GOVERNMENT OF
WESTERN AUSTRALIA

Infant, Child and Adolescent (ICA) Taskforce Implementation Program

Emergency Departments and Child Safe Spaces: A Model of Care

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1 Introduction

This document will guide the delivery of a **new model for improving the experience of infant, child and adolescent (ICA) mental health emergency department[1] (ED) presentations, and establishment of Child Safe Spaces as a safe, peer-led alternative to EDs that can provide respite and stabilisation**. This will deliver safer, calmer, and more comfortable environments for children in a mental health crisis, and improve the capacity of EDs to respond to their needs in a trauma-informed and culturally appropriate way.

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.[2] Under this Model of Care, **EDs** will move away from an environment that has previously been described as intensive, chaotic, oriented towards physical trauma, and distressing – towards providing an experience that is safe, therapeutic, and culturally appropriate for children and families in crisis. Further, establishment of **Child Safe Spaces** across Western Australia (WA) will enable some mental health crises to be safely and more appropriately supported in the community, subsequently reducing further strain on EDs and hospital capacity. These peer-led environments will be located near EDs, providing an option for respite, assessment, low-intensity treatment, therapeutic counselling, and supported access to Community ICAMHS.

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 that the future system needs to have two levels of responses in place for children in crisis, and the key features that should guide the development of the ED and Child Safe Spaces Model of Care to address the challenges identified by children, families and carers with living and/or lived experience of mental health issues, clinicians, system leaders, and the broader WA community. This included: 'immediate' responses to children in crisis, and 'follow up' care provided in the days and weeks post-discharge; a staffing model that enables safer, more appropriate responses; deliver a therapeutic model of care focused on providing respite and

[1] Note, this applies to all emergency departments, not just those operated by CAHS and WACHS.
[2] NSW Agency for Clinical Innovation, (2013), Understanding the process to develop a Model of Care. An ACI Framework, Sydney, 2013.

stabilisation; and an expansion of CAMHS Crisis Connect and WACHS ETS to support children waiting to access Community ICAMHS supports following an ED presentation.

Based on these key functions, this Model of Care was developed through the establishment of a Working Group that was responsible for designing the key features of the ED and Child Safe Spaces 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 Emergency Departments and Child Safe Spaces 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 safe alternatives to EDs will be provided to children in a mental health crisis; and where this is not possible, how the experience of children presenting to EDs will be improved through more supportive environments, trauma-responsive practice, and clearer pathways to follow-up support. 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 ICA 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.

The term ‘Aboriginal peoples’ has been used throughout the document and is intended to refer to all Aboriginal and Torres Strait Islander peoples.

Figure 1 | Service Guarantee Principles

Figure 2 | ICA Culturally Safe Principles

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 Case for change

More children and families 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 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/outreach 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 for children and families with needs

Gaps in where and how services are delivered have contributed to families and carers struggling to access appropriate community-based supports, 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. Further, 50% of presentations were by 12–15-year-olds – the cohort that has seen the largest growth in presentations since 2010, and 36% were by 16-17-year-olds alone. This increase in mental health ED presentations 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.

EDs are often distressing places for children experiencing a mental health crisis, and presenting can be a traumatising experience

While alternatives to the ED are required, for some children and adolescents, attending an ED in times of crisis will continue to be necessary. Children, families and carers report that EDs are not child friendly, trauma-informed or sufficiently accessible during a crisis. There are several reasons for these experiences:

- When a child experiences a severe mental health crisis, sometimes presenting at an ED can exacerbate their distress. They can be intense and chaotic, with long delays.
- Specialist paediatric hospital EDs are typically oriented towards physical trauma, while **rural EDs are primarily focused on adult healthcare**. This creates significant barriers to accessing immediate and acute mental health care.
- The ED can also be a highly stimulating environment characterised by bright lights and loud noises. This can exacerbate a person's distress and worsen the symptoms of their mental ill-health.

Furthermore, while many children and adolescents have positive interactions with emergency services, it was identified that children and adolescents tend to have poor interactions when presenting to the ED for mental health-related reasons. Many reported issues that negatively impacted their experience, including feeling judged, not listened to or a lack of confidentiality. At present there are no alternatives to EDs for ICA mental health crises.

What needs to happen?

We must improve the experience of children and adolescents presenting to EDs by enhancing the capabilities of staff working in EDs to appropriately treat mental health crises and supporting children to access follow up care post discharge. There is also a need for the establishment of safer, calmer and more comfortable environments adjacent to EDs for cases where a high stimulus environment is not appropriate.

