GOVERNMENT OF
WESTERN AUSTRALIA

Infant, Child and Adolescent (ICA) Taskforce Implementation Program

Acute Care and Response Teams: A Model of Care

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1 Introduction

This document will guide the delivery of a **statewide mobile, intensive and timely service, that can both respond to children and adolescents that are in a mental ill-health crisis and provide ongoing care to those who require intensive support in the community.** This service will improve access to mental health care for children and adolescents who are in a mental health crisis and can be safely, appropriately, and effectively supported in the community, but also provide intensive treatment to children with severe and enduring mental ill-health.

The future ICA mental health system will be organised into local 'networks', which will include a central 'hub' in each area, and a network of local services and clinics providing place-based, consistent care in their communities. This new model of Community Infant, Child, and Adolescent Mental Health Services (Community ICAMHS) will enable children, families and carers to receive the care they need closer to home, in a more timely manner. **ACRTs will represent the acute and crisis arm of Community ICAMHS, where each area-based network will have an ACRT embedded in the Hub**. ACRTs will be responsible for delivering two key roles:

- provide crisis response to children who can be safely supported in the community and avoid presenting to an ED, and
- provide intensive treatment to children with severe and enduring mental health issues who require more frequent support – supplementing what is provided by existing local Community ICAMHS supports alone.

ACRTs will work with lots of different services in their communities to provide a connected response that best meets the needs of children and families in crisis.

This Model of Care has been developed by people with living and/or lived experience of mental health issues, clinicians, and system leaders

The Final Report of the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years (the ICA Taskforce) articulated a vision for the future ICA mental health system, which had Community ICAMHS at its centre. The ICA Taskforce outlined the key objectives of a new ACRT Model of Care[1] to address the challenges identified by children, families and carers with lived and/or living experience of mental health issues, clinicians, system leaders, and the broader WA community.

[1] A 'model of care' broadly defines the way a specific health service is delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition or event.

Based on these findings, this Model of Care was developed through the establishment of a Working Group that was responsible for designing the key features of the ACRT Model of Care, with support from relevant good practice models in other jurisdictions. The Working Group provided a forum for people with knowledge and experiences of ICA mental health services to share their expertise to inform the design and development of this Model of Care, with a broad range of voices including clinicians, children, families and carers with lived and/or living experience of mental health issues, and other system leaders. To ensure a broad reach, a survey was subsequently designed and shared with a broader cross-section of stakeholders across the ICA public mental health system.

Service Guarantee, and ICA Culturally Safe Care Principles underpin this Model of Care

A Service Guarantee has been developed to outline what children, families and carers should expect to experience in their interactions with the ICA mental health system. The Service Guarantee has eight principles, outlined in Figure 1. These principles apply to all ICA mental health services and are intended to guide how all models of care, including the ACRT Model of Care, are implemented.

Alongside the Service Guarantee, ICA Culturally Safe Care Principles have been developed to guide and enable the delivery of culturally safe and appropriate care to Aboriginal and Torres Strait Islander children, families and carers across all ICA mental health services, including this Model of Care. Figure 2 provides a summary of the ICA Culturally Safe Care Principles.

Purpose of this document

The purpose of this document is to describe how ACRTs will deliver crisis response support and intensive treatment across WA to ensure care is accessible, high-quality and integrated for children that are in a mental ill-health crisis and/or are experiencing severe and enduring mental ill-health. This document is not intended to define specific approaches, provide clinical advice, or outline specific workforce, infrastructure or other resource requirements. Further, it is not intended to provide guidance for specific regions, districts or communities. Rather for these communities, this Model of Care provides an overarching framework to create consistency, while also allowing scope and flexibility for care to be adapted to the local context and needs.

A note on language and terminology

The intention of this document has been to use language that is clear and inclusive. However, it is recognised that there is not always consensus around the language associated with infant, child and adolescent mental health. For this Model of Care, the term children, family, and carers has been used and is inclusive of all children, family, carers, supporters, and community members. Section 8 contains a list of the key terminology used within this document. The term ‘Aboriginal peoples’ has been used throughout the document and is intended to refer to all Aboriginal and Torres Strait Islander peoples.

Figure 1 | Service Guarantee Principles

All children, families and carers are empowered to achieve and maintain their best possible mental health and wellbeing regardless of who they are or where they are from

You can easily access the care you need		All children, families and carers have flexible access to public services which feel welcoming, and receive the right service at the right time without barriers.
You are at the centre of the care that you receive		All children, families and carers receive care that is tailored to their needs and preferences, where they are informed and have choice about their care.
You have a voice in your care		All children, families and carers can actively contribute to the design and delivery of the services they might receive, and feel that their care is responsive to their needs.
Your family and carers are partners in your care		Families and carers are empowered and involved in their child's care in a way that is safe, appropriate and collaborative, while respecting the child's wishes.
Your care wraps around you		All children, their families and carers experience care that is effectively coordinated in an integrated service system, resulting in harmonious supports.
Care improves your wellbeing		All children, their families and carers receive care that is meaningful to their goals and supports their recovery in line with their definition of wellbeing.
You have lasting support and care		All children, families and carers are supported through their care journey to access or transition between services based on their needs.
You receive care from resourced and capable services		Care is provided by services that are fully resourced, with the capacity, capability and infrastructure necessary to provide tailored care.

Figure 2 | ICA Culturally Safe Principles

1	**Spiritual:** *We respect you, your connection to inner-self and your culture.*
2	**Accessible:** *Your journey of healing begins now.*
3	**Responsive:** *You are precious and your time matters.*
4	**Trauma-informed:** *Let us better understand the journey walked to now.*
5	**Wrap-around:** *Let us walk this journey side by side.*
6	**Empowering:** *Your story, your health – you are the driver.*
7	**Connected to the community:** *Your relationships and place in the community matter to us.*

ICA CULTURALLY SAFE CARE PRINCIPLES

Child, family, carer

SOCIAL AND EMOTIONAL WELLBEING DOMAINS

1	**Connection to community:** *Opportunities for individuals and families to connect, support each other and work together.*
2	**Connection to mind and emotions:** *The ability to manage thoughts and feelings.*
3	**Connection to body:** *Feeling physically strong and healthy and able to physically participate as fully as possible in life.*
4	**Connection to family and kinship:** *Connections to family and kinship systems are central to the functioning of Aboriginal and Torres Strait Islander societies.*
5	**Connection to culture:** *Connection to a culture provides a sense of continuity with the past and helps underpin a strong identity.*
6	**Connection to Country:** *Connection to Country helps underpin identity and belonging.*
7	**Connection to spirit, spirituality and ancestors:** *Spirituality provides a sense of purpose and meaning.*

2 Background: Case for Change

2.1 Acute and intensive response

Governments across the nation have stressed the need for mental health services to move away from hospital-based care, and toward prevention and early intervention. In addition to the WA Government's focus on strengthening prevention and early intervention initiatives as part of the ICA system transformation, there is recognition that the future ICA mental health system needs to respond very differently to the state's most acutely unwell children and have the capability to provide safe and intensive responses to children in crisis.

All children should be able to access intensive and responsive support in the community when they need it, to the extent that it is safe and appropriate. This means having access to child-friendly and trauma-sensitive care in times of crisis – at home, in school, in a community setting, or in a hospital setting, as appropriate. Delivering this care effectively in the community is critical to providing safe care, and limiting repeated presentations, extended hospitals stays, and ongoing severe mental health issues.

2.2 Case for change

More children are seeking support in a crisis, but struggle to access the care they need

Mental health continues to be a critical challenge for WA children and families, with increasingly complex issues and needs. Since 2014, the population of children aged 0-17 has risen by 5.5 per cent, but during that same period:

- attendances to Emergency Departments (EDs) for a mental health condition have risen by 64.9 per cent.
- admissions to hospital for mental health have risen by 79.5 per cent.
- referrals to community mental health treatment services have risen by 70.1 per cent.

Funding of these services has not kept up with this growth in demand or complexity. Today, although children make up almost 25 per cent of the WA population, only 8 per cent of all mental health funding goes to services for infants, children, and adolescents.

There are critical gaps in the range of community-based services available to support children and families in crisis

Children, families and carers should have access to child-friendly and trauma-sensitive care in times of crisis, including alternatives to the ED that are provided in the community. Although addressing the capacity issues in the current system is critical, it is equally important to

understand there are significant gaps in the overall range of services provided to meet the needs of children, families and carers. This includes:

- Higher-intensity services in the community that either keep children out of hospital or support children on discharge from hospital. This may be in residential bed-based services (such as step-up/step-down facilities) or in-reach/out-reach services to the home, school or other settings.
- Crisis response services, both in the community and supporting EDs when an individual presents in a crisis.

Further, children, families, carers and staff have reported issues with existing models of care for regional and metropolitan community-based services. This includes how long it takes to receive care, the duration of care, the operating hours of services, and the locations of where services are provided, and the extent to which care is coordinated across the system.

