and ART (16.2). Three positions were abolished, and staff accepted a VSS; 2.8 FTE were assigned to the 1800 number; 5.4 FTE were assigned to PMH/PCH IPU; and 20.9 FTE were assigned to Community CAMHS teams (17.9 FTE clinical, 1 FTE consultant psychiatrist and 2 FTE administrative staff). All permanent staff were allocated to a position either at PCH or within Community CAMHS. Staff on fixed term contracts backfilled leave, secondments and temporary vacancies until the conclusion of their contract.

Responsibility for implementing the new model sat with each individual team including the provision of training, professional development and support to the ACIT and ART workers and the team more broadly.

The steering committee met for the final time on 6 February 2017 closing out actions regarding physical resources (allocation of vehicles and IT equipment), human resources and reviewing initial staff feedback that had been collected from five staff members. It was noted that issues relating to the Urgent Pathway after that time were to be tabled at the Community CAMHS Governance Meeting.

The endorsed Model of Care (MOC) detailed a clinical pathway comprised of the following:

- **Acute referral process** – Any referral received by Community CAMHS during business hours will be processed by the Choice Coordinator on the same day. Referrals received from Mental Health Practitioners deemed urgent will be offered urgent pathway and others will be reviewed to determine level of priority. Referrals received outside business hours from the 1800 number or EDs will be processed the following business day. The Choice Coordinator will ensure that attempts are made to contact the adolescent and/or family the same business day and a Choice appointment will be offered within 2 working days in a venue and at a time that is clinically indicated.

- **Choice Appointment process** - Face to face clinical assessments will ensure that all children, adolescents and their families have access to appropriate mental health
services. Urgent clinical assessments will be offered within 2 working days. For predictable periods of high demand, such as Easter and Christmas holiday periods, teams will schedule additional urgent Choice appointments immediately following these holiday periods to increase capacity.

- **Clinical case management and evidence based clinical interventions** - These will be offered by CAMHS clinicians to all children, adolescents and their families requiring specialist mental health input. This will be consistent with National Mental Health Standards and the National Safety and Quality Health Standards. CAMHS clinicians will offer case management, short term acute intervention and/or longer term clinical intervention depending on clinical indication and in negotiation with children and families accessing service.

- **Community outreach** - Community CAMHS workers will provide outreach services to the local community including facilitating assessment and treatment at suitable locations outside of CAMHS facilities, where appropriate. They will also liaise with relevant service providers involved in the child and adolescent’s treatment. (CAMHS, 2016, pp 9-10).

The 1800 number was retained under the governance of the Acute CAMHS directorate.

Within CAMHS, Heads of Service and Service Managers are responsible for meeting the demands of their local communities within the existing resource constraints and in accordance with the CAPA service delivery model and the Community CAMHS Entry Protocol and the Access and Entry Process for Urgent and Routine Referral.

Each team responded differently to integrate acute model operations and incorporate affected staff into existing clinical teams. Of the 10 clinics, five have a separate stream (or worker) to respond to urgent referrals. For some clinics, an urgent team had already been in place for many years and others have adopted the separate stream model more recently. Table 1 illustrates the variability in application of the integration in terms of which staff deliver Urgent Choice appointments and how many Urgent and Routine Choice appointments are scheduled weekly.
Table 1: How do Community CAMHS teams respond to demand for urgent mental health needs?

<table>
<thead>
<tr>
<th>Model</th>
<th>Staff Delivering Urgent Choice</th>
<th># Urgent Choice Scheduled per Week</th>
<th># Routine Choice Scheduled per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armadale</td>
<td>Single Stream Whole team</td>
<td>as required</td>
<td>10</td>
</tr>
<tr>
<td>Bentley</td>
<td>Separate Stream Acute Team</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Clarkson</td>
<td>Separate Stream Acute Team</td>
<td>5</td>
<td>~16</td>
</tr>
<tr>
<td>Fremantle</td>
<td>Separate Stream Acute Team</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Hillarys</td>
<td>Single Stream Whole team</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Peel</td>
<td>Separate Stream Choice Coordinator</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Rockingham</td>
<td>Single Stream Whole team</td>
<td>3</td>
<td>4 Choice clinics</td>
</tr>
<tr>
<td>Shenton</td>
<td>Single Stream Whole team</td>
<td>2-3</td>
<td>4</td>
</tr>
<tr>
<td>Swan</td>
<td>Single Stream Whole team</td>
<td>4</td>
<td>15-17</td>
</tr>
<tr>
<td>Warwick</td>
<td>Separate Stream Acute worker + Choice Coordinator (other clinicians as required)</td>
<td>As required</td>
<td>5-6</td>
</tr>
</tbody>
</table>

*Single stream: Shares acute work across the clinical team*

*Separate stream: A group of clinicians work specifically on urgent referrals*
Figure 1: Timeline of events surrounding the decision to integrate services and the implementation of the new model

- **2016**
  - **14 June**: Service Design Team (SDT) established
  - **16 June**: CAMHS Exec. communicate decision that services are to be integrated with Community CAMHS teams and that this is to occur by 27 July 2016
  - **1 July**: SDT commence meetings (total of 11 meetings between 16/6 and 26/7)
  - **5 July**: SDT and CAMHS Exec meet to discuss two preferred models: cluster; and integration
  - **7-25 July**: Decision to proceed with the integration model
  - **27 July**: Decision communicated to HoS/ SMs and staff
  - **29 July & 4 August**: Consultation on the two models with • ACIT and ART staff (7/7) • ACIT and ART staff; HR and union representatives (11/7) • Medical Advisory Committee (12/7) • Two staff forums (13 &14/7) • Meetings with affected ACIT and ART consultants (25/7)
  - **1 August**: HR Working Group work with affected staff and Service Managers regarding allocations
  - **Aug & Sept**: SDT and CAMHS Exec meet to discuss two preferred models: cluster; and integration
  - **19 October**: Decision to proceed with the integration model
  - **17 Dec.**: Endorsed MOC circulated to Service Managers and Heads of Service

- **2017**
  - **14 June**: Final draft Model of Care (MOC) tabled at CAMHS Executive
  - **6 Feb.**: Close out meeting of Steering Committee
Reviewing the process and outcomes of integration

As part of the integration of ACIT and ART into Community CAMHS, a commitment was made to undertake a review after six months of integration having been completed (CAMHS, 2016, p12).

The purpose of the review was to evaluate the outcomes of the integration of selected acute services into the Community CAMHS Directorate. Specifically, the project aimed to identify:

1. Whether the required functions of the previous ART and ACIT teams have been integrated into the community teams and implemented effectively; resulting in a high standard of care with improved efficiency?
2. The lessons learned through an assessment of the planning and change process used for the integration project.
3. Learnings for future change management across CAMHS.
4. Opportunities to engage staff in continuous improvement of the model.

The scope of the review did not include a review of the reasons for the decision to integrate ACIT and ART into the Community CAMHS directorate; the decision to implement the integration model; or a comparison of the models of care pre and post devolution.

Objectives were designed to evaluate the integrated model in practice in 2018 and where possible to compare areas of service delivery to ART and ACIT.

1. Assess the performance of the ten (10) integrated teams across Community CAMHS in the following areas:
   - Compare intended stated project deliverables and objectives of the endorsed integrated model of care against delivery of the model in practice
   - Review KPIs and internal targets for provision of acute services in community mental health settings for the 2017/18 FY post implementation.
   - Compare activity data and funding for ART and ACIT and the Community CAMHS Teams including the 1800 urgent helpline over 2015/16 FY, 2016/17 and 2017/18 FYs, noting changes pre and post the January 2017 integration.
2. Hear and learn from staff about their perceptions and experiences as individuals and within teams regarding the change process and the integrated model in practice.
3. Seek feedback from stakeholders (internal and external) and importantly from children and families on their experience of the acute patient journey within current integrated model and ways to improve their experience.
4. Identify gaps, vulnerabilities and strengths and variability in the application of the integrated model and to provide recommendations to support improvement and to further embed the model.

**Methodology**

A mixed method approach was used with a strong emphasis on qualitative information. Specifically, the methodology included:

1. Consultation with Community CAMHS, affected ART and ACIT staff and external stakeholders (focus groups, interviews and written feedback) to review the change process and how the model is working in practice;
2. Analysis of activity data from PSOLIS for time periods pre and post the integration of ACIT and ART into Community teams;
3. A parent and child survey to understand their expectations and experience following urgent referral to Community CAMHS; and
4. Review of funding, costs and the funding context across financial years

**Qualitative data**

**Identifying participants**

ART and ACIT interview participants were identified by accessing previous staff lists, which documented where the ART and ACIT staff had been deployed to; and through Service Managers. Some staff had left CAMHS, or had moved to a different Community CAMHS team or role within CAMHS. Some were not available for interview as they were on leave; where possible they were interviewed on their return.

Other stakeholders were identified through reviewing the stakeholder list from the 2016 project for the ‘Integration of ART and ACIT into Community CAMHS’ and through liaising with CAMHS corporate and clinical staff, metropolitan ED staff, and senior staff in the various Health Service Providers (HSPs). Interviewees also identified additional stakeholders and they were subsequently contacted to provide feedback.

**Timeframes for consultation**

Consultations were undertaken between May and October 2018.

**Interviews and focus groups**

Interviews were semi-structured using open-ended questions that were adapted to the role of the stakeholder or staff member being interviewed to reflect their area of responsibility and interface with, or their role, within CAMHS. Prompts and summarising of themes back to interviewees was used to check understanding of responses.