3 Overview of the ED and Child Safe Spaces Model of Care

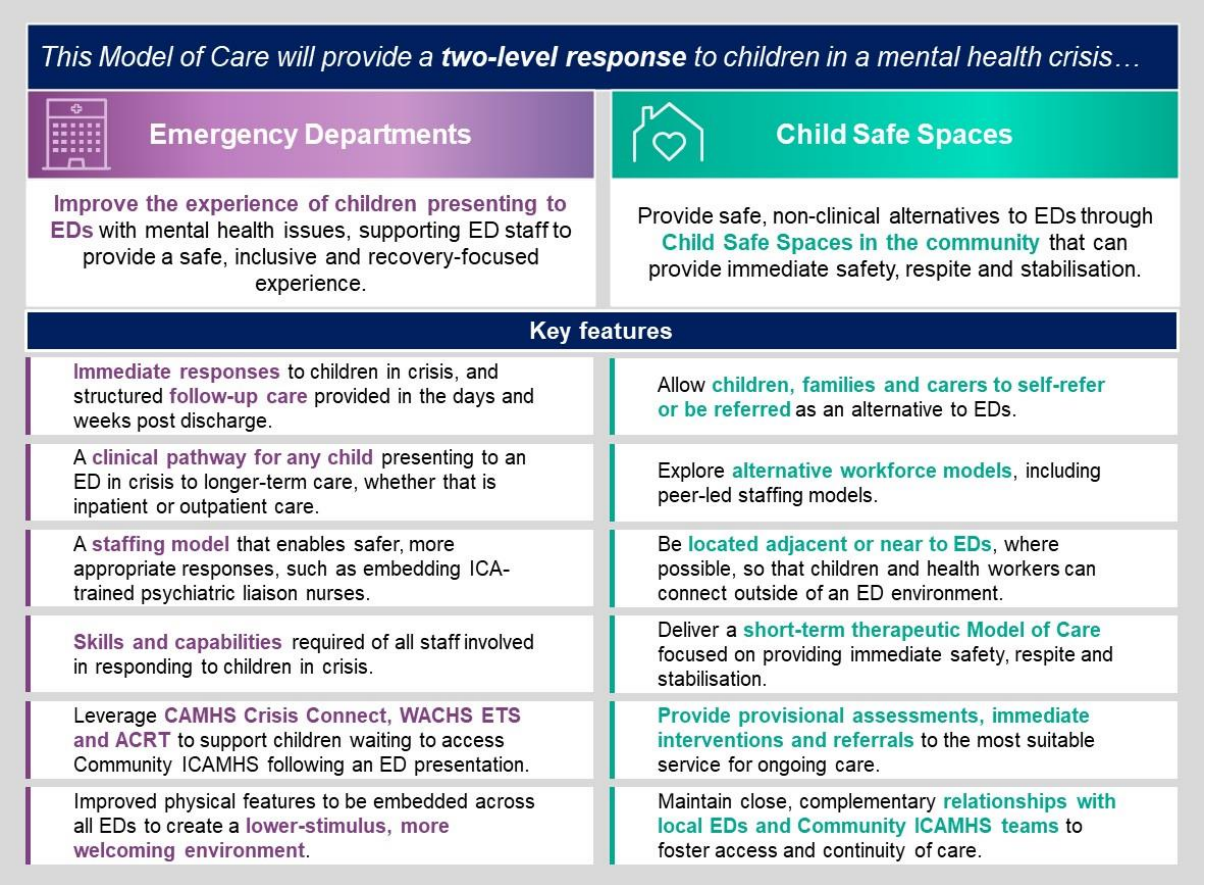
3.1 What is the ED and Child Safe Spaces Model of Care?

This model will provide a two-level response to children experiencing a mental health crisis:

1. **A new model for ICA mental health ED presentations.** A range of recommended features to improve the capacity of EDs to provide a safe, therapeutic and culturally safe experience for children presenting in a mental health crisis.
2. **Child Safe Spaces in the community.** Peer-led environments will be developed as a safe alternative to EDs for children in crisis that require respite and stabilisation.

A summary of the key functions provided by these two services is outlined in Figure 3 below.