A lack of alternative services places pressure on EDs, which should be a last resort

Gaps in the where and how community-based services are delivered have contributed to crisis, families and carers struggling to access community services and resorting to attending EDs in crisis. In 2020, there were 8,340 separate attendances at an ED by 0–17-year-olds for a mental health reason. This is an average of 22 attendances per day, and a 127 per cent increase from the 3,674 presentations in 2010. This increase in ED attendances by 0–17-year-olds for a mental health reason comes at a time when EDs are under increasing pressure across WA; both in terms of the care provided and the issues of ambulance 'ramping' outside of EDs.

Most importantly, episodes of poor mental health should not be left to escalate to a crisis level. Attending an ED should be a last resort; for when an individual's health cannot be managed at home or in the community with face-to-face or telehealth services. There is a further need to foster continuous care in the community, requiring proactive and assertive outreach of mental health supports to ensure children with ongoing mental ill-health can receive safe, appropriate support closer to home, preventing ongoing crises. Children, families and carers report that EDs are not child friendly, trauma responsive, or sufficiently accessible for seeking support during a crisis. Currently, there are no alternatives to EDs for ICA mental health crises.

What needs to happen?

There is a need for a WA service that provides a mobile and intensive crisis response for children that are in a mental ill-health crisis, in a space they feel safe, and provides intensive treatment to children with severe and enduring mental ill-health. The service needs to be flexible and serve the 'hard-to-reach' cohorts.

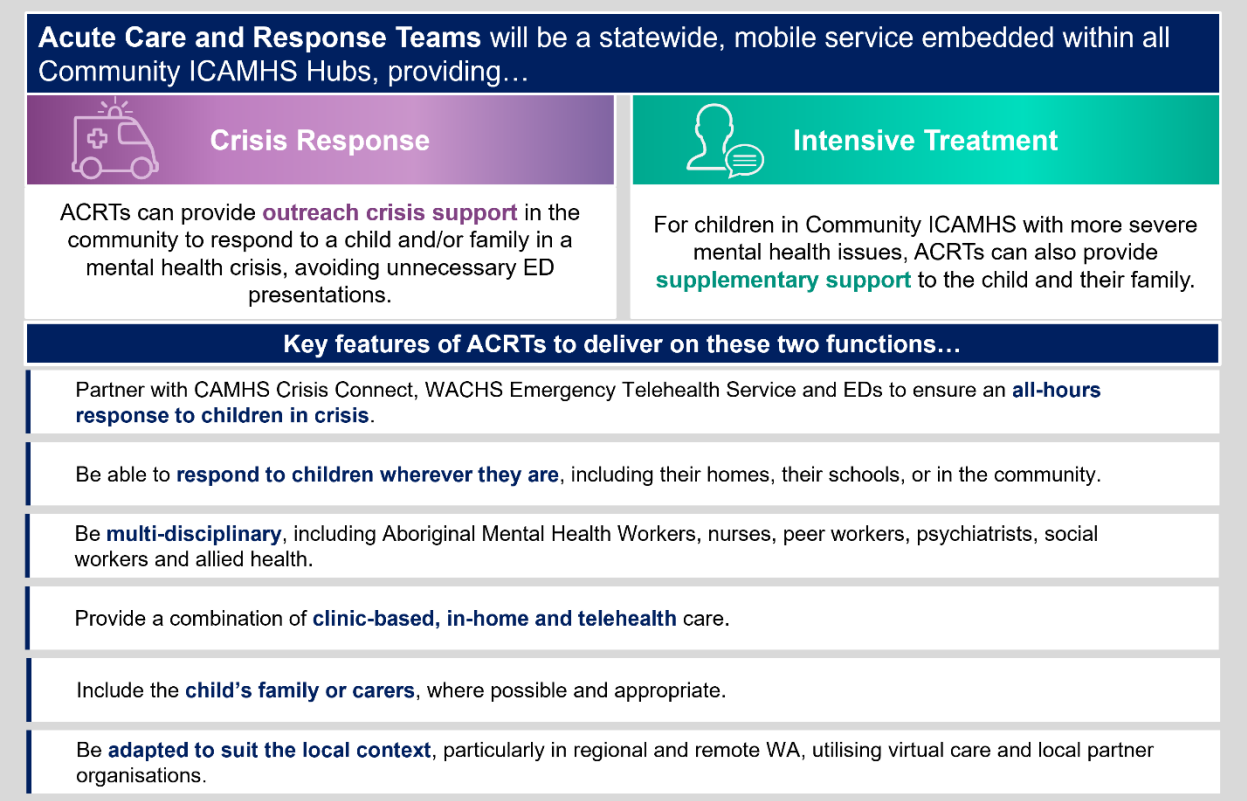
3 Overview – ACRT Model of Care

3.1 What is the ACRT Model of Care?

ACRTs are a hub-based mobile team that can respond to children in a crisis or provide additional support to children who need more frequent mental health support. This new service will improve the care provided to children that require urgent or intensive care by enabling access to mental health support in the community. ACRTs will be housed within Community ICAMHS Hubs, and provide two functions (see Figure 3):

1. **Crisis support to children in a mental health crisis.** ACRTs will respond to children in crisis, who can be safely, appropriately, and effectively supported in the community.
2. **Supplementary care for children with severe and enduring mental ill-health.** ACRTs can support children with severe and enduring mental ill-health in Community ICAMHS to access more frequent or out-of-hours care, where required.

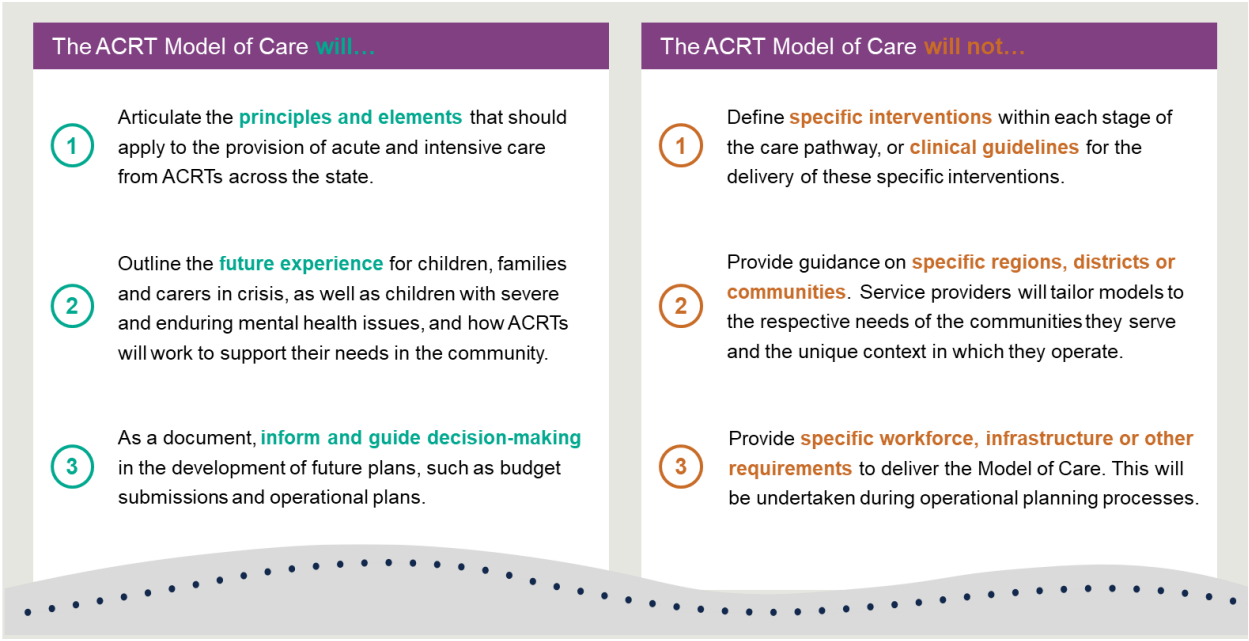
Figure 3 | Core functions



Model of Care's purpose and objectives

The purpose of this Model of Care is to describe the key functions, capabilities, and requirements for how ACRTs will work across WA to provide both crisis response and intensive treatment to children requiring acute care in the community. Given the broad nature of a model of care, Figure 4 below outlines the objectives and limitations of this Model of Care.

Figure 4 | Objectives and limitations of the ACRT Model of Care



3.2 Model of Care outcomes

ACRTs will deliver a range of outcomes to children, families and carers, staff that work within these teams, and the broader ICA mental health system. These are outlined in Table 1 below.