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2 This was limited to a broad overview of the funding environment; a forensic analysis of funding and costs was not able to be completed within the resources and timeframes of this review.
Focus groups were used to assess the integrated model, including benefits, risks, knowledge and skills required and practicalities of application. Barriers, enablers and further improvements were explored.

Questions to staff and stakeholders centred on the following broad themes:
1. Capacity of Community CAMHS to meet the acute needs of children and families in their local area
2. Strengths and challenges of the integrated model in practice
3. Interface between stakeholders and Community CAMHS
4. Their experience of, and perception of, the change process
5. Suggested improvements to the change processes
6. Changes in current needs of children and families
7. Contextual issues; current and at the time of integration
8. Personal experience of change, adjustment, acceptance, ongoing needs (specifically, for ART and ACIT staff and Service Managers)
9. Suggestions for improvements to the model

Each team was interviewed in their preferred format; in focus groups for whole teams, as a combined group interview (2 or more participants) or individual interviews. Affected ART and ACIT staff were given the option to be interviewed separately from the wider team.

Interviews were conducted at the staff’s work site or over the phone, and ranged from approximately 15 minutes to 1 hour, with an average of around 40 minutes. Most interviews were recorded, some preferred not to be recorded so notes were taken (this occurred in 14 of 90 instances) and were also submitted for qualitative analysis. Transcripts were submitted to an external company for transcription and consent was obtained from participants for this process.

Written feedback
Stakeholders were emailed a one-page summary of the project with a request to answer a set of questions. They were offered the option of participating in a focus group or providing consolidated team or verbal feedback over the phone. Due to the timeframes, written feedback and phone interviews were used. Written feedback from stakeholders consisted of feedback from individuals and consolidated feedback from whole teams and agencies, following their own internal consultation.

The voice of parents and children
The role of the survey was to understand patient and carer expectations around timeframes and experiences following urgent referral and intervention for acute needs in Community CAMHS.
The survey was designed following consultation with a consumer, a Community CAMHS Service Manager, the CAMHS Consumer Engagement Project Officer and the Project Director. Some teams provided feedback that they were reluctant to ask families to complete another survey and did not consider it to be sufficiently objective or different to the Experience of Survey Questionnaire (ESQ) that is provided to children and families at various points in their care journey. Implementation varied significantly between teams. The ESQ was not reviewed retrospectively as there was no way to separate feedback received following an urgent referral as distinct from a routine referral.

Instructions were provided for surveys to be offered at Choice and at Partnership; at a point soon after referral, and only to those patients that entered the service via an urgent referral. A limitation is that some patients with urgent needs are referred via the routine pathway and these could not be sampled. Patients were identified by clinical staff, in particular the Choice Coordinator or the staff member who had conducted the urgent Choice or Partnership appointment. Administrative staff made the survey available and the clinician provided it to patients alongside the usual ESQ.

The survey asked patients and parents whether they would be willing to provide feedback over the phone or in a focus group and whether they wished to receive results of the review and they could provide contact details and email.

**Quantitative data**

The Project Brief identified a wide range of potential data sources for review and analysis including:

- CAMHS and metropolitan ED activity data;
- finance and budget information
- safety and quality data; and
- Key Performance Indicators (KPIs) measures.

The data sources were refined following consultation with Community CAMHS teams and data analysts to take account of data limitations and what was achievable within the timeframe of the project.

A data request was subsequently submitted for the following:

- Waiting times to access services
- Referral volume
- Referral source
- Referral outcomes
- Geographic location of services provided

Further information regarding data and limitations is provided in the section “What the data tells us” and Appendix 3.
Where possible, activity data was reviewed for 2015/16, 2016/17, 2017/18 FY for ACIT and Community CAMHS Teams. For ART data, it was not possible to determine whether the service event related to contact with the client, a referrer or another agency/organisation so and activity data for ART has not been analysed.

**Who provided feedback**

We received feedback from 284 people/organisations

- 17 written submissions
- 27 focus groups
- 126 survey responses from patients and families
- 46 interviews

Due to the volume of information gathered and a desire to analyse the data using a rigorous approach, a qualitative researcher was employed through the Telethon Kids Institute (TKI).

The researcher adopted a general inductive approach (Thomas, 2006) to analysing the qualitative data. Inductive approaches generate a new theory from emerging data and use research questions to narrow the scope of study. These are more often associated with qualitative research. In comparison, deductive approaches begin with a hypothesis and tests a theory. These approaches aim to identify causal relationships and are usually associated with quantitative research. This approach results in a clear summary and links between the questions asked and the findings in the overall response data. The researcher produced a qualitative data summary that outlined overall themes and feedback received by stakeholder group. The report also included tables that summarised the main themes and identified the number of sources (the number of interviews and/or focus groups that the theme was apparent in) and references (the number of times that the theme was discussed overall) was provided. Analysis was completed using Nvivo software.
CAHS feedback received
Feedback was received from a range of CAHS staff including previous ART and ACIT workers, Community CAMHS teams, members of the CAMHS Executive, CAMHS staff working in the inpatient unit and the PCH Emergency Department. Refer to Appendix 4 for further details.

External stakeholders
A request for feedback was sent to all nine (9) metropolitan EDs; comments were received from six:
1. Armadale
2. Fiona Stanley Hospital (FSH)
3. Joondalup Health Campus
4. Rockingham and Peel
5. Royal Perth Hospital/RAPID Team
6. St John of God (SJOG) Midland

Requests for feedback were also sent to a range of non-government organisations and other government agencies:
- Education: State-wide School Psychology Service (SPS) branch
- Headspace: Mandurah, Midland, Osbourne Park, Rockingham
- The Mental Health Advocacy Service (MHAS)
- Mental Health Emergency Response Line (MHERL)
- WA Police
- Youth Mental Health Services: Youth Axis, YouthReach South, Youthlink, Youth Community Assessment and Treatment Team (YCATT) (via FSH ED)

WA Country Health Service (WACHS), the Youth Advisory Council of WA (YACWA), the Western Australian Primary Health Alliance (WAPHA) and Youth Focus were contacted but they did not provide a response. Youth Focus manages several headspace offices that did provide a response. The Department for Communities, the Disability Services Commission and the Department of Justice were not consulted.

Patients and their families
Children and parents that had indicated on the survey that they were willing to be contacted regarding their feedback were emailed and/ or phoned to arrange a time to explore their views in more detail. A total of six (6) interviews with interested families were conducted at a convenient time following their appointment with CAMHS or over the phone. Interviews were recorded and transcribed with participant consent.
What people told us

Limitations

The interview questions differed slightly for each group, and some interviews were very long and the interviewer was not able to get through all questions. In addition, as the interviews were semi-structured participants focused more on specific topics – e.g. some groups spoke at length about issues with the current model so did not have time to reflect on other areas. As a result, the data is not representative for all groups, especially smaller groups that had a minimal number of individuals interviewed or attending focus groups to represent their views.

With regards to the consumer and carer survey, selection bias may have been a factor in the results both in terms of the clinicians’ selection of patients as well as the patients and families that chose to respond. Further, the questions regarding waiting times relied on the respondents’ recollection, which cannot be independently verified as the data was not linked.

What consumers, carers and families told us

They’ve given him a lot of tools. … So that warm and welcoming environment, I suppose, and not judging and giving solutions without throwing it in your face, that's what CAMHS did extremely well in our situation.

Encouraged my daughter to be happy to continue and receive help which I wasn't sure she would consider receiving help.

Most consumers who responded to the survey and/or were interviewed stated they did not think there were any improvements which could be made to improve their experience with CAMHS. e.g,

No, we are very grateful for the service and support we received.

Participants reported that accessing CAMHS was relatively easy and accessible. Of the 126 respondents to the consumer and carer survey, 70% felt that it was Certainly True that they were able to book an appointment easily.

Others reported that while the system worked smoothly once they were in; it was difficult to make that initial connection with CAMHS.

My recollection is once we got here and got in, then everyone just sort of flowed.
A comparison of consumers’ expectation and experience of waiting times was undertaken. Of the 90 respondents who could recall how long they waited for a Choice appointment, the waiting time matched the expectation for 37%; the waiting time was faster than expected for 29%; and the waiting time was longer than expected for 34% of respondents.

The most common valuable aspect of CAMHS to consumers was being able to talk and have someone listen to them.

>Took me seriously about my child’s issues. Gave me confidence that I was helping my child.

Consumers felt that the services that CAMHS provides are helpful, meet their needs and are of good quality. CAMHS staff also provided extra resources and support for consumers to use, such as providing emergency contact information.

>So, the Choice appointment was great. It’s sort of like as parents, you do your best and you don’t know how to deal with situations like this. So, they gave us the reassurance that everything was okay and there was help there. It was really pleasing because we left here thinking, “Okay. We’ve got help.” Where sometimes you go to a GP or you go to a medical facility and you leave, and you think, okay, you’ve wasted your time or your money or so forth. And we never had that feeling here. It’s been nothing but advice, help, caring, and warm environment from reception all the way through.

Some consumers did have issues with their CAMHS experiences. These ranged from feeling that the response from CAMHS was too slow, feeling helpless even when in the system, being unable to see a practitioner of their choice, and physical issues with the building (e.g. not having a CAMHS sign). Some participants described the convoluted journey they had experienced getting to CAMHS.

>So I call around to private clinic at the time. So then they refer me to headspace. Then ... after a month, she went to headspace. Again, now she was seen by a social worker for three times ... then she was asked to go to Children’s Emergency Hospital because she said that she wants to hurt herself. ... So we went there and now we went three, four hours there. And then the clinical nurse, [told us?] to come and then she came and then interviewed, I mean, for one hour. And then, not even seen by a psychologist. She referred her to CAMHS.