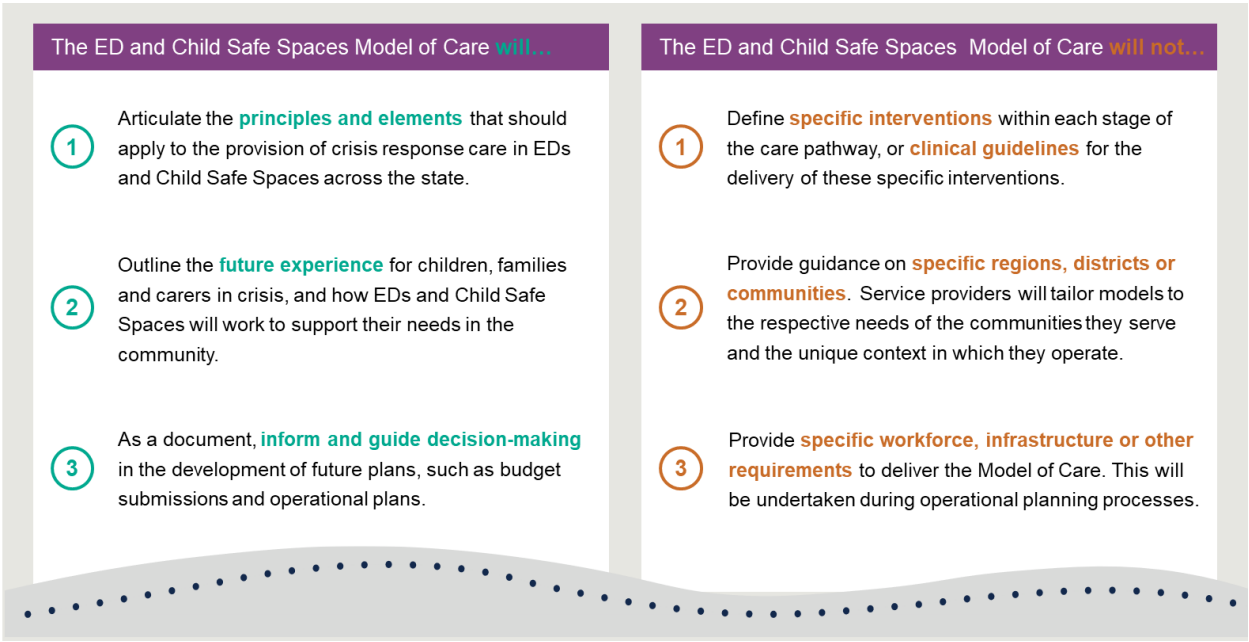
Figure 3 | Core features of the ED and Child Safe Spaces Model of Care



Model of Care's purpose and objectives

The purpose of this Model of Care is to establish safer, calmer, and more comfortable environments adjacent or proximate to EDs for children in a mental ill-health crisis, and improve their experience at EDs through enhancing the capability of ED staff to respond to children in a mental health crisis in a trauma-informed and culturally appropriate way. It will also support children to access follow up care through Community ICAMHS. 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 ED and Child Safe Spaces Model of Care



Under this Model of Care, crisis response care can be accessed by **all children** from 0-17 years old across WA in a mental health crisis, as well as their families and carers. This includes children who are experiencing significant emotional, psychological, behavioural or other mental health challenges, and require urgent support to keep themselves and others safe. While not all children will need to present to an ED or Child Safe Space, 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 EDs and Child Safe Spaces is intended to be as broad and inclusive as possible, but limited to those who require immediate support.** Sections 4 and 5 go into more specific detail about who may access each setting, given the range of supports available in these two environments.

A separate Model of Care is concurrently being developed to establish Acute Care and Response Teams (ACRT), a mobile intensive outreach unit that will be able to provide intensive treatment to children with severe and enduring mental ill-health, as well as responding to children in a mental health crisis who can be safely, appropriately and effectively de-escalated and stabilised in the community.

3.2 Model of Care outcomes

Collectively, this Model of Care 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 key outcomes are outlined below in Table 1.

Table 1 | ED and Child Safe Spaces Model of Care intended outcomes

Outcomes that the ED and Child Safe Spaces Model of Care 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 and adolescents feel listened to, **validated** and free from judgement when seeking crisis support. Support is delivered in a **welcoming and inclusive** setting with privacy measures in place.
	Children, families and carers are **supported to connect with local follow-up services** that will support them in their recovery journey. They are guided in their transition out of hospital into other services.
	Children, families and carers receive **education, information, and resources**, so that the reliance is not on families and carers to independently manage care or navigate the system, increasing their capacity to prevent future crises.
	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 these areas**	Staff in EDs feel **supported**, **trained** and **empowered** to deliver safe, high-quality and trauma-responsive acute mental health care to children, families and carers experiencing a mental health crisis, not only in cases of physical trauma.
	ED and Child Safe Spaces 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, supported by peer workers that are equipped to provide relationship-driven support.
	Staff have a **safe and sustainable environment**, where they are provided with adequate supports and resources to undertake their roles, no matter the location of where they work.