Table 1 | ACRT Model of Care intended outcomes

Outcomes that Acute Care and Response Teams will achieve for …	
 **Children, families, and carers**	Children, families, and carers should have access to **child-friendly** and **trauma-sensitive care** in times of crisis, including alternatives to the ED that are provided in the community.
	Children have more **flexible and equitable access** to crisis response care, such that different modes of delivery can support children in regional and remote areas, or where virtual care may be more appropriate for children, families and carers.
	Children, families and carers have **more intensive treatment options** available if their mental health is deteriorating and require a 'step-up' in intensity for a period of time.
	Children, families, and carers are provided with **ongoing** and **follow-up crisis support** to make them feel heard and supported in their recovery journey.
	Care provided **builds the family** and **carer's capacity** to support children, family and carers, and helps family members and carers identify and address their own needs.
 **Staff working in ACRTs**	**Staff feel supported**, **trained** and **empowered** to deliver safe, high-quality, and appropriate acute mental health care to children, families and carers.
	Staff are supported by a **flexible model of service** (e.g. virtual) that will enable **multi-disciplinary teams** and clinicians to provide care in a safer environment.
	Staff have a **sustainable workload**, where they are provided with adequate supports and resources to undertake their roles, no matter the location of where they work.
	Staff work within a **psychological safe environment**, where they can speak up and raise concerns without fear.
 **The broader system and WA community**	There is **reduced pressure on EDs** across WA due to children being safely supported in a crisis in the community by ACRTs.
	The system is aware of the supports available to refer children, families and carers in crisis, and **know where to go for support in these vulnerable periods**.
	There is **greater connection** between **emergency** and **community services**, such that care provided by EDs is connected to follow-up community supports and treatment.

4 Acute Care and Response Teams in practice

4.1 Who is this Model of Care for?

ACRTs can be accessed by **all children from 0 to 17 years old** across WA who require more intensive outreach support in the community. This includes:

- those who are experiencing a **mental health crisis**, as well as their families and carers.2
- children who have severe and enduring mental health issues and require more **intensive support** than what is available within Community ICAMHS

While not all children will need to access to ACRTs, there is flexibility in the intensity of supports available to children, families and carers to best meet their needs, such that all children have the option to access crisis response care if required**. As a result, access to ACRTs is intended to be as broad and inclusive as possible, but limited to those who require immediate and/or intensive support.**

In some crisis response instances[3], children accessing ACRTs may be existing consumers of Community ICAMHS supports – in which case ACRTs will work with care coordinators to provide connected, integrated care that best meets the needs of the child, their family and carers.

Inclusion criteria

Children in a mental health crisis should be supported through a 'no-wrong door' approach that ensures they feel heard, acknowledged, and supported. Please refer to Section 5.2 for further detail on the broad range of situations in which children may access ACRT crisis response support. This will ensure that children are not turned away in a vulnerable period of their lives.

[2] Note – children may experience a mental health crisis due to a social crisis that has occurred as a result of a family disturbance, or behaviour induced by alcohol and other drug use.
[3] Note – as per Sections 5 and 6, while the 'Intensive Treatment' function of ACRTs is focused on supporting children in Community ICAMHS, 'Crisis Response' is available to all children and families.

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

ACRTs will comprise **a small, multi-disciplinary unit of clinical staff and lived experience workers**, delivering face-to-face and telehealth acute response to children and their families in schools, homes and communities. ACRTs will be based in all Community ICAMHS Hubs and have the capability to provide intensive community-based treatment to children with more severe and enduring mental health issues. While children, families and carers can access a broad range of mental health supports in all Community ICAMHS Hubs, **ACRTs will be capable of providing these supports out-of-hours on a daily basis, and through sessions that are longer in duration on any given day**. ACRTs will provide this short period of intensive care management, monitoring and support, until the child's condition can be stabilised and they can 'step back down' to less frequent instances of Community ICAMHS support, in line with the acuity of their need. This team will also have the clinical expertise to provide immediate support, de-escalation or stabilisation for young people experiencing a mental health crisis. This includes crisis assessment, specialist clinical care and short-term therapeutic interventions to children, families and carers in the following ways:

- **Mobile crisis outreach**. The ACRT will travel to a home or other setting to de-escalate a situation and prevent ED admission or further harm[4].
- **Non-emergent outreach**. The ACRT can provide support within 24-48 hours of being contacted.
- **Crisis stabilisation**. After an acute crisis, children and families can access crisis stabilisation check-ins and outreach to ensure they are safe and connected to follow up supports.

The following two sections outline how these two core functions will operate in practice, noting:

- Community ICAMHS is the first point of contact for all children, families and carers requiring mental health supports, with ACRTs representing the crisis and acute care arm of each Community ICAMHS area.
- Each Community ICAMHS Hub will have one ACRT, with a dedicated resourcing unit responsible for fulfilling each function. While this may mean that different workers are responsible for different functions, the ACRT should be connected as a single unit given the similarity of skillsets required.
- There is some degree of overlap between the type of supports provided across the two functions, given both functions focus on crisis care.
- There will also be some degree of overlap between who accesses these two functions (i.e. a child may receive crisis response care, and follow-up intensive treatment from the same ACRT worker).

[4] In some cases, this can be achieved via the telehealth component of ACRTs (see more detail below).

5 Crisis response

5.1 Overview

ACRTs can provide outreach crisis support in the community to respond to a child and/or family in a broad range of mental health crises, who can be safely, appropriately, and effectively supported in the community, avoiding unnecessary ED presentations or further harm.

5.2 Who might access the crisis response function of ACRTs?

The target cohort of the **crisis response** arm of ACRTs, those 'experiencing a mental health crisis', encompasses a broad range of situations related to mental ill-health from the perspectives of children, family and carers, and service providers. Therefore**, 'children in a mental health crisis' should be treated as a broad definition with various presentations, and is not confined to any particular cohort, situation, acuity level or timepoint. This acknowledges that there is a broad spectrum of risk in terms of crisis and suicidal behaviours – and that ACRTs will have the ability to safely manage risk across all of these circumstances.** It is critical that this flexibility is communicated with all families, and that children can get immediate crisis support in relation to mental ill-health either during a period of crisis, or at any point of their vulnerable period, and that it need not be at the 'peak' of their heightened state. **Further, these children need not be under the care of Community ICAMHS – any child in a crisis can receive crisis response from an ACRT, so long as it is safe for them to be de-escalated in the community.** Examples of a child who an ACRT may provide crisis response could include but is not limited to:

- A child under the care of a local Community ICAMHS has quite complex psychological behavioural needs, but one evening has become increasingly agitated and has expressed active suicidal ideation.
- A family member who requests help due to a domestic violence situation whereby their child has become increasingly unstable, and they are worried they might become threatening or aggressive, but will be triggered if taken to an ED.
- An adolescent who has recently become street-present and is experiencing worsening mental health issues, and requires non-judgmental support to keep them stable, avoid further deterioration, and know where to go to get help.
- A child recently presented to the ED with self-harm and received immediate support, but 48 hours later is feeling very unstable and continues to have suicidal ideation.
- A carer who looks after a child with psychosocial issues is concerned that the child is becoming unstable but has not yet 'peaked'.
- A child previously diagnosed with borderline personality disorder that is currently receiving care from Community ICAMHS is feeling very overwhelmed and distressed while at

school. A teacher is worried that the child may hurt themself but feels that calling an ambulance to go to ED may be triggering.

While ACRTs will be an open, flexible service – they are not the most appropriate service for **children experiencing a medical emergency**.[5] The needs of these children will be more appropriately met by expert paediatricians and mental health clinicians in local EDs.

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

ACRTs will also have the clinical expertise to deliver immediate support, de-escalation or stabilisation for young people experiencing a mental health crisis. This will include crisis assessment, specialist clinical care, and short-term therapeutic interventions to children, families and carers in the following ways:

- **Mobile crisis outreach.** The ACRT will travel to a home or other setting to de-escalate a situation and prevent ED admission or further harm.
- **Non-emergent outreach**. The ACRT can provide support within 24-48 hours of being contacted.
- **Crisis stabilisation.** After an acute crisis, children and families can access crisis stabilisation check-ins and outreach to ensure they are safe and connected to follow up supports.

The broad range of supports provided by ACRTs as part of its crisis response function are outlined across three broad phases (shown in Figure 5 below).

Figure 5 | Three broad phases of a child's experience receiving crisis response support from ACRTs

[5] Examples of a medical emergency include but are not limited to: physical self-harm, unconsciousness, and physical concerns related to ingestion of medication, alcohol, or other drugs.

5.3.1 Access

ACRTs will receive or identify requests to provide immediate support, de-escalation or stabilisation for children experiencing a mental health crisis.

ACRTs will be able to receive requests to respond to crises from an array of sources and referral pathways

ACRTs can enable access through a broad range of referral pathways. Some of these pathways include EDs, Community ICAMHS, school psychologists, paediatricians, GPs, self and family referral, other community services, and justice services. A child's social setting (i.e. where they would like to be supported) should not determine whether or not they can access crisis response in a timely manner that is convenient to them.