Specific aspects of the services provided that were helpful were good counselling services, helping to plan (safety and future planning) and the availability of medication.

>I was just wondering, “This is my first therapy time.” So, I wasn’t sure what to expect. They got me to summarise the situation, went through it with me, gave me options and different opportunities, made sure I was okay with everything, and gave me some tips how to handle stuff mentally, and make me feel better, gave me options, making me feel good that I actually have a way out of this to work out of it with them.
Other positives included CAMHS staff clearly explaining what the service does, liaising with patients’ schools, having friendly reception staff, providing advice, and being nonjudgmental.

What staff and other stakeholders told us

The previous model

“If I had a case that was going to go off over the weekend, I could phone up, give them a heads up and say “Look, could you phone this client over the weekend to contain their risk?” and that reduced ED admissions dramatically.” [Community clinician]

“You could get ART and ACIT to call the family over a weekend …” [Team Management – Service Managers and Heads of Service]

“… people who were really passionate about the service …” [Inpatient Unit]

When reflecting on the previous model, many participants stated that it was a good and valuable service. A number of positive aspects were identified including that there was consistent management of risk of young people; that the service helped to divert ED presentations and hospital admissions; and that young people were linked with services that were appropriate for that young person’s level of risk. Youth Mental Health Services commented that they valued the outreach service that was previously provided and that the acute response was more consistent prior to the services being devolved.

“You could get ART and ACIT to call the family over a weekend …” [Team Management – Service Managers and Heads of Service]

“… but if they (patients or family) knew they were having somebody actually seeing them, coming out and seeing them the next day, you could safety plan with the family, and that would be part of the safety plan thing, … so that would actually prevent that admission.” [Emergency Department] 

The second strongest theme related to issues with how these services were previously provided. Issues identified included that there were inconsistencies; that they did not cover all CAMHS catchment areas; that often Community CAMHS could provide a more timely response; and that the service was unreliable or unable to handle the caseload they had resulting in delayed follow-up with EDs.

“I found, when it was ART/ACIT, it was frustrating … because we were quicker. And you’d kind of think “Why did ED refer them? Why didn’t they just refer them to us?” And then they went to ACIT, had an assessment, came to us, had another assessment”. [Team Management – Service Managers and Heads of Service]

“So the service we had prior to the devolution of ART and ACIT was suboptimal … because the service was so central to the centre of Perth that actually, if we had anyone present to either Peel emergency department or Rockingham emergency
department and needed their input, invariably it would be days, literally days before someone was able to get down there. [Emergency Department]

The change process

Key issues identified were a lack of consultation; poor communication; staff unhappiness and uncertainty; a lack of transparency regarding the allocation of staff to Community teams; a lack of training and support for the ACIT and ART staff; the impact of staff leaving the service; and the process for managing voluntary severances.

Of these issues, poor communication was the strongest theme that emerged.

“So, we would be asking our management, “What’s happening?” And they would say, “We’re going to talk about this on this date, but we can’t discuss it before then.” So, there was, again, that sense of uncertainty and people know things about our futures and we’re not allowed to know it. Yeah, there was lots of secrecy.” [ACIT staff]

‘If there is no money there is no money’ – honesty would have been better. More up front. Felt like there was a false consultation and it led to it feeling indecisive. Felt long, chaotic. All the management were lost. It was painful to be there- there was no leadership and it dragged on. I lost motivation- did not want to be there anymore. [ART staff]

“… the fact that there wasn’t an email from our exec saying, “These people are no longer with us. We value the work that they did while they were blah blah blah.” But that’s not how we heard it first.” [Team Management — Service Managers and Heads of Service]

Past and current Executives also commented on the challenges with communication, noting that they felt that at times it was difficult to communicate with some staff. They also commented that there was already interest in combing ART and ACIT into community CAMHS and that this further complicated the communication process.

“We were pulled up for actually making them more anxious, apparently because we didn’t write to AMA and allow them to have the right to representation. So for me, it was-- I was being collegiate. I was being absolutely collegiate and being transparent with them and telling them, ‘You have now come up on the steering group with this idea that it should be decentralised. … These are the options you have. You tell us what you would like within the options we have given you.’” [Executive group].

“One of the perceptions that I encountered during the whole transition was that community had been discussing this. So of course, exec must have had this plan all along and that ART and ACIT clinicians were the last to know. That’s not true because the discussions that were happening in community were happening due to local solutions to problems that we were
encountering because of ART and ACIT not being able to service far-flung areas.”[Executive group].

The Executive group also acknowledged that communication could have been improved on their part.

“Look, and maybe it would have been better when we first communicated the decision, I think maybe doing it in smaller groups rather than bringing the entire group together. Now, clearly, we wanted everyone to hear the bad news at the same time. Or maybe some follow-up.”[Executive group].

Staff unhappiness and the impact this had on ACIT and ART workers, before and following the integration, as well as other CAMHS staff, was the second strongest theme.

“Huge amounts of anxiety and stress, yeah. And to the point where some people had to take stress leave during that time. We had a few staff who either had to reduce their hours or take some time away.”[ACIT staff]

“But it was really hard saying goodbye to people. Every week you were having goodbye things as well because we kept losing staff because contracts finished, people found new jobs… There was an ongoing grief and loss for the staff and losing colleagues and friends and managers. We just lost everyone here those six months.”[ACIT worker]

“Because [Name] was the one I noticed that really struggled here. She struggled every single day. She had no idea what she was doing. She questioned everything she was doing and if she was doing it right. She was always upset. She was always working late and panicking.”[Admin worker]

These issues were acknowledged by the Executive group who stated that the transition and change in job requirements could have been handled better.

“The staff from both ART and ACIT, they were very much of a view that they weren't familiar with the therapies that were being delivered in a community-based environment, and with the benefit of hindsight, I wish we’d identified that as a part of the transitioning, because that could’ve been dealt with pretty easily and pretty quickly prior to that transitioning to the teams.”

With regards to the allocation of staff, participants identified issues with the decision making process as well as dissatisfaction with the outcome of the allocation process.

“But one of the things in terms of how it was allocated, and how people were allocated places, there was an absolute lack of transparency. There was a sham of process.”[Community clinician]

“And then we got told there was an admin FTE as well, and that never materialised either.”[Choice Coordinator]
A key issue identified by the Executive group was that impetus for the devolution was due to the cessation of Commonwealth funding, which was outside of their control.

“So, the whole impetus for the change came out of advice that the National Partnership Agreement funding for the service would not be renewed. So that was a three-year funding arrangement, and the WA government had a clear position that, because it was federal funding, the state wouldn’t commit to funding the shortfall beyond the three-year time frame. [Executive group].

“… We all knew it was coming, but it was a hope that Mental Health Commission would pick up the funding. They announced in May they wouldn't do that.” [Executive group].

They also highlighted the fact that the development of the model was guided by analysis of different clinical models including risk assessment, as well as consultation with a steering group which ultimately suggested the decentralised model.

“And they came up with some five or-- phoenix, they called them phoenix. Some five or six phoenixes, they came up because they actually looked at it that way. We are going to be burned down, and we can arise from it, and we can thrive, yeah? And they came up with six models, and in that, they themselves came down to two models and said-- they suggested the community decentralised model.” [Executive group].

External agencies also commented on the lack of consultation.

And there was no consultation. That’s the other thing. There was never an official consultation about, “What do you need in this area or what’s your experience”… The level of consultation wasn’t — from my experience — thorough.” [Emergency Department]

“Participants reported they were not consulted on the implementation of the integration of ART/ACIT with Community CAMHS until after implementation.” [Publically funded youth services]

The one exception was the school psychologists and education staff who indicated that the process was handled adequately in terms of receiving information; however, the timing was poor as it was undertaken during the school holidays, which resulted in delays in providing information to students and families.

What’s working well?

A large number of participants thought that despite issues with the change process the new model is currently working well, or at least some aspects of it are. Services that have capacity for urgency when required is seen as a strength, as is staff having flexibility to adapt to different needs that come up in the service. Others highlighted that CAMHS are now seeing more complex cases and that the service is more accessible for consumers.
“We make phone contact for acute cases within 24 hours of the referral and see the patients within 48 hours if high risk. So, I think … that’s been working quite well.” [Team Management – Service Managers and Heads of Service]

“What we did is we definitely introduced the acute Choice, which is basically the ad hoc choice given to the young person that presented with urgent need or in the crisis, and so we try to do different methods, whether it's ad hoc, as in, okay, they phone in, "When you got space?" and so on.” [ART worker]

“Acutely psychotic kids always picked up quickly.” [Community clinician]

“Our team deal with the capacity issue well - staff are flexible and make appointments.” [Administrative Officer]

“I think it just demonstrates that there's a real appetite in the community for these services, and by delivering from the community, it just makes them so much more accessible. And as you know, the socioeconomic profile of our families, most of them are out in the periphery and are struggling financially. Trying to get to PCH is a challenge. You just have to duck down the road to your local CAMH clinic.” [Executive group]

“I think so it's a far more efficient and effective-- and I think it's far more client-centred in that they've got one story told, one entry, one service, rather than being forced to go via ED which inevitably means you're seen by one clinician in ED, then you're transferred onto an ACIT clinician, then you tell the story again, and then you'd probably be transferred onto a clinic again.” [Executive group]

At the individual team level, ACIT and ART workers reported that staff were friendly and welcoming and that they have settled in well; from the community clinicians’ perspective, they value and appreciate the skills and experience that the acute workers have brought to the team.