Outcomes that the ED and Child Safe Spaces Model of Care will achieve for …	
 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 Child Safe Spaces and ACRTs.
	The **system** is **aware** of the **supports** available to refer children, families and carers in EDs, and know where to go for support in these intense 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 ICA-specific mental health presentations to EDs

4.1 Overview

This model will improve the experience of children presenting to EDs with mental health issues. It includes a range of features across resources, infrastructure, roles, process and systems that should be embedded across all EDs to make the experience of children in a mental health crisis safe, inclusive and recovery focused.

Importantly, these features consider the contexts of all EDs across WA. Where necessary, information is provided about how this might look in a regional setting where the ED is not ICA-specific – but in all cases reference can be made to how local Community ICAMHS resources can support management and implementation of these initiatives.

4.2 Who might access EDs in a mental health crisis?

The target cohort of ICA-specific mental health presentations to EDs, those 'experiencing a mental health crisis who cannot be safely supported in the community', **encompasses a broad range of situations related to mental ill-health from the perspectives of children, family members and carers, and service providers.**

For this cohort, while it is assumed that they cannot be safely treated, stabilised and supported in a community setting through alternative services, and that the ED is the safest place for that child at that point in time, all children, families and carers will still have ultimate choice to present to an ED. Therefore, the cohort of children that may present to an ED in a mental health crisis should be treated as a broad definition with various presentations, and is not confined to any particular age-group, situation, acuity level or timepoint. This includes but is not limited to:

- children in a medical or psychiatric emergency as a result of acute mental health issues
- children who have self-harmed or at immediate risk of self-harm or harm to others
- children displaying actively aggressive behaviours due to mental ill-health who are an imminent risk to their own and/or others safety
- children presenting with acute mental ill-health symptoms such as suicidal ideation or unstable emotional distress
- any other situation in which the child, family or carer determines that they require support, and attend an ED.

This is to ensure that all children presenting to an ED requiring urgent mental health support can get access to the care they need, avoiding further deterioration of their mental health or

increased risk of physical harm. Further, it is critical that this flexibility is communicated with all potential referrers, 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.

Types of EDs this Model of Care applies to

This Model of Care applies to all EDs across WA, and therefore provides opportunities for all HSPs to improve the experience of children in a mental health crisis presenting to an ED, not just CAHS and WACHS. Note, this Model of Care provides broad opportunities for improvement, and therefore can improve the experience of:

- children attending specialist paediatric hospitals (e.g., Perth Children's Hospital)
- children who cannot attend Perth Children's Hospital, and therefore attend other Perth-based EDs that cater to all age cohorts
- children who attend regional EDs.

Given that the context of each of these settings is likely to differ, the opportunities described throughout this Model of Care are sufficiently broad and pragmatic to allow flexibility in how they are delivered. Where possible, detail has been provided on what this might look like for specific settings to provide clarity.

Further planning is required at HSP-levels to determine appropriate implementation of these initiatives, and where Community ICAMHS may support local improvements.