Referrals and requests for support will be undertaken through a single 'front door' telehealth line, managed by a centralised intake team

Collectively, existing Emergency Telehealth Services (ETS), such as Crisis Connect and WA Country Health Service (WACHS) ETS, will be the single front door into accessing ACRTs across the state. To compliment this service, there will be a 24/7 chat function to ensure equitable access – both of which are free to engage with. Emergency Telehealth Services will connect children, families, and carers in crisis to a local ACRT, who can provide varying levels of crisis response. The current CAMHS Crisis Connect and WACHS ETS services will form the telehealth component of the ACRT service, and should be available via telephone, videocall and an online chat. This phoneline will provide an enhanced 24-hour-a-day, seven-day-a-week single point of contact for people seeking crisis response information and support, referral, and system navigation to anyone concerned about a child in a mental health crisis or requiring intensive support. This phoneline will connect to regional ACRTs, and interface with other care services and chatlines such as Lifeline or the Kids Helpline. A critical success factor is that this phoneline is made as the primary pathway, or a 'single front door' for all children and families to receive crisis response support and must be clearly communicated and highly accessible to the community. Promotion of this phoneline will be managed by each Community ICAMHS Hub through a targeted public education campaign to encourage use of the phoneline, and address barriers to help seeking to encourage use of ACRTs. It is expected that this promotion will address help-seeking motivations and lead to a decrease in unnecessary ED presentations. Further, ongoing training and support will be required to be provided these staff in the same core competencies expected of ACRT staff (see Section 7) in order to ensure a safe, effective, trauma-responsive contingent of phoneline staff.

5.3.2 Support

ACRTs will provide crisis response to children, families and carers who can be safely, appropriately, and effectively supported in the community.

The first point of contact with an ACRT should be flexible to determine the child's current situation and the nature of support required

The ACRT will provide a first point of contact for children, families and carers, or service provided concerned about the wellbeing of a child experiencing a mental health crisis. This first point of contact will be critical in ensuring expedited access to appropriate crisis response care from an ACRT. Upon contact, the ACRT should work with the referrer to assess the child and family's current situation and presenting needs to be determined. This conversation should provide immediate emotional support and de-escalation where possible, but also provide information about current symptoms being experienced, possible medical issues, and risk of harm to self or others.

This conversation should determine the type of support required by an ACRT, which could include:

Table 2 | Types of crisis response support available from ACRTs

Scenario	Description
ACRT not required – Community ICAMHS manages care	Given the capabilities of the core Community ICAMHS clinical team and care coordinators, many situations of children experiencing heightened states of distress can be safely managed without intervention from an ACRT.
Supported de-escalation	In some cases, de-escalation may be possible over the phone during the first point of contact. For example: ▪ If a family member calls the phoneline worried about their child's mental health, the phoneline operator can provide virtual de-escalation, and begin the referral process to a local Community ICAMHS Team to provide ongoing support. ▪ If a local mental health service supporting a child calls the phoneline for help, the operator could provide de-escalation support to the staff member from that service to ensure the child's safety, therefore removing the need to access an ACRT or ED.
Immediate crisis outreach	The crisis requires imminent response to avoid further harm to the child and others, and a mobile ACRT outreach unit (either face-to-face [preferred] or virtual) is deployed to the setting to provide de-escalation support, risk planning, and ensure immediate follow-up supports until the child is no longer at risk of harm.
Non-emergent outreach	There is not an imminent risk of harm to the child or others, but timely support is needed. The ACRT can provide both immediate virtual de-escalation support in the interim, and then look to provide clarity on when the child and

Scenario	Description
	family will be receiving either virtual or face-to-face support next at an arranged time. Ideally, this would mean an ACRT has an arranged time to visit the child and family within 24-48 hours of contact to avoid the child entering a crisis.
Short-term stabilisation	This is the most intensive form of support available from an ACRT before being transitioned to other settings. This would require an ACRT to provide immediate crisis outreach (as above), but if it is clear that the child is at extremely high risk and will require ongoing monitoring, the ACRT can provide children and families with crisis stabilisation services in the form of ongoing check-ins and safety planning, until they are connected to Community ICAMHS.[6]
ACRT not appropriate - Emergency	The child is experiencing a medical emergency, which requires support to access an ED. The telehealth phoneline operator has direct access to 000, and should call this number to ensure safe and timely access to the ED.

Service delivery should also be flexible to best meet the needs of the child and family

While face-to-face crisis response is likely to be the most effective mode of support from an ACRT, there should be consideration for how the team can remain flexible, particularly to meet the needs of 'harder to reach' cohorts. This includes:

- **Virtual care.** While it should be considered as a 'last resort' by preference of the child or family, all of the above modes of crisis response support should have virtual care options, particularly for regional and remote families to avoid wait times in what is a vulnerable period. This mode may only be considered if the child and family would consider it more appropriate due to cultural, social, or other reasons. It should be noted, however, that virtual care can sometimes have limitations around identifying immediate environmental risks, such as unstable home environment that is limiting the ability of the ACRT staff member to communicate safely with the child and/or family members. Ideally, any virtual crisis response is conducted with a clinician in the room with the child and/or the family.
- **Crisis response in partnership with local services.** In some cases (such as regional and remote settings), it may be more appropriate for the ACRT to leverage local services that have pre-existing relationships with the child and family such as the Police, Aboriginal Medical Service (AMS), or other local community mental health services.
- **Crisis response support in a range of environments to make the child feel safe.** While there are a range of environments that ACRTs can provide mobile outreach to, the child and family should also be provided with choice as to the specific location (e.g. a park, local community centre, home, other) so to ensure they feel comfortable. This will improve the likelihood of the ACRT being able to stabilise the child from their heightened state and establish trust and rapport.

[6] Further planning is required at a local level to determine the length of time that short-term stabilisation can be provided for.

- **Education and support.** The ACRT phoneline should also be able to provide education on relevant local resources and supports the child and family can access if there is a waiting period for follow-up support, or the family has any questions.

Optional co-response

As mentioned above, in some Community ICAMHS area networks, Health Service Providers (HSPs) may deem it appropriate for the ACRT to provide a co-response with local Non-government organisations (NGOs) or the Police to provide more effective de-escalation of children and families in crisis. This will require further planning and decision-making at a local level to understand need, necessity, and the benefits of undertaking a joint response approach to mental health crisis support in terms of both service effectiveness, and resource efficiency.

ACRTs can provide a broad range of immediate crisis response supports and interventions available to a child, family, and carer

When engaging with the child and family, ACRTs will have the capability to provide a broad range of evidence-based crisis response interventions, depending on their situation and needs. This includes but is not limited to:

- **A bio-psycho-social assessment.** Explicit attention to screening for suicidality using an accepted, standardised suicide screening tool should be a part of initial contact, with withdrawal needs also being assessed. The assessment should include[7]:
    - causes leading to the crisis event, including psychiatric, substance abuse, social, familial, and legal factors
    - safety and risk for the individual and others involved, including an explicit assessment of suicide risk
    - strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports.
- **De-escalation and resolution.** Children will be engaged in supportive interventions in a low-stimulus throughout their engagement with an ACRT in order to de-escalate the presenting crisis. The goal of the engagement is to both determine the level of care required in order to provide appropriate intervention and referral for the child, and also to resolve the situation so a higher level of care is not necessary.
- **Active engagement.** Throughout this, ACRTs should provide meaningful activities and opportunities for the child to feel safe and engaged, such as using sensory toys or other games.

[7] It is critical that ACRT staff provide these supports in a trauma-informed, culturally safe manner to support the safety and comfort of child and family. This could include explaining why they are asking certain questions, finding alternative ways to support the child to communicate how they are feeling, or taking the time to explain to family members and carers what is going on.

- **Family support and psychoeducation.** ACRT staff will also provide emotional support and counselling to family members and carers to ensure their distress is minimised, and that they feel empowered to manage the crisis situation in the future.
- **Medication.** If children require medication to be de-escalated, in very limited cases, ACRTs will have capacity to administer a limited range of sedative medications, in order to prevent ED admission.
- **A safety risk management plan.** See below

A safety risk management plan should be collaboratively developed with the child and family to outline 'next steps'

Having de-escalated any immediate risks and built trust and rapport with the child and family, ACRTs and the family will co-develop a **safety risk management plan**. This plan will:

- be a summary of the current situation, and any support provided by the ACRT
- outline the approach to identifying and monitoring physical risks to the child and family
- provide the family with mechanisms to manage these risks on an ongoing basis
- be tailored to the family's social and cultural contexts, and individual preferences
- provide safety training for family members to empower them to potentially prevent future crises
- be flexible, to acknowledge that the young person's circumstances may change
- a list of immediate next steps and support from either an ACRT or other local mental health supports (i.e. Community ICAMHS)

These plans should be collaborative so that the family knows how to make themselves feel safe, but also are aware of what they can do in future crises.

ACRT should provide ongoing support to the child and family while other services are getting involved to ensure their safety and continuity of care.