“Team were very welcoming. It was quite clear that the team didn't really know how it was going to be shaped or what it was going to look like, us coming into the team. So that has just evolved. It's been a bit clunky and that's okay. But the team's been very welcoming.” [ACIT worker]

“I mean, because we've got two extra FTEs now on the team, and I guess what they've brought is their own knowledge and expertise in terms of managing acute calls .. that has a ripple effect on the team about how we manage things.” [Community clinician]

Services that have acute teams embedded within them are seen and experienced as working well. CAMHS that respond quickly to clients are also viewed favourably.

Aboriginal Mental Health Workers (AMHWs) identified a number of positive aspects of the new service including that there is continuity of care for Aboriginal consumers who come to the
service; that some CAMHS locations are providing a culturally appropriate and responsive service; and that the AMHWs have been able to build positive relationships with other services; that there is the capacity for urgent responses; and there is good case management.

“We have the Aboriginal stream at CAMHS, and then we have just the routine stream, which is the normal choice for ATSI … because we have a lot of Aboriginal referrals at this clinic. I mean, at one stage we had 30 kids active and 16 referrals. It was ridiculous and we really struggled. But we’ve come up with weekly ATSI Choice slots … which has (sic) been really helpful. And not only that, with the acute -- pretty much when we’re notified that a kid’s on the way to the hospital or is about to be discharged, we see them within that week or within the next working week.” [Aboriginal Mental Health Worker]

The integrated model in practice

“So, at some stage, my problem — and I think the problem for the whole system is at some stage, we’re going to be full. You can’t continue—we can’t continue with these numbers. We can’t continue with offering and maintaining the KPIs without being full.” [Choice Coordinator]

The main issue identified was that Community CAMHS have experienced a significant increase in demand, which has resulted in an increased workload for staff. This was highlighted as an issue by ACIT and ART staff, Heads of Service and Service Managers, clinicians, Choice Coordinators and Administrative staff.

“Yeah, but the FTEs to admin just doesn’t increase ever. They just keep adding more and more tasks and duties – and processes, and it might just look like a little process, but they all involve a lot of time and once you add it up over a day.”

[Administrative Officer]

“We’re just flexing and responding as best we can, and I think we do a good job… Like every community CAMHS clinic, we’re stretched, we’re flat tack. Everyone’s got a full load and then some, and there’s no increase in FTE. We’re doing what we can, and we feel like we’re scrambling day-to-day, but I think we do a pretty good job of it.”

[Community clinician]

For staff working in small teams, they identified additional pressures around the increase in demand and workload, particularly when a staff member needs to take unplanned leave. Staff reported that there is no capability to call in extra staff at short notice, creating additional pressure for staff. Some participants feel that their service consistently has a shortage of staff.

“[Team] has an issue with long term sick … major problems when Choice coordinator not around/ on leave.” [Community clinician]
Another prominent theme was that the current system is not integrated with inconsistencies and gaps in service provision. An issue raised by all stakeholder groups is that under the current model there is very limited capacity to provide in-reach and outreach services or after-hours support, which results in unnecessary ED presentation and hospital admissions and ultimately much poorer patient outcomes.

Having no set model for community CAMHS was viewed as both a positive and a negative; some participants enjoy the flexibility this provides; others noted that it can cause confusion and issues for other services who may not be aware of the different services offered at different CAMHS sites and that it results in inequities for consumers.

“... assertive outreach varies markedly from team to team. So different teams have adopted functioning (sic) in different styles.” [IPU]

“Some CAMHS, if you ask for an acute appointment, you’re looking at two or three weeks.” [Emergency Department]

“... we had a young person who presented with deteriorating (sic) in the community. They were linked in with Community CAMHS and they presented to ED with [inaudible] suicidal ideation, clear intent, plan in place and there was discussion around whether or not she needed admission or not. Anyway, she was discharged home with a safety plan in place but then the Community CAMHS clinic didn’t follow up for two weeks ... families are reporting it’s not really, I suppose meeting their needs in the initial appointment especially given that they’ve gone through a period of acuity. So, it feels a bit clunky. [MHAS]

“So the integrated model is working differently in different teams and this goes back to the issue of lack of time to properly plan this. And so some of the larger teams have the capacity to have or dedicate Acute workers to do some of the more acute stuff within their teams, but the smaller teams don’t have the capacity to do that. And that goes back to the differences in demographics in history and ethos and all of that of our teams. And that’s where it’s working as well as it can in individual teams, but it’s not providing equity of service across the metropolitan area in my view.” [Executive group].

A number of participants stated that there has been an increase in ED presentations and inpatient admissions; and that these environments can have a negative impact on young people’s mental health.

“I think a lot of the kids that were getting onto the ward now particularly could have done with more at home intensive service or even been seen by a specialist child adolescent team in other EDs, and we could have avoided admissions for these young people who then come onto the ward and are exposed to the contagion.” [Inpatient Unit]
“... we used to have more of a role of being able to discharge to ART and ACT in the discharge plan and to avoid admissions.” [Emergency Department]

“I've had a number of consumers who are young, very young 12- and 13-year-olds, who are presenting to ED and then they're discharged being told they have a CAMHS appointment in maybe seven or eight days but then representing in three or four days because the families just can't hold them for that-- even if it's a week, they can't hold them for that length of time.” [MHAS]

Further improvements

The primary theme that emerged was the need for assertive in-reach and outreach services.

“I think that there is a lot of value in having more specialised youth-focused emergency crisis services that can support the EDs or can support the in-home -- providing in-home, either face-to-face or phone contact.” [Management Team – Service Managers and Heads of Service]

“Specialist CAMHS in-reach into ED.” [Emergency Department]

“And ART used to do home visits and going en route into EDs and stuff. We can't do any of that. So, I think that is a big loss, actually.” [Choice Coordinator]

“Participants reported all Community CAMHS clinics should have enough vehicles to allow them to do community visits. Community visiting will allow more young people to access Community CAMHS. Participants reported community visits provide valuable information on the community and home environments the young person resides in, improving insights into their functioning and the functioning of their parents.” [Publicly funded youth services]

The need for training and professional development opportunities was also highlighted as an area for improvement with some reflecting that this was needed in the past, but many stated that this upskilling was still very much needed.

“No PSOLIS training offered- that would have been good. I knew nothing about CAPA- would have been good to have known before coming in.” [ART worker]

“Training in neurodevelopmental disorders, autism, ADHD, child development and the display of MH disorders in children is needed.” [Management Team – Service Managers and Heads of Service]

The need for better information and training was also a key area for improvement identified by administrative staff. In particular, participants stated that more information should have been provided to acute workers at the time as well as an ongoing need for clinicians to have a better understanding about what administrative staff need in order to perform their role effectively.
“At the change the acute worker role should have been more clear and the system and about going through the choice coordinator and liaising with admin needed to be clear for those workers.”

“Problem with the patient files not coming back to admin following Choice appointments as the case manager follows up the patient after Choice. PSOLIS not always updated and paper file sits with case manager- admin not sure what is going on. For admin and Choice coordinators- communication is the key. We need to make sure these things are updated.”

The need for sufficient training for those going into new or different roles was also highlighted as an area for improvement by the Executive group.

Many participants stated that better communication and information was needed at the time of devolution; however many stated that this is still needed, both internally and externally to CAMHS. The need to improve communication in both directions between CAMHS and hospitals (both IPUs and EDs) was highlighted.

“Definitely a work in progress. Yeah. And I think when they ring now -- because we try and tell them to ring, just give us a ring if someone’s there, ring us and we’ll let you know when we can see them and all that kind of stuff.” [Choice Coordinator]

Carrying on from this, many participants described the need for more liaison and consultation within and outside of CAMHS to work together to decrease gaps in services and ensure continuous case management. For staff working in the IPU and EDs, they reported that there should be increased education and exposure of Community CAMHS staff to the unit and wards.

“I just feel that I would like a bit more involvement with CAMHS with the ward. I feel that were mental health workers managed by general medicine-- and I’m not sure general medicine and our managers fully appreciate some of the limitations of our role and some of the complexities.” [Emergency Department]

Other participants identified the need for better liaison between CAMHS and other service providers in order to minimise risk and support an improved patient journey.

“There is a concern that CAMHS are not always considering the information provided by the school when a request has been made for an urgent appointment. In particular, the anticipation of triggering events in a social setting do not appear to be included in determining immediacy of risk.” [School psychologists and education staff]

“A vulnerability and gap in the system between CAMHS and headspace is that headspace is unable to request an urgent Choice apt (sic). This can have a huge impact on young people as they have already been vulnerable once by having to tell us their story and then we need to
request them to attend the GP or ED to re-tell their story again, hoping that they will be referred to an urgent CHOICE appt.” [Headspace]

Another area for improvement is the need to increase staff in services. Many staff reflected feeling overworked with an increased caseload, and some expressed concern about staff burnout and the sustainability of the current system.

“Good model but needs more resources, more FTE.” [Community clinician]

The need for improved financial management was a strong theme amongst the Executive group with a key focus on forward planning and financial incentives.

“I think from my observation, WA Health, one of the biggest problems we have is that we don’t understand our finances, …And this is what creates the tension between administrators … and clinicians, and it’s really being very transparent about the numbers.” [Executive group]

“I think going forward, there needs to be financial incentives for health services to drive reform. I think that health services need to be rewarded for engaging in reform rather than these incremental requests via service agreements to increase throughput.” [Executive group]

The importance of continuing to improve the model of care that CAMHS provides was also a prominent theme for further improvements.
What the data tells us

Limitations

Due to limitations in the consistency of data recording for ART, ACIT and Community CAMHS across the past 3 financial years, activity data was not always comparable. KPIs and targets of the respective services and relative resourcing have also changed and must be considered when considering the relative value and performance of the model. For a detailed description of the data limitations, refer to appendix 2.

Access times

The Integration of acute mental health care in Community CAMHS: Model of Care document specified that “90% of referred patients are contacted within 1 working day and, where clinically indicated, offered an appointment within 2 working days” (Child and Adolescent Health Service, 2016 p17).

In relation to patients being contacted within 1 working day, it is not possible to extract reliable data regarding phone contacts and therefore this review did not consider performance against this KPI. With regards to offering an appointment within 2 working days, the definition provided in the model of care is open to interpretation: some participants stated that it should be based on whether the service had an appointment available for a patient within a 2 day timeframe (noting that some patients and families may choose to attend at a later time for various reasons); others stated that it should measure whether an appointment was booked/scheduled within a 2 day timeframe. Additional information regarding the data limitations and definition is provided at Appendix 3.

It is noted that there are differences in the models of care that impact on this KPI: urgent referrals to Community CAMHS teams are all offered a face to face appointment; referrals to ACIT were triaged and as a result, some referrals were not accepted.
Access for urgent referrals to ACIT prior to devolution
Table 2: Access times for ACIT referrals – 1 January 2015-30 June 2016; 2014/15 FY; and 2015/16 FY.

<table>
<thead>
<tr>
<th>ACIT</th>
<th>1 January 2015 - 30 June 2016 (n = 481)</th>
<th>2014/15 FY (n = 348)</th>
<th>2015/16 FY (n = 304)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median waiting time in days (range)</td>
<td>4 (0-38)</td>
<td>4 (0-36)</td>
<td>3 (0-38)</td>
</tr>
<tr>
<td>% seen within 2 days (number)</td>
<td>40% (190)</td>
<td>38% (133)</td>
<td>41% (126)</td>
</tr>
<tr>
<td>% seen within 4 days (number)</td>
<td>59% (282)</td>
<td>56% (195)</td>
<td>61% (184)</td>
</tr>
</tbody>
</table>

There is very little variation in performance over the three time periods with a slight improvement in performance in the median waiting time and the percentage of children seen within 2 days and 4 days in the 15/16 FY when compared to the 1 January 2015 to 30 June 2016; and the 15/16 FY periods.

Access for urgent referrals to Community CAMHS teams post devolution
Table 3: Access times for urgent Community CAMHS referrals (all teams) for 1 January 2017-30 June 2018; and 2017/18 FY.

<table>
<thead>
<tr>
<th>Community CAMHS - all teams</th>
<th>1 January 2017 - 30 June 2018 (n = 1444)</th>
<th>2017/18 FY (n = 914)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median waiting time in days (range)</td>
<td>6 (0-168)</td>
<td>6 (0-168)</td>
</tr>
<tr>
<td>% seen within 2 days (number)</td>
<td>25% (354)</td>
<td>23% (214)</td>
</tr>
<tr>
<td>% seen within 4 days (number)</td>
<td>40% (580)</td>
<td>40% (365)</td>
</tr>
</tbody>
</table>

The median waiting time across all CAMHS teams was 6 days for both time periods. A quarter (25%) of urgent referrals were seen within 2 days for the 18 month period 1 January 2017 to 30 June 2018; there was a slight decrease in performance of the 2017/18 financial year (23%). Similarly, the percentage of children seen within 4 days remained constant over the two time periods (41% for 1 January 2017 to 30 June 2018 and 40% for the 2017/18 FY).

Across all Community CAMHS teams, the median waiting time is higher than ACIT (6 days compared to 3-4 days) and the percentage of children seen within 2 days and 4 days is lower. The raw number of children seen within 2 days and 4 days is higher in Community CAMHS than ACIT across all time periods.
Table 4: Access times for urgent Community CAMHS referrals by team for 1 January 2017-30 June 2018; and 2017/18 FY.

<table>
<thead>
<tr>
<th>Community CAMHS Team</th>
<th>1 January 2017 - 30 June 2018</th>
<th>2017/18FY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median waiting time in days (range)</td>
<td>% seen within 2 days (n)</td>
</tr>
<tr>
<td>Team 1 - single stream</td>
<td>2 (0-39)</td>
<td>63% (75)</td>
</tr>
<tr>
<td>Team 2 - separate stream</td>
<td>5 (1-59)</td>
<td>23% (56)</td>
</tr>
<tr>
<td>Team 3 - separate stream</td>
<td>5 (0-66)</td>
<td>28% (50)</td>
</tr>
<tr>
<td>Team 4 - separate stream</td>
<td>6 (0-168)</td>
<td>18% (30)</td>
</tr>
<tr>
<td>Team 5 - single stream</td>
<td>4 (0-43)</td>
<td>23% (25)</td>
</tr>
<tr>
<td>Team 6 - separate stream</td>
<td>2 (0-52)</td>
<td>54% (44)</td>
</tr>
<tr>
<td>Team 7 - single stream</td>
<td>7 (0-85)</td>
<td>22% (20)</td>
</tr>
<tr>
<td>Team 8 - single stream</td>
<td>5 (0-91)</td>
<td>23% (17)</td>
</tr>
<tr>
<td>Team 9 - single stream</td>
<td>14 (0-136)</td>
<td>10% (27)</td>
</tr>
<tr>
<td>Team 10 - separate stream</td>
<td>10 (0-104)</td>
<td>9% (10)</td>
</tr>
</tbody>
</table>

Access to services varies by team with the median waiting time ranging between 2 days and 14 days; and between 2 and 16 days over the two time periods. This variability is also reflected in the percentage of children seen within 2 days (between 9% and 63%; and between 7% and 66% across the two time periods) and 4 days (13% to 73%; and 11% to 76%).

**Service demand**

As discussed in the data limitations section, prior to 2017 there were no consistent business rules for recording urgent referrals received by Community CAMHS teams. While a review of the data indicates that there were referrals marked as ‘urgent’ in the system, it is impossible to determine the accuracy of this data; whether there is double counting of urgent referrals received by Community CAMHS and subsequently referred to ACIT; and/or how the ACI-NE referrals were treated in the system.

As a result of the above, data has been presented on the overall demand for services including urgent and not urgent referrals as detailed below:

- For the period prior to the devolution of ACIT and ART to Community CAMHS, this includes all referrals to ACIT and all referrals received by Community CAMHS teams; and
- For the period post devolution, this includes all referrals to Community CAMHS with a breakdown of the proportion of referrals that have been identified as urgent.
This information is displayed for Community CAMHS as a whole and by individual team. Information has been analysed for the 18-month period 1 January 2015-30 June 2016 and 1 January 2017-30 June 2018; and by financial year commencing in the 2016/17 FY as CAPA was fully implemented by the beginning of the 2015/16 FY.

Table 5: Overall demand pre and post devolution.

<table>
<thead>
<tr>
<th>Time period</th>
<th>Referrals to ACIT</th>
<th>Referrals to Community CAMHS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/01/2015-30/06/2016</td>
<td>560</td>
<td>6307</td>
<td>6867</td>
</tr>
<tr>
<td>1/01/2017-30/06/2018</td>
<td>Nil</td>
<td>8691</td>
<td>8691</td>
</tr>
</tbody>
</table>

There has been a 27% increase in total referrals (including ACIT and Community CAMHS) when comparing the 18-month periods 1 January 2015-30 June 2016; and 1 January 2017-30 June 2018.

Figure 2: Referrals to Community CAMHS over three financial years, 1 July 2015 to 30 June 2018.

Note: The labels on the X axis refer to the financial year ending on 30 June that year, for example, ‘FY 2016’ refers to the 2015/16 FY.

When comparing referrals to Community CAMHS over an 18-month period pre devolution (1 July 2015 - 30 December 2016) and post devolution (1 January 2017 - 30 June 2018), there has been 32% increase (6580 compared to 8691) in referrals. The devolution of ACIT and ART resulted in an additional 18 clinical FTE being assigned to Community CAMHS. This
represents a 20% increase based on a comparison of FTE as at August 2016 (90 FTE) compared with 108 FTE following the devolution.

Figure 3: Referrals to Community CAMHS by team for 2015/16-2017/18 financial years.

When comparing the demand by team over three financial years (2015/16-2017/18), all teams have experienced increased demand however the size of the increase varies with Hillary’s, Fremantle and Swan having experienced the biggest increase at 69%, 55% and 58% respectively.

Referral outcome

Table 6: Referral outcomes for ACIT by financial year, 2014/15 and 2015/16.
The majority of ACIT referrals were admitted to the service in both financial years analysed with 74% in 2014/15 and 84% in 2015/16. While 10% of children were referred to another service in 2014/15, this dropped to 3% in the following financial year. Less than 5% of children and families declined the service or did not engage/attend their appointment over both years.

Table 7: Referral outcome for urgent referrals to Community CAMHS for the 2017/18 financial year.

Less than half (46%) of all urgent referrals were admitted to the service, with just under a fifth (18%) referred to another service; and 16% having ‘no further action’ entered into the system. A total of 7% of children and families declined the service and 10% did not engage or attend their appointment.
Geographic access

Figure 4: Residential postcode of children who received a face to face service from ACIT, January 2015-30 June 2016.³

The shading on the maps is based on a different range of data for each map.

³ The shading on the maps is based on a different range of data for each map.
Figure 5: Residential postcode of children with an urgent referral who received a face to face service from Community CAMHS, January 2017-30 June 2018.

Table 8: Services for urgent referral by catchment

The residential location of children who received a face to face service for urgent referrals across Community CAMHS catchments remains relatively unchanged pre and post devolution.
with the exception of Bentley (increased by 8.2%); Armadale (increased by 5%); and Shenton (decreased by 4.1%).