Following the immediate crisis response, it will be critical to ensure the child and family have clear pathways to access follow-up supports to manage the child's mental health and wellbeing. Following the initial outreach, ACRTs can provide regular check-ins (either face-to-face or virtual) with the child and family, with support from a social or peer worker to monitor the family's situation and identify any further needs. Some cases may require partnership with local organisations that can support ongoing de-escalation or stabilisation.

Further, ACRTs could support access to Crisis Family Therapy at a local Community ICAMHS, or other relevant supports to manage their mental health and family circumstances. It is important that ACRTs and Community ICAMHS acknowledge the needs of the systems surrounding the child, that is, how the crisis has impacted the whole family. Over time, ACRTs may look to transition the child and family into Community ICAMHS family therapy.

In any event, ACRTs will provide information to the child and family about potential services they can access. This could include the ACRT supporting the child and family to access an updated directory of local non-government organisations (NGO) or AMS' that could provide community-based support to the child and family. It is important that there is some level of

guarantee that the service will be available at that point in time in their location, and so the ACRT should liaise with local services to confirm availability before providing this information.

5.3.3 Transition

ACRTs will ensure children have adequate supports in place to keep them stable and safe in the community.

Following response, ACRTs will support children and families to transition to care under Community ICAMHS and receive ongoing mental health supports

ACRTs should work to respond to children in crisis in the community, but then have a critical role to play in ensuring they have access to follow-up supports that will maintain their mental health and wellbeing in the community. ACRTs should support a careful transition of setting to ensure the child and family feel safe, supported, and stable. This means that the ACRT should not discontinue its crisis response engagement with the child until:

- they have confirmed access to follow-up services
- identified follow-up services are the right services for the child and family (e.g. accessible, culturally appropriate)
- their level of need does not require crisis care
- the level of service that can be provided elsewhere meets the requirement of the child.

ACRTs can support this process in two ways, summarised in Table 3 below.

Table 3 | Transitions from ACRTs to other services following a crisis response

Service	Description
Community ICAMHS	The ACRT should liaise with the local Community ICAMHS to submit a fast-tracked referral for the child to start receiving supports. In the interim period, the ACRT will continue to provide crisis response care and stabilise the child and family's situation and will not cease intensive support until it is determined that the child is safe and stable. ACRTs will provide a thorough summary of the child's circumstances and next steps, as outlined in their safety risk management plan.
Other community mental health services	Following a period of engagement, ACRTs can support children and families to access a range of local NGOs or community-based mental health organisations that can support their ongoing needs. This could include slowly transitioning the child to the support of a local Aboriginal Community Controlled Health Organisation (ACCHO).

Child Safe Spaces

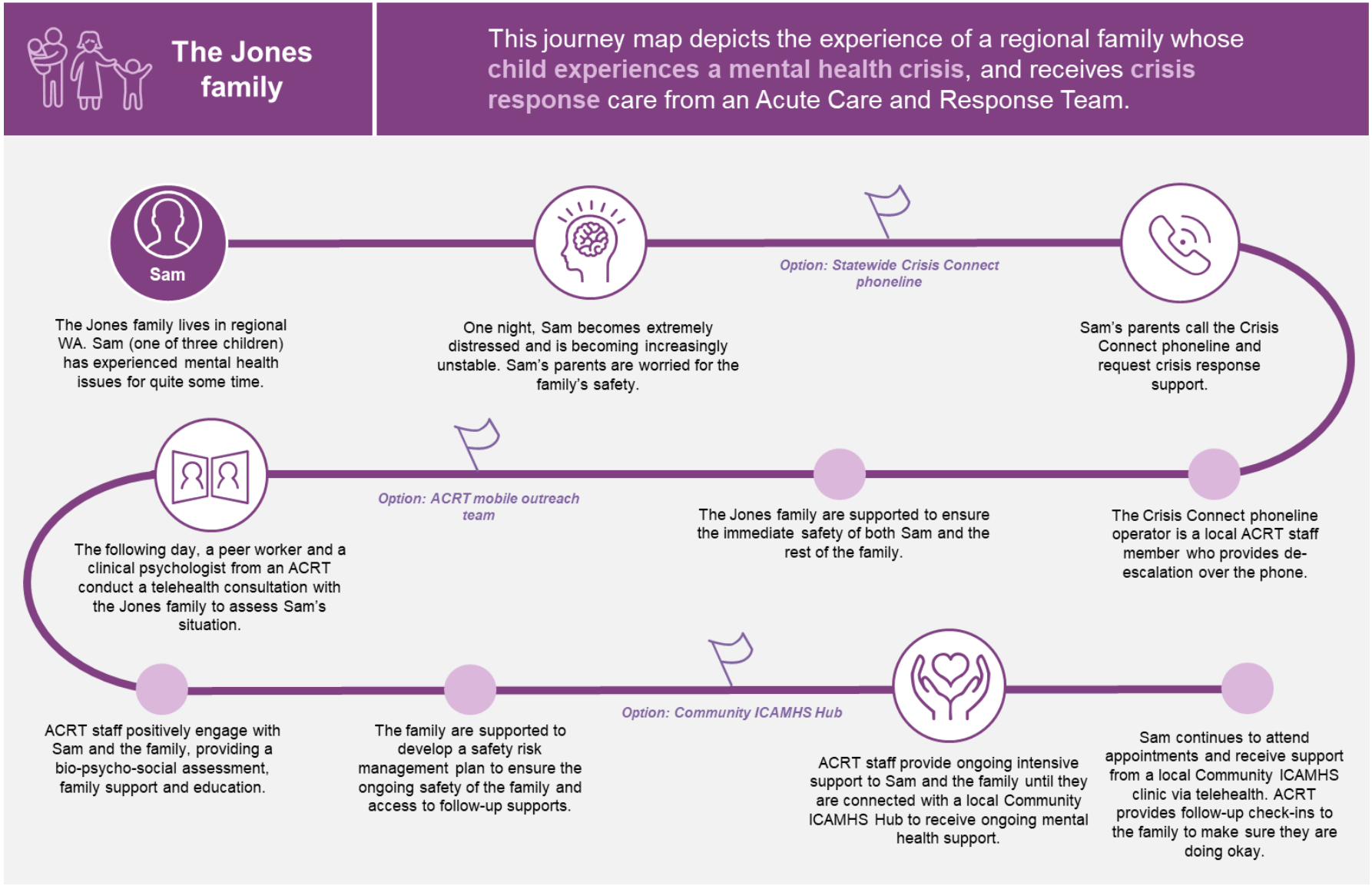
Where relevant, the ACRT should communicate to the child and their family the existence of local Child Safe Spaces that have been developed in the community as a safe, peer-led alternative to EDs. These Child Safe Spaces can provide a low-stimulus, supportive environment for the child if they do not require intensive clinical support but are looking to receive de-escalation and stabilisation support from a small contingent of peer workers, with some clinical support on site.

For example, an ACRT may provide the initial de-escalation – but a child may still require some ongoing short-term support at a lower intensity. One option is for the ACRT to support the child and their family to access the Child Safe Space as part of an ongoing immediate safety plan.

5.4 Journey map example

Figure 6 overleaf depicts an example experience of a child that could receive crisis response support from an ACRT. It is not intended to represent the experience of any specific individual or child – rather it is an illustration of what this function might 'look and feel like' in practice.

Figure 6 | A sample journey map experience of a child receiving crisis response support from an ACRT



6 Intensive treatment

6.1 Overview

For children in Community ICAMHS with more severe mental health issues, ACRTs can also provide ongoing, intensive treatment to the child and their family – providing supplementary support sessions to existing care and supports provided by Community ICAMHS.

6.2 Who might access the intensive treatment function of ACRTs?

The target cohort of the **intensive treatment** function of ACRTs is children who have severe and enduring mental health issues and are currently receiving mental health support from Community ICAMHS. This should be treated as a broad definition and be open to any child and their family who may require more intensive support in the community, beyond what is available in Community ICAMHS clinics. Given that ACRTs will be embedded in all Community ICAMHS Hubs, the decision as to whether a child may need, or would benefit from more intensive treatment will be made collectively by the child, family, and ACRT staff. Generally, intensive treatment from an ACRT represents an opportunity for children requiring intensive mental health support to access all-hours, more frequent support from expert mental health professionals in the community.

Availability of intensive treatment function

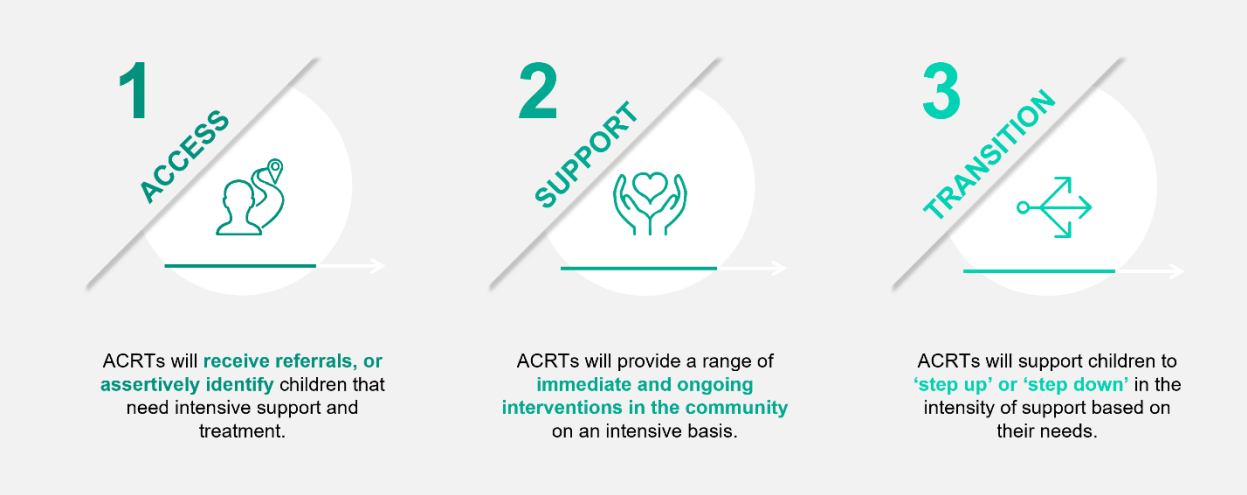
Currently, the scope of the intensive treatment function of ACRTs in each Community ICAMHS is focussed on providing supplementary support to each hub and local clinics in a Community ICAMHS network through out-of-hours or more frequent support sessions. This is based off the idea that Community ICAMHS is the ‘single front door’ to mental health support from the ICA public mental health system, and ACRT represents the ‘acute arm’ of Community ICAMHS. It is conscious that this does not include children only accessing private mental health services in the community at this point in time, but this Model of Care is particularly cognisant of demand and ensuring quality of access.

In this sense, Section 5 details that Crisis Response is available to all children – and can include various levels and intensity of outreach. For the purposes of this function however, the focus remains on children currently receiving care from a local Community ICAMHS, as ACRTs will operate to support local capacity and provide these children with an ‘all-hours’ access option.

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

ACRTs will provide additional support to children with severe and enduring mental health issues, supplementing the existing support provided by local Community ICAMHS. Note, Community ICAMHS is the first point of contact for all children, families and carers requiring mental health supports, with ACRTs representing the acute care arm of each Community ICAMHS area. **Critically, this means that Community ICAMHS will focus on providing the bulk of mental health supports to all children, and the intensive treatment arm of ACRTs will focus on supplementing this care through additional sessions, or care where required.** ACRTs will provide a broad range of supports to children and families requiring intensive treatment across three broad phases (Figure 7).

Figure 7 | Three broad phases of a child's experience receiving intensive treatment from ACRTs



6.3.1 Access

ACRTs will work in partnership with Community ICAMHS and community services to identify children with severe and enduring mental ill-health who are at risk and require intensive treatment.

Community ICAMHS care coordinators will notify the ACRT if a child requires additional support

While under the care of Community ICAMHS, some children may experience an increase in support needs due to a range of social, emotional, psychological, or behavioural factors. At a local level, a care coordinator may identify that the child is at-risk of further deterioration if they do not receive more intensive support or may require support at unconventional times that is unavailable in a hub setting. In these instances, the care coordinator can liaise with the ACRT to identify at-risk children who are experiencing deteriorating mental health and require a 'step up' to receive additional support from an ACRT, on top of what they are already receiving in the Community ICAMHS care plan. Through communication with the child and family, Community

ICAMHS staff will have the option to request more intensive support for the child and family to be delivered by the ACRT, with options to request

- out-of-hours support to the child and family
- supplementary outreach sessions to increase the frequency of support available to the child and family
- intensive care management of the child
- dedicated ACRT resources to provide intensive liaison support with the child's local school, if required.

For children under the care of Community ICAMHS who have recently presented to an ED, intensive support is critical to re-entering the community safely

Children, families, and carers can also receive intensive support from an ACRT in the community following discharge from an ED or intensive care settings. This assumes that children under the care of Community ICAMHS will likely need more intensive support than one check-in every month from a Community ICAMHS care coordinator, and an ACRT could support the care coordinator to monitor the stability of the child in the weeks following discharge.

In this case, ACRTs will also work with local EDs, inpatient wards and Community ICAMHS care coordinators to identify children who would benefit from follow-up crisis support and treatment following discharge from hospital or other acute settings for a short period of time. Relevant clinicians in these settings can identify if the child would benefit from follow-up support from an ACRT and communicate this with the child and their family. EDs, statewide services (such as the Eating Disorders Service) and inpatient units will liaise with the local Community ICAMHS and provide a summary of the child's circumstances, their current situation, and immediate needs. Community ICAMHS (the care coordinator) could then engage the ACRT to support the family either prior to discharge or shortly following it to communicate the range of supports they can offer and plan for next steps. This could include arranging a time for the ACRT to come to the family's home 24-48 hours after discharge to provide any range of supports listed in the following section.

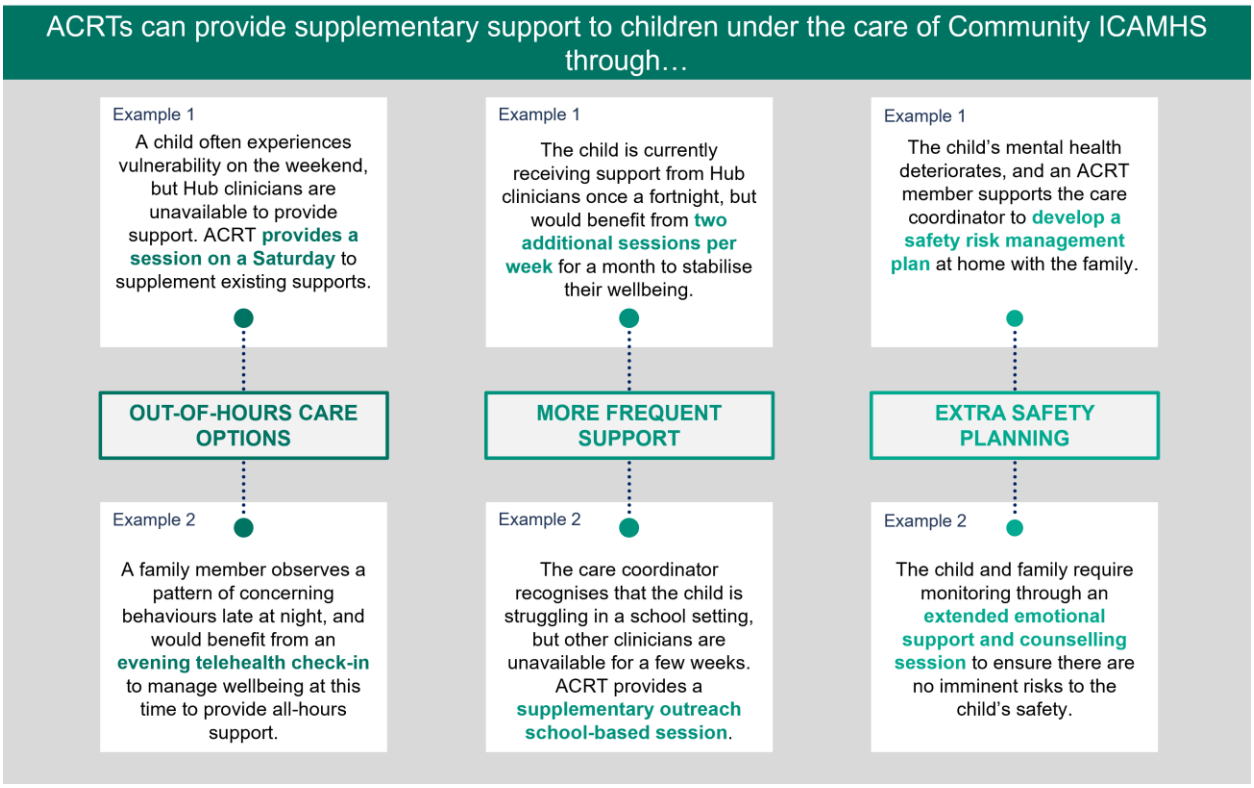
6.3.2 Support

ACRTs will support children with severe and enduring mental ill-health in Community ICAMHS to 'step up' and receive more intensive treatment as required.

ACRTs will work flexibly with local Community ICAMHS to identify how children could benefit from additional support

ACRTs and Community ICAMHS will provide a joint response to children with severe and enduring mental ill-health, summarised below in Figure 8.