Just under half of face to face services for urgent referrals are provided to children and families living in the Swan, Fremantle and Clarkson catchments across both ACIT (46.1%) and Community CAMHS (42.1%). A total of 16.4% of face to face services for urgent referrals in Community CAMHS are provided to children and families living in the Bentley catchment.

**Referral source**

Table 9: ACIT referral source per financial year, 2015/16 – 2015/16.

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Program</td>
<td>23</td>
<td>43</td>
</tr>
<tr>
<td>Family/Friend</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Hospital</td>
<td>87</td>
<td>77</td>
</tr>
<tr>
<td>Internal Program</td>
<td>213</td>
<td>195</td>
</tr>
<tr>
<td>Medical Practitioner</td>
<td>21.0%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Other Organisation</td>
<td>11.6%</td>
<td>42</td>
</tr>
<tr>
<td>Unknown</td>
<td>0.2%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

More than half of all referrals to ACIT were from an ‘internal program’; with a fifth coming from each of the categories ‘hospitals’ and ‘other organisations’. Referrals from an ‘internal program’ and ‘hospital’ remained stable over the two time periods; there was decrease in referrals from ‘other organisation’ down from 21% to 12%.
Table 10: Community CAMHS urgent referrals source per financial year, 2017/18.

For the 2017/18 FY, just under half of urgent referrals to Community CAMHS come from ‘hospital’ (42%), with ‘medical practitioner’ being the second highest referral source at 23%.

Across all referrals to Community CAMHS, the majority of referrals are received from ‘medical practitioners’ (between 41 and 45% over the four financial years). The second highest referral source is ‘other organisation’, followed by ‘school’ and ‘hospital’.
Reflections and lessons learnt

Information gathered has been reviewed and analysed against the specified aims of the project, namely:

1. Whether the required functions of the previous ART and ACIT teams have been integrated into the community teams and implemented effectively; resulting in a high standard of care with improved efficiency?
2. The lessons learned through an assessment of the planning and change process used for the integration project.
3. Learnings for future change management across CAMHS.
4. Opportunities to engage staff in continuous improvement of the model.

Given the overlap between the second and third aims, findings and recommendations have been grouped under the following headings:

- The model in practice
- The change process
- Further improvements to the model

The model in practice

Have the ACIT and ART functions been integrated into Community CAMHS teams and implemented effectively; and has it resulted in a high standard of care and improved efficiency?

As part of the devolution process, a number of potential benefits and risks of the integration model were identified. It should be noted that this process was not undertaken to inform the decision to devolve ACIT and ART services to Community CAMHS; rather, they were identified as part of the process of selecting the preferred model when comparing the two short listed models (cluster and integration) following the decision to devolve services.

Notwithstanding the above limitations, the benefits and risks provide a framework for measuring the effectiveness of the integration, the standard of care being provided and whether it has resulted in improved efficiency.

The anticipated benefits were:
- The ability to maximise limited resources available through utilisation of existing facilities and avoiding additional costs associated with lease, administration, overheads and management costs;
• It provided care closer to home resulting in increased convenience for families and decreased travel time for clinicians and families;
• Decreased service transitions for children and families;
• Improved access to children and families in outer suburbs;
• Improved district based knowledge of community resources;
• Up-skilled Community CAMHS clinicians in acute intervention.

It was confirmed at the time that there were additional costs associated with the cluster model as identified above and it is therefore accepted that this benefit was realised.

Data was not collected that enabled analysis as to whether each benefit has been realised. However, participants identified a number of strengths of the current model that address some aspects of the anticipated benefits.

A review of the feedback from CAHS staff as well as other government and non-government service providers highlighted the following:
• The Community CAMHS teams that have the capacity to respond quickly are viewed favourably.
• Under the current model, Community teams have the flexibility to adapt to the different needs of families that come to the service.
• That Community CAMHS are seeing more complex cases.
• The service is more accessible for consumers and families.
• That services with acute teams embedded within them are seen and experienced as working well.

From a consumer and carer perspective, their experience of the current model was reported to be very positive with feedback highlighting the following strengths:
• Services are easy to access.
• That CAMHS is providing a helpful, high quality service that meets their needs.
• Patients and families feel heard and listened to.
• That CAMHS staff are friendly and non-judgemental.
• That CAMHS is liaising with other providers such as schools, which is seen as very helpful.
• That patients and families are being provided with additional resources and support to as required.

Further, consumers could not identify any improvements needed in the current model.

With regards to accessibility of services the data indicates that ACIT was providing face to face appointments to children who lived in suburbs across the metropolitan area. There has been
little, if any, change in the proportion of children and families receiving services that live in outer suburbs compared to other catchments following the devolution of ACIT and ART to Community CAMHS. The only changes of note were the proportion of face to face appointments delivered to families living in Bentley (increased by 8.2%); Armadale (increased by 5%); and Shenton (decreased by 4.1%). However, given that the data does not indicate the actual location of service (e.g. home, clinic etc), it is not possible to determine whether the anticipated benefits of providing care closer to home and improved access to children and families living in outer suburbs, have been realised.

**Impact on the demand for, and access to, Community CAMHS services**

An analysis of both quantitative and qualitative data indicates that there has been an increase in demand for Community CAMHS services following the devolution of ACIT and ART. This is evidenced by a 32% increase in referrals to Community CAMHS when comparing 18-month periods prior to and post devolution. The increase in demand varies across teams.

The increased demand and the additional pressure that this places on staff was highlighted as a key issue by staff working across CAMHS. Specifically, participants expressed concerns about staff burnout and services being at capacity.

For reasons already stated, it is not possible to compare performance of ACIT with the devolved model. In terms of the KPI used in this review (that children are offered an appointment within 2 working days), this was analysed for 2 days and 4 days to take account of weekends. Across Community CAMHS, 25% and 40% of children are being seen within these timeframes respectively with a median waiting time of 6 days. There is also considerable variability across teams.

The variability observed in terms of demand and access times across teams would suggest the need to review current resource allocations and/or catchment areas across CAMHS to ensure that there is an equitable allocation of resources.

**Recommendation 1**

That CAMHS undertake a review of optimal resources to meet demand across the metropolitan area.

For the time periods analysed, there were a lower proportion of urgent referrals admitted to the Community CAMHS service compared to the ACIT service (41% compared to more than 74%). Due to differences in the models of care, and in particular that ACIT referrals were triaged while all referrals to Community CAMHS received a face to face appointment, it is not possible to draw specific conclusions from this data.
**Gaps in current service provision**

A prominent theme was that the current system is not integrated with inconsistencies and gaps in service provision. The most significant gap identified is that there is very limited capacity to provide in-reach and outreach services or after-hours support, which results in unnecessary ED presentations and hospital admissions and ultimately much poorer patient outcomes. This was raised by all stakeholder groups and was identified as a concern with the existing model as well as the most significant area for improvement. It was recognised that there is limited capacity to deliver these services given the current demand and the resources available.

**Recommendation 2**

That CAMHS seek additional funding to enable delivery of an intensive and assertive assessment and intervention service, including after-hours support for those children and young people who need more care than it is usually possible to provide within the CAMHS settings.

**Sustainability of the model and impact on Community CAMHS services**

In addition to the increased demand for Community CAMHS, feedback expressed concerns about the sustainability of the model for smaller teams including the impact of not being able to cover unplanned leave.

**Impact on acute workers**

A number of risks were identified that related to the impact of the proposed model on acute workers. A review of the qualitative data reveals that these risks were not sufficiently mitigated for all staff with a number of participants stating that they experienced feelings of loss and grief at the dismantling of their team; significant levels of stress and anxiety as a result of the way the change was handled as well as the sudden loss of acute leadership roles; and poor communication resulting in confusion about the reason for the change.

While the change clearly had a significant impact on a number of the acute workers, a positive aspect of the process was that they felt very welcomed by the Community CAMHS teams.

**The change process**

*What lessons can be learnt about the planning and change process used; and what does this mean for future change management processes?*

Effective change management is central to successful implementation of any project. In simple terms project management focuses on the tasks required to complete the project deliverables; while change management focuses on the people impacted by the change.

*Project management*
A review of project documentation related to the decision to devolve ACIT and ART services to Community CAMHS and the process for implementing the new model revealed that a project management framework was utilised. This included:

- Development of a project plan that was signed off by CAMHS Executive;
- Appointment of a Project Manager who had clinical and management experience in Community CAMHS;
- Identification of a project sponsor (the Head of Department of Community CAMHS);
- Establishment of a SDT with representation from Community, Specialised and Acute directorates, including ACIT and ART staff and clinicians from a range of disciplines;
- Establishment of a Project Steering Committee with representation from Community, Acute and Specialised directorates including managers and clinicians; a clinical planning officer; data analyst; and project officers;
- Development of working groups with broad representation (including subject matter experts) to develop a HR plan and the model of care implementation and transition plan;
- Regular reporting of progress to the CAMHS Executive and briefings to the CAHS CE and Health Service Executive Committee (HSEC);
- A variety of communication strategies and processes;
- Completion of data analysis and risk assessments;
- Financial analysis and costings of models; and
- Consultation with a range of stakeholders.

While there is evidence of a range of project documentation and governance, a project close-out report was not completed. This would have provided staff with an objective summary of the project process and outcomes as well as immediate reflections for the organisation. Importantly, it may have provided some staff with a sense of closure.

**Recommendation 3**

That future project documentation includes completion of a project close-out report.