Figure 8 | A stepped care approach to intensive treatment between ACRTs and Community ICAMHS



Through any of the options listed in Figure 8 above, ACRTs can provide supplementary support to children in the community or other settings if their needs are not being met by Community ICAMHS supports alone. Service delivery should also be flexible to best meet the needs of the child and their family. As with crisis response, ACRTs can provide all supports face-to-face or virtually in a range of environments that best suit the needs of the child and family, and can be delivered in partnership with local services (e.g. ACCHOs) who have developed existing relationships with the household. The core supports offered as part of ACRTs intensive function include:

- **Care and safety planning.** ACRTs can partake in a care planning meeting between the child, family, and the care coordinator, to understand the role they can play in providing more intensive support. A new care and safety risk management plan should be formulated to articulate how all the child and family's various supports will work together to meet the needs of the child and family.
- **Community-based assessment.** If required to understand the level of severity of mental ill-health and whether any other complex needs have surfaced (e.g. a personality disorder), the ACRT can provide a community-based assessment (informed by past assessments) to provide the child and family with a clear picture of their situation and needs at that point in time.
- **Therapeutic support.** There are a broad range of therapeutic supports that ACRTs will be able to provide on a regular (i.e. daily, if required) basis to manage the severity of a child's mental health issues. It is important to note that this support is only to be considered

as supplementary to existing Community ICAMHS supports. ACRTs can provide psychiatry, individual, family and group interventions, counselling and therapy, and ongoing risk assessments to monitor the child's safety and wellbeing.

Continuity of care

As much as possible subject to resourcing constraints, Community ICAMHS should look to prioritise continuity of care between a clinician and a child – such that ACRTs should only provide these supports if absolutely required.

If it is determined that in particular circumstances a child requires more intensive support for a brief period of time but that can be undertaken by the same clinician – that existing relationship and trust can often be crucial to ensuring the child feels safe and heard.

As much as possible, Community ICAMHS should work to be able to provide flexibility of support, and not just defer to ACRTs for supplementary support in all cases.

6.3.3 Transition

ACRTs will support the child to 'step down' to be supported by local Community ICAMHS resources or 'up' to an inpatient ward in limited circumstances.

The timeframe in which the child receives supplementary support from an ACRT depends on both their needs and access to other appropriate services

While supplementary support should be provided by the ACRT for as long as is necessary to stabilise the child's mental health, the length of engagement with this team should not be considered as long-term. This means that ACRTs should work intensively with the child and family until the level of service being provided by the ACRT is more than what they require, **and** they are able to receive sufficient supports from either Community ICAMHS or other community services.

ACRTs should support a careful transition of setting to ensure the child and family feel safe, supported, and stable. This process should only commence when the following criteria are satisfied:

- the level of support available in Community ICAMHS is appropriate
- when their level of need does not require daily care

Note, this could mean the child requires less intensive supports, and only requires Community ICAMHS or other community-based mental health services, but also considers if ACRT support is no longer sufficient for a child whose mental health continues to deteriorate. This is summarised in Table 4 overleaf.

Table 4 | Children can step 'up' or 'down' from ACRT supports

Service/area	Description
Community ICAMHS	Following a period of additional support from an ACRT, children and families will be supported to 'step back down' to receive less frequent and intensive care from the local Community ICAMHS. This is warranted when the child's circumstances have stabilised to the point where they no longer require daily support to keep them safe in the community.
Inpatient wards	If a child's mental health continues to deteriorate towards a crisis, or new and complex needs have arisen, ACRTs and Community ICAMHS can support referral onto metropolitan-based inpatient wards for more intensive care. This is considered as a 'step up' from ACRT and Community ICAMHS support and should be considered as a last resort option for only the most acutely unwell children at extremely high-risk, particularly for regional and remote families.

Child Safe Spaces

Where relevant, the ACRT should communicate to the child and their family the existence of local Child Safe Spaces that have been developed in the community as a safe, peer-led alternative to EDs. These Child Safe Spaces can provide a low-stimulus, supportive environment for the child if they do not require intensive clinical support but are looking to receive de-escalation and stabilisation support from a small contingent of peer workers, with some clinical support on site.

7 Delivering the ACRT Model of Care

There are various considerations that need be taken into account to implement and operationalise the ACRT Model of Care. These considerations have been outlined below in the following categories: key relationships and partnerships; workforce; infrastructure; and other delivery considerations.

7.1 Key relationships and partnerships

It is recognised that there is a critical relationship between Community ICAMHS and ACRTs to deliver this Model of Care – particularly to enable a response that enables children to receive supplementary support as required. Both services will work together via embedded capabilities in all Community ICAMHS Hubs to best meet the needs of children, families and carers. ACRTs will need to establish strong relationships with a range of other services that will be pathways in and out of the service, particularly given the crisis response function that ACRTs will deliver. These relationships are summarised in Table 5 below.

Table 5 | Required relationships to deliver ACRT supports effectively

Service	Relationship	Example
Community ICAMHS	The bulk of mental health supports available to children and families in the community will be provided by the local Community ICAMHS clinic. ACRTs will provide supplementary support to children with severe and enduring mental health issues in partnership with Community ICAMHS. Separately, ACRT and Community ICAMHS staff will work closely to ensure children, that have accessed ACRTs in a crisis, are connected to follow-up supports in Community ICAMHS, and are receiving a range of supports to best manage their needs.	A child currently under the care of Community ICAMHS is experiencing increasingly severe and complex mental health issues. Community ICAMHS and ACRTs work in partnership to provide a more intensive response, in the child's home and community that best meets the needs of the child, their family, and carers.
Emergency Departments	While many children experiencing a mental health crisis will present to the ED, upon discharge they should be provided with follow-	A child has presented several times to an ED in a mental health crisis – the ACRT can

Service	Relationship	Example
	up support from ACRTs to provide support and planning to prevent further crises.	be notified and provide crisis stabilisation support following discharge for the child, and their families or carers, to avoid re-presentation.
Emergency Telehealth Services (e.g. Crisis Connect, WACHS Emergency Telehealth Service (ETS))	Emergency Telehealth Services, such as Crisis Connect and WACHS ETS, will be the single front door into accessing ACRTs across the state. To compliment this service, there will be a 24/7 chat function to ensure equitable access. Emergency Telehealth Services will connect children, families and carers in crisis to a local ACRT, who can provide varying levels of crisis response.	A family member has contacted Crisis Connect to seek information and support for a family member showing signs of mental health crisis. ACRTs can be contacted by Crisis Connect to provide a mobile response where required – and so the family is triaged immediately to a local ACRT staff member to provide over-the-phone de-escalation support and coordinate a time to connect with the family.
Inpatient wards and statewide specialist services	Children receiving intensive treatment from an ACRT may have other complex needs that surface due to the severity of their mental ill-health, and could be supported to access more intensive and specialised care.	A child receiving daily support from an ACRT is showing early signs of a personality disorder and can be referred on to receive care from Touchstone.
Local mental health services	To suit local contexts and community needs, ACRTs may need to partner with local organisations to support children with severe and enduring mental health needs.	An ACRT providing intensive daily support to a child in a regional area is supported by a social and emotional wellbeing worker from a local AMS to ensure care is delivered in a culturally safe manner.
Schools	Children in school settings may show signs of a mental health crisis, or may require ongoing intensive mental health support in that setting. ACRTs will liaise closely with schools to ensure they can respond safely to children in schools who are in a mental health crisis.	ACRTs may respond to a crisis situation that occurs within the school environment.

7.2 Workforce

The workforce for ACRTs will comprise of many roles, both clinical and non-clinical. The following describes the workforce required to deliver these teams for all regions across WA.

Multidisciplinary team

ACRTs needs to be delivered by a multi-disciplinary team (MDT) with the skills, experience, and capabilities to respond to children in crisis and provide a broad range of mental health supports to children, families and carers. These staff should have demonstratable experience of working with children with complex mental health issues. These roles should include, but are not limited to (*listed in alphabetical order)*:

- Aboriginal Mental Health Workers
- Nurse and nurse practitioners
- Peer workers
- Psychologist
- Occupational therapists
- Social workers

The staff profile should reflect a focus on emotional trust and rapport, rather than reflecting a clinical facility such as a hospital or other institution. Peer workers with lived experienced and those from similar backgrounds are most able to relate and build trust with children and families in a mental health crisis.

Soft skills

ACRT staff must have the soft skills required to effectively support children, families and carers in crisis, as well as children with severe and enduring mental ill-health. These include:

- strong rapport building and relationship development skills
- work from a recovery and strengths-based approach
- provide non-judgemental support when interacting with children who are exhibiting challenging behaviours
- actively listen to and support children in a vulnerable state to identify what their most critical and immediate needs are, rather than being in ‘solution mode’
- ability to remain calm when interacting with highly erratic children who are in a mental health crisis
- resilient and child-focussed, that is, they are willing to go the extra mile to ensure the individual is supported to access follow up supports that best meet their needs.

By recruiting a workforce who possess soft skills and share similar values with individuals, families and carers who access crisis support via ACRTs, these teams will be able to establish a reputation within the community as a trusted and approachable provider of mental health crisis support, increasing the number of people who access support in the community and avoiding unnecessary ED admissions.

ACRTs must ensure that staff delivering clinical and non-clinical supports are open-minded, inclusive, empathetic and have demonstratable experience working with diverse people including those who are neurodiverse, LGBTQIA+, Aboriginal and Torres Strait Islander, and ethnoculturally and linguistically diverse. Recruitment within these teams should be focussed on

employing a workforce who can meet all the needs of children, families, and carers, not just the clinical capabilities they possess.

Staff wellbeing, training, and development

Stable, supportive staff environments will be critical to attracting, supporting, and retaining staff across ACRTs. There are a range of mechanisms to support the wellbeing and development of all staff working in these teams:

- where possible, permanent contracts of employment
- suitable living conditions and housing for all regional and remote staff
- clear professional development pathways for staff in ACRTs (including providing opportunities for peer workers and Aboriginal Mental Health Workers (AMHWs) to progress into new fields)
- flexibility of resources i.e. resources within Community ICAMHS might be able to transition between working in an ACRT and returning to their general scope of practice
- robust workforce planning and strategic rostering is critical to enabling ACRTs can provide a 24/7 crisis response service
- removing barriers to entering the workforce, as well as attracting and retaining staff. This could include removing the barriers to costs of training for Community ICAMHS staff to upskill to work as part of an ACRT.

Team structures

While Each Community ICAMHS Hub will have one ACRT, it is recommended that ‘Crisis Response’ and ‘Intensive Treatment’ be treated as two discrete functions. It is advised that individual roles should be clearly defined across these two functions to avoid ‘resource pull’. This acknowledges that there are similar skillsets and values required across both functions, and some degree of overlap between the type of supports provided given both functions focus on crisis care, and so a cohesive unit is important to building a supportive team environment. However, separation of duties and functions is critical for the success of this team upon rollout.

7.3 Infrastructure

Physical infrastructure

Given that ACRTs are primarily a mobile outreach team, physical infrastructure is less important to consider for the purposes of this Model of Care. The following is a summary of physical infrastructure considerations for ACRTs to deliver face-to-face care.

Location

ACRTs can provide crisis response and intensive treatment in settings that make children feel safe and comfortable and are easily accessible for families and carers. For example, services can be delivered in local Community ICAMHS Hubs, in a hospital setting, in the home, at school, or anywhere else in the community that makes the child and family feel safe. Where families and carers need to attend a physical location, these should be accessible by public

transport and have parking available. In many crisis response situations, it is likely that ACRTs will be required to travel to the child's home.

Facilities

ACRTs will be housed within Community ICAMHS Hubs, which will be accessible, child-friendly, and purpose-built facilities that enable trauma-informed and culturally safe mental health support to children, families and carers. ACRTs will be co-located with Community ICAMHS teams to provide a stepped response to care for children requiring intensive treatment. At each Community ICAMHS Hub, there should be a central office room that houses the phoneline component of ACRTs – where a staff member is on call to provide crisis response and de-escalation over the phone when connected.

Fleet and other equipment

Given that ACRTs are a mobile outreach unit that can provide face-to-face response – each ACRT requires a small fleet of vehicles that are suitable for transporting the multi-disciplinary team (MDT) to a crisis response situation or intensive treatment sessions with a child. Additional safety features should be considered if the child would need to be transported in the ACRT vehicle to another setting (e.g. an ED). In order to provide engagement activities to support de-escalation, ACRTs should have access to equipment such as:

- a 'toolbox' of sensory toys to support positive engagement with children and promote a calming, stable environment
- duress alarms
- a (locked) box of medications if this intervention is required
- technology to support de-escalation (see below).

Digital infrastructure

Reliable and suitable digital infrastructure will be a critical component in enabling ACRTs to provide flexible crisis response support, whether this be delivering care and treatment via telehealth, or capturing, accessing, and sharing information and resources digitally. In addition, technology can help make care more accessible, timely and easier to manage for children, families, and carers. Table 6 summarises the key digital infrastructure requirements for this Model of Care.

Table 6 | Digital infrastructure requirements

Digital infrastructure requirements to support staff and children, families and carers include…	
For staff	Appropriate portable devices, such as laptops, iPads, and smart mobile phones, with reliable internet connectivity / Wi-Fi and high-quality cameras to enable videoconferencing and telehealth.
	A data system that securely stores consumers' information and can be accessible by all those caring for the child, as long as permission has been granted by the child, family, and carers. This system should allow all staff involved in caring for the child to

Digital infrastructure requirements to support staff and children, families and carers include…	
	see the care plan, the appointments scheduled and undertaken, digital medical records, clinical information, child, family, and carer information, contact details, etc.
	Contemporary technology administration processes to streamline effort of non-frontline tasks.
For children, families and carers	A single point of contact phoneline to access crisis support (e.g. the Crisis Connect phoneline), as well as chatline features to be monitored 24/7.
	Access to virtual systems and tools that can support children to feel safe and communicate how they are feeling, and remain engaged with ACRT staff. This includes consideration of digital tools including headphones, iPads, phones, virtual reality, and augmented reality.

7.4 Other delivery considerations

Communication

As previously identified, it will be critical to ensuring the option of accessing ACRTs as an alternative crisis response support to EDs is clearly communicated to children, families and carers, as well as the broader community. Community ICAMHS should lead a public promotion and education campaign, including clear and ongoing promotion of the evolved Crisis Connect phoneline and 24/7 chat feature, with public communication in all local clinics, EDs, community centres, and online. This promotion campaign could consider people with lived experience of mental health issues as part of the team driving this initiative, as this may support accessibility of the service.

Pilot service

The size, scale, and composition of service delivery modes of ACRTs will vary significantly depending on demand within each region, and proximity to alternative services (particularly in regional and remote locations). It is recommended that one metropolitan and one regional pilot ACRT service be developed to understand the levels of virtual and face-to-face engagement required, so to understand how the team can complement Community ICAMHS services and also provide a sustainable alternative to EDs, where it is safe to respond to children in crisis in the community. Project management resources will be required initially to plan, coordinate service implementation, and monitor and evaluate the pilot service. Subsequently, this planning and monitoring should inform the development and set up of the service expansion to other sites.

8 Terminology

Table 7 below contains a list of the key terminology used within this Model of Care document.

Table 7 | Key terms used within this document

Term	Its intended meaning and use
ACCHO	Aboriginal Community Controlled Health Organisation
ACRT	Acute Care Response Team
AMHW	Aboriginal Mental Health Worker
AMS	Aboriginal Medical Service
Carer	A person who provides care to another person, such as a child who is living with mental ill-health. They may have statutory responsibility for a child, be a family member who supports a child in their family or be another peer or community supporter.
Children/Child	Any person who is under the age of 18. This term is sometimes used to describe all infants, children and adolescents aged 0-17 years of age.
Clinicians	Professionals engaged in the provision of mental health services, including but not limited to Aboriginal Mental Health Workers, administrative staff, allied health workers, nurses, paediatricians, psychiatrists, psychologists, and others.
Clinical supervision	Experienced health professionals providing guidance and oversight to less experienced health professionals.
Community ICAMHS hub	A central 'hub' in each region within WA that leads the provision of mental health supports and is a single point of entry for all children, families and carers.
Community ICAMHS clinic	A local clinic that can deliver care close to home for children, families and carers. The Community ICAMHS hubs will coordinate and support these clinics.
ED	Emergency Department
Family	A child's family of origin and/or their family of choice. It may include but not be limited to a child's immediate family, extended family, adoptive family, peers, and others that share an emotional bond and caregiving responsibilities.
GP	General practitioner
HSP	Health Service Provider
ICA	Infant, child and adolescent
ICA Culturally Safe Principles	ICA Culturally Safe Principles are intended to guide the delivery of culturally safe, responsive and quality health care to Aboriginal and Torres Strait Islander peoples.
ICAMHS	Infant, Child and Adolescent Mental Health Service
ICA mental health system	The public specialist infant, child and adolescent mental health services. This relates to services funded and provided by the WA Government.
MDT	Multi-disciplinary team

Term	Its intended meaning and use
Mental ill-health	This is a broad term that is used to include mental health issues, mental health needs, and mental illness. It relates to an experience of mental health issues impacting thinking, emotion, and social abilities, such as psychological distress, in addition to diagnoses of specific mental health disorders, such as depression and anxiety.
Model of care	A model of care broadly defines the way health care is delivered, informed by evidence-based practice. It outlines the care and services that are available for a person, or cohort as they progress through the stages of a condition or event.
NGO	Non-government organisation
People with lived experience	A child or young person who is or has lived with the impacts of mental ill-health and a person who is or has provided care to a child who is living with mental ill-health.
Service Guarantee	The Service Guarantee outlines what children, families and carers will expect to experience in their interactions with the ICA mental health system.
Staff	People who work within the ICA mental health system.
WACHS	WA Country Health Service

GOVERNMENT OF
WESTERN AUSTRALIA

GPO Box X2299, Perth
Business Centre WA 6847

Level 1, 1 Nash Street
Perth WA 6000

T (08) 6553 0600