**Change management**

Despite the level of project management and governance, the feedback received about the change process highlighted that some staff were dissatisfied with the process. The following issues were highlighted to varying degrees by all CAMHS staffing groups, including the Executive:

- a lack of consultation
- poor communication
- lack of clarity regarding the reason for the change
- staff unhappiness and uncertainty
• a lack of transparency regarding the allocation of staff to Community teams
• the impact of staff leaving the service, particularly the suddenness of the departure of staff who accepted a voluntary severance
• a lack of training and support for the ACIT and ART staff

Like many change processes, the devolution of ACIT and ART services was undertaken at a time when there were a number of other significant changes and reforms being implemented across the organisation and with a very short timeframe in which to complete the project. It is possible that staff were also affected by other changes that were occurring at the time; however, this was outside the scope of this review and was therefore not explored through the consultation.

Other factors that may have contributed to staff dissatisfaction include the fact that staff were originally asked to participate in a performance check for ACIT and ART as part of the preparation for the planned move to PCH; this process was commenced but not completed as events were overtaken by news of a funding shortfall and a decision to devolve ACIT and ART services into Community CAMHS teams. The aim of the performance check was to review services and identify improvements using the service redesign methodology, with no preconceived view about what the changes would be. The performance check concluded quite suddenly without a formal close out process and was replaced by the SDT. In addition, the SDT had a very short timeframe of six weeks to complete the task of identifying a preferred model; this may have resulted in additional stress and anxiety for staff.

There was a number of communication strategies used throughout the project including formal committees and working groups; discussion at regular business and governance and clinical leadership meetings; meetings with ACIT/ ART staff; and forums in which each site was represented with the expectation that they would communicate with, and seek feedback from, their local team. These communication strategies relied on information being cascaded down through the organisation, which can lead to gaps in communication and information flow.

**Recommendation 4**
That CAMHS consider using additional evidence-based strategies and processes or frameworks published in the implementation (or de-implementation) science literature in conjunction with a cascading model of communication for significant change processes. This could include more accountability for staff that are responsible for cascading the information, for example, requiring staff to provide evidence of how the information has been shared and ensuring that all feedback is documented and confirmed with the team prior to circulation.
A key communication issue that emerged from the feedback from previous ACIT and ART workers and the community clinicians was that they felt there was a lack of transparency about key decisions and that at times, the consultation was tokenistic. These comments may suggest a lack of trust between some staff and the CAMHS leadership team at the time. The involvement of external representative/s including consumers and carers on the Steering Committee may have been a useful strategy to ensure that there was an appropriate level of independence and objectivity in the project; and that this was perceived to be the case.

**Recommendation 5**

That CAMHS consider including external representation on Steering Committees for projects as appropriate.

There were a number of comments about the impact of the voluntary severances and in particular, the suddenness of the staff’s departure. This had a two-fold effect: firstly, it resulted in a leadership void for the ACIT and ART services during a time of significant change; and secondly, it contributed to an overall sense of instability when some staff were already distressed by the loss of their identity as an ACIT/ ART team. Under the voluntary severance scheme, staff received an incentive payment if they resigned immediately following acceptance of the severance. This often resulted in staff leaving within a very short time frame with little if any time for handover. It is noted that the VSS was a WA State Government program and as such, the terms of the VSS were outside the control of CAHS.

The review did not identify evidence of any specific change management approach or methodology used. A review of the CAHS website revealed a number of project management tools and templates (particularly through the Project Management Officer); however, no change management framework or strategy to guide change within the Health Service. There are many change management resources available that could inform a CAHS framework, including a resource guide for change management in child and youth mental health that was developed by the Ontario Centre of Excellence for Child and Youth Mental Health (2016).

**Recommendation 6**

That a CAHS change management framework/ strategy is developed to ensure consistent and transparent approach to change across the health service.

While the ACIT and ART staff commented that they felt very welcomed by the Community CAMHS team, they also stated that they did not receive the appropriate training and support to undertake their new role. This was reiterated by Heads of Service and Service Managers who stated that they did not have sufficient time to plan for the staff coming to their teams. The allocation of staff was finalised by the end of September and the final Model of Care was circulated to Heads of Service and Service Managers on 17 December. The responsibility for implementing the new model sat with each individual team. Given the heterogeneous nature of
teams including the size of the team, the demographics of their local catchment and other services available in the region; there is merit in devolving responsibility for implementation to the local level. Given the scale of the change, and the fact that many of the acute workers had very little, if any experience in community based services, it would have been beneficial to provide additional resources to support the implementation phase. This could have included the roll out of a training package as well as a more structured approach to implementation across the ten teams.

The importance of providing training and support for ACIT/ART workers was recognised through this being a standing agenda item on the Steering Committee. At some point, it was removed from the agenda and while it is not clear as to the precise reason for this, it may have been due to time and resource constraints. Another option would have been to refer the development of a training strategy to the CAMHS Education and Training Steering Group.

**Recommendation 7**
That CAMHS consider the resources required at the local level to support implementation of change including development of appropriate education/training packages.

Further improvements to the model

*How can we continuously improve the model?*

The importance of assertive outreach and in-reach services for children with acute and urgent mental health issues was highlighted by all groups consulted. There is currently limited capacity to provide these services with only a small number of teams providing these services.

Other inconsistencies across the teams were noted and while some participants viewed this as a positive aspect of the model, it has also resulted in inequities for consumer and families. There is always a tension between enabling local innovation to respond to the community’s needs whilst also ensuring that services do not end up being a ‘postcode lottery’ with families having access to different services depending on where they live. Given that it is not more than two years since the services were devolved to Community CAMHS, it is timely to review and refine the model to ensure the best possible outcomes for children and families.

**Recommendation 8**
That CAMHS clearly identify which aspects of the model are essential to ensure a minimum standard across the ten teams. Consideration should be given to ensuring outreach and in-reach services are built into the model across the metropolitan area. This could include increased use of telehealth within the metropolitan area.
The Aboriginal Mental Health Workers (AMHWs) consulted identified that some teams have adopted a more culturally appropriate approach and structure, which has resulted in positive outcomes for Aboriginal children and families through providing a more accessible and culturally secure service. The AMHWs have been able to develop positive relationships with other services, which has resulted in improved continuity of care and case management for Aboriginal. They also commented that there is a need to further improve the cultural awareness across CAMHS through training and professional development to ensure better engagement with Aboriginal children and families. The employment of more Aboriginal staff was identified as an important strategy to ensure that CAMHS services are more inclusive; this needs to occur through use of s.50(d) and s.51 of the Equal Opportunity Act, 1984 as well as through appointment to non-specified positions. An established career path for Aboriginal Mental Health Workers is critical to the growth and sustainability of the workforce.

The increased demand and pressure being experienced by Community CAMHS was a strong theme in the consultation. This is by no means a new or unique issue to health and in particular, mental health services. The quantitative data provided in this report on access times for urgent and acute services provides further information to support requests for additional resources.

**Document management**

Information for this review was accessed from multiple locations, which was time consuming and possibly resulted in some information being overlooked.

**Recommendation 9**

⭐ That CAMHS progress implementation of RM (the CAHS Records Management system) as a priority.
References


Appendices

Appendix 1: Functions of ACIT and ART teams over time

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td><strong>ACIT established as PMH alternative to admission/discharge support</strong></td>
</tr>
<tr>
<td></td>
<td>• Alternative to inpatient admission for children less than 16 years from PMH ED</td>
</tr>
<tr>
<td></td>
<td>• Post-discharge support to Ward 4H, if no other community mental health service in place</td>
</tr>
<tr>
<td></td>
<td>• Time limited Community based follow up in a least restrictive environment</td>
</tr>
<tr>
<td>2011</td>
<td><strong>Expansion of ACIT to a metropolitan wide service</strong></td>
</tr>
<tr>
<td></td>
<td>• Expanded referral sources to include Bentley Adolescent Unit, metro-wide Emergency Departments and ART</td>
</tr>
<tr>
<td></td>
<td>• Children less than 18 years</td>
</tr>
<tr>
<td></td>
<td>• Rapid assertive intervention, risk assessment, crisis intervention, stabilisation and transition to other services</td>
</tr>
<tr>
<td>2011</td>
<td><strong>Establishment of ART</strong></td>
</tr>
<tr>
<td></td>
<td>• 24hr/7 day 1800 phone line: triage, information, support</td>
</tr>
<tr>
<td></td>
<td>• Bed flow (state-wide) for CAMHS inpatient units</td>
</tr>
<tr>
<td></td>
<td>• Emergency assessments at PMH (Psychiatric Liaison Nurse role)</td>
</tr>
<tr>
<td></td>
<td>• Emergency community assessments in metropolitan Emergency Departments, homes and the community, daily between 8:00am and 10:00pm</td>
</tr>
<tr>
<td>2013</td>
<td><strong>Expansion of services under the ACI initiative to include:</strong></td>
</tr>
<tr>
<td></td>
<td>• Expansion of ART service</td>
</tr>
<tr>
<td></td>
<td>• ACIT weekend service</td>
</tr>
<tr>
<td></td>
<td>• ACI North East; a brief Intervention to manage active clients of Swan, Hillarys and Clarkson Community CAMHS</td>
</tr>
<tr>
<td></td>
<td>• Partnership with Mission Australia’s Children and Family Support Service (CAFSS).</td>
</tr>
</tbody>
</table>
Appendix 2: Summary of CAPA

The Choice and Partnership Approach is a clinical system that evolved in Richmond and East Hertfordshire CAMHS and is now being widely implemented across the UK, New Zealand and parts of Australia. The approach is rooted in the theory of demand and capacity and is part of the modernisation agenda as outlined in the CAMHS Review 2008. There are a number of similar clinical systems working within CAMHS services.

The aim of CAPA is to engage young people and their families in care and therapeutic interventions while at the same time optimising service efficiencies and managing supply and demand within the service.

Children seen by a traditional CAMHS service are screened, assessed and accepted for treatment or judged to be inappropriate. If accepted, they are often referred within the service for specialist interventions by specialist clinicians.

In the CAPA process newly referred children and their families are invited to attend an initial ‘Choice appointment’ with the service and are offered a choice of day, time, and venue negotiated directly with the family to promote engagement and to provide information about what they can expect.

Children and families are seen by select members of the CAMHS team who have the necessary expertise and skills to ensure that young people and their families are directed to the most appropriate care pathway from the start. Having the right people in the right place at such an early stage of the care process ensures safe and timely access to effective care.

Families who choose further support from the service are invited to book directly with a second member of the team in what is referred to as ‘Partnership’ where a range of shared treatments and interventions can be provided by the CAMHS clinical team. One of the core principles of ‘Partnership’ is to enable clinicians to develop and share their skills to enable more children to be seen by more of the team.
Appendix 3: Limitations of quantitative data

With regards to the data analysed as part of this review, the following specific limitations are noted.

Community referrals

- The differentiation between urgent/routine is based on the ‘Comments’ section, which is a free text field. Urgent referrals have been identified through the inclusion of a comment in the referral that contains ‘urg’ to cater for any spelling errors. However, there are a number of referrals that have a blank comment field and it is therefore not possible to determine if these are routine or urgent referrals.
- In January 2017 business rules were put in place for all community teams to use the comments field to record Routine/Urgent. Prior to this some teams had already been using this field to do so. However, because this was not a consistent practice among all community teams, it is not possible to reliably determine the number of ‘urgent’ referrals that community received prior to ACIT devolution.

Service events (duration to first face to face contact)

- Data is sourced from PSOLIS into which data is entered manually. If the Service event has been recorded incorrectly i.e. incorrect medium (face to face, phone, not applicable etc.) or if client present has not been ticked when the client was indeed present, these service events will not be included in the data.
- Given that the data extraction is based on time from referral to first client present face to face contact, there may be cases in which a service contact happened earlier but it will not have been picked up due to errors in the recording of the service event.
- There may be cases where the relevant service event may not have been entered into PSOLIS at all.
- There is no ‘referral code’ linked to any service event; it is therefore impossible to know, without confirming record by record, that the service event that occurs after the referral is linked to that particular referral.
  - For example young person (YP) has a referral in 2016; did not engage and had no client present service events. YP is referred again in 2017; YP engages, attends a choice appointment and is activated. The way the data is extracted means that that first client present appointment (choice appointment in the above case) would be linked to both the 2016 and the 2017 referral as it is the first client present face to face contact for both referrals.
  - The above issue has been attempted to be eliminated
- When analysing the ACIT service events, the geographical location of the service event could not be determined. This is due to the fact that PSOLIS only allows venue to be recorded from a pre-determined list of a generic locations (e.g. Hospital, Clinic, School etc.). Therefore, unless a manual audit of notes is undertaken, the exact geographic location of the service cannot be determined.
Referral outcomes

- The use of ‘No Further Action’ as a referral outcome does not provide sufficient information to determine why the referral was not activated. As per business rules, it is meant to be used when a referral is inappropriate, however anecdotal feedback would suggest that this referral outcome is being used more widely and for cases in which the referral outcome would more appropriately fit under a different category (i.e. client declined, referred to other service etc.).

- Referral outcomes OTHER THAN ‘Admitted to service’ (i.e. Referred to Other Service, Client Declined, Did not Engage etc.) does not mean that the young person did not receive a service.
  - There would be cases where a young person may have attended choice and partnership, and then did not engage, for which the ‘Did not Engage’ referral outcome would have been used.
  - Another example would be where the young person had a choice appointment and then declined the service, in which case a ‘Client Declined’ referral outcome may have been used.

Referral sources

- On PSOLIS, the ‘Referral Source’ field is a free text field. This means that the person entering the referral into PSOLIS can write anything without limitation. In some cases a person’s name has been written into the ‘referral source’ box with no indication of their profession or place of work. There is a referral type category which breaks referrals into broad categories of ‘hospital’, ‘medical practitioner’, ‘other professional’ etc. However, these categories are not refined enough to reliably estimate for example how many referrals come from ED as the field ‘hospital’ may include outpatient hospital services etc. Further, it relies on the person entering the free text description, to select the appropriate category type.

Duplicate referrals

- As a rule, only one referral to the same service per young person, per calendar month is counted. This rule is applied to avoid counting duplicate referrals for the same person that may come from multiple sources within a few days, but acted upon only once.
- This may result in legitimate multiple referrals (perhaps 30 days apart) within the same month being excluded as they fall under the above rule.
- This may also result in someone that has duplicate referrals from multiple sources within a few days during the end of one month and the beginning of another. As referrals cross over calendar months, there is a chance that some duplicates may still be counted.
Geo mapping
- ACIT services often occurred within the young person’s community setting. In order to determine the geographical breakdown of those young people who were receiving a service, their residential suburb and relevant CAMHS catchment have been analysed.
- It is assumed that the residential catchment of the person is where the service took place; the same criteria was applied to urgent community referrals.

Access times
All referrals have been included regardless of the referral outcome. Data was also analysed based on specific referral outcome, i.e. only those that ended up being admitted to the service, or excluding the referral outcomes ‘Did not engage/Attend appointment’ and ‘Client Declined’. However, results for ACIT and Community CAMHS showed no significant difference when filtering based on these referral outcomes.

Due to limitations with the data collection and reporting, CAMHS is not able to accurately report on the waiting time between referral received and the first available appointment. Data is therefore reported based on the waiting time between referral received and the first face to face appointment attended: specifically, the percentage of children seen within 2 days of referral; and the percentage seen within 4 days of referral. The reason for including a 4 day time period is to take account of weekends; if a referral is received on a Thursday, the maximum waiting time (excluding weekends), would be 4 days with the appointment offered/available/scheduled on the Monday.

The KPIs for ACIT were that the patient and family would be contacted by phone within 24 hours of referral; and a face to face appointment provided within 5 days of referral (Department of Health, 2014 p20). Given that this review is not intended to compare performance of the two models and for the purposes of transparency, the same waiting time data has also been reported for children referred to ACIT prior to devolution. Caution should be exercised when drawing any conclusions from these data sets.

‘Days’ is a raw count of days; this count does not take into account weekends and public holidays. This is because:
- Some referrals are reported to have been received on a weekend – it is unclear whether the date on the referral letter has been entered, or the date of receipt of referral at ACIT/community CAMHS clinic.
- ACIT provided a weekend service for a period of time, which created inconsistencies when applying a general formula to a large data set.
Calculations were performed as follows:

- **Numerator** - number of urgent referrals within the time period with a subsequent client present face to face service event within the specified amount of days.
- **Denominator** - total number of urgent referrals within the time period with a subsequent client present face to face service event that was deemed relevant to the urgent referral\(^4\).

\(^4\) This is not to be confused with total number of urgent referrals; the denominator will not count those who have an urgent referral and then do not have a subsequent face to face client present service event (as they do not have a 'waiting time' to measure).
### Appendix 4: List of CAHS staff consulted

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Number of participants (interviews or focus group)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal CAMHS &amp; CAHS staff</strong></td>
<td></td>
</tr>
<tr>
<td><strong>ACIT and ART</strong></td>
<td></td>
</tr>
<tr>
<td>ACIT staff</td>
<td>8</td>
</tr>
<tr>
<td>ART staff (includes 3 x 1800 number staff)</td>
<td>9</td>
</tr>
<tr>
<td>ACIT and ART Service Managers</td>
<td>3</td>
</tr>
<tr>
<td>Total ACIT and ART staff</td>
<td>20 (including 3 Managers)</td>
</tr>
<tr>
<td><strong>Other CAMHS staff</strong></td>
<td></td>
</tr>
<tr>
<td>Aboriginal Mental Health Workers</td>
<td>4</td>
</tr>
<tr>
<td>Acute team staff (not ex ACIT/ART)</td>
<td>2</td>
</tr>
<tr>
<td>Choice Coordinators</td>
<td>10 (2 at Swan)</td>
</tr>
<tr>
<td>Service Managers</td>
<td>10</td>
</tr>
<tr>
<td>Heads of Service</td>
<td>8</td>
</tr>
<tr>
<td>Culturally and Linguistically Diverse (CaLD) staff</td>
<td>1</td>
</tr>
<tr>
<td>Administrative Officers</td>
<td>13</td>
</tr>
<tr>
<td>Executive Director</td>
<td>1</td>
</tr>
<tr>
<td>Director and Head of Department Community CAMHS</td>
<td>2</td>
</tr>
<tr>
<td>Professional Leads Advisory Committee</td>
<td>8</td>
</tr>
<tr>
<td>Paediatric Consultation and Liaison Program</td>
<td>27</td>
</tr>
<tr>
<td>1800 helpline staff</td>
<td>3</td>
</tr>
<tr>
<td><strong>PCH CAMHS</strong></td>
<td></td>
</tr>
<tr>
<td>Director and Head of Department PCH CAMHS</td>
<td>2</td>
</tr>
<tr>
<td>Inpatient Unit Ward 5A PCH staff</td>
<td>8</td>
</tr>
<tr>
<td>Emergency Department, PCH</td>
<td>4</td>
</tr>
</tbody>
</table>

Some staff were both interviewed individually and in focus groups - this was accounted for in the number of total people providing feedback.