4.3 What are the key features that can be embedded to improve ICA-specific mental health ED presentations?

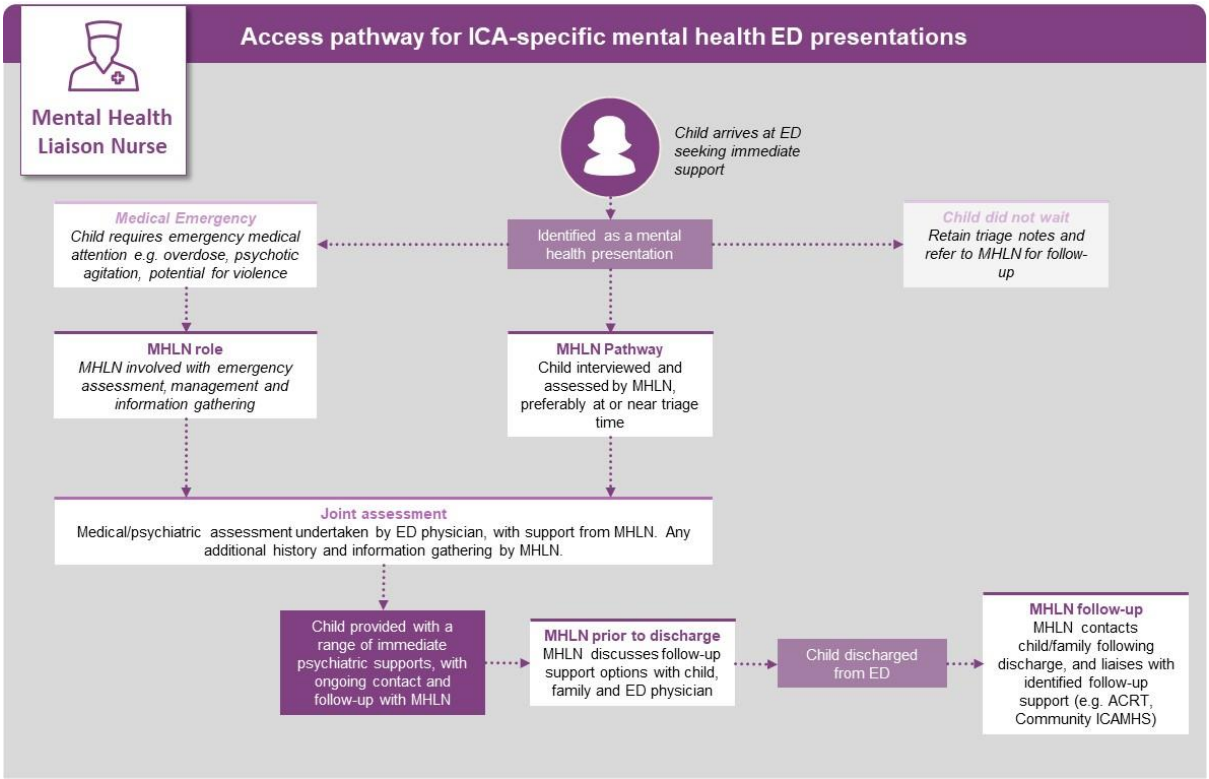
The following sub-sections describe the range of features that can be embedded to improve the capacity of EDs to respond to the needs of children in crisis in a trauma-responsive and culturally appropriate way. All other aspects of ED operations will remain 'business as usual', that is, the below is a list of specific opportunities for HSPs to enhance the ED experience for children, families and carers, and does not signal any change to ED management and governance.

Figure 5 | There are five broad opportunities to improve the ED experience of ICA-specific mental health presentations

4.3.1 The first point of contact should be a trauma-informed, ICA-trained Mental Health Liaison Nurse (MHLN), supported by peer workers

Access to EDs will be welcoming, equitable and responsive. Upon presenting to an ED, children in a mental health crisis, and their families and carers, should have immediate access to a ICA-trained MHLN for immediate support. The MHLN sees infants, children and adolescents with mental health concerns, and begins the process for coordinating care. This includes mental illnesses and disorders as well as drug and alcohol problems, behavioural and emotional disturbances, psychosocial issues, and patients having difficulty coping with physical illness. A flow chart outlining the pathway for mental health related presentations to the ED illustrates how the MHLN service adds considerably to the structure already in place.

Figure 6 | How a MHLN will be embedded for ICA-specific mental health ED presentations



In this first point of contact, children, families and carers may also be supported by a peer support worker to reduce distress and deliver an improved experience (see Section 4.3.4).

What are the benefits of a dedicated MHLN?

Recent evaluations[3] of MHLNs have found significant benefits for mental health ED presentations through reduced waiting times, streamlined experiences and improved access to follow-up care. This will also reduce workloads in other ED staff.

[3] Wand T. MHLN in the ED: on-site expertise and enhanced coordination of care. Aust J Adv Nurs. 2004

Resourcing constraints and regional options – MHLNs

This Model of Care is cognisant of current resourcing constraints, associated with recruiting MHLNs with existing training and/or capabilities in providing ICA-specific trauma-informed mental health care, particularly across regional WA. Given the large number of regional hospitals and EDs across WA that cater to all cohorts (i.e. are not ICA-specific), implementation of the MHLN initiative may require flexibility at a local level. This could mean that in a regional ED setting, the MHLN coordinates care for all (i.e. including youth and/or adult) mental health ED presentations if resourcing constraints apply, or if demand is insufficient a dedicated position may not be warranted. Alternatively, regional EDs can consider implementing a 'distributed' MHLN position, such that a small contingent of nurses receive ICA-specific mental health liaison training, and are committed to a proportion of their time being allocated to these presentations, while still undertaking other 'business as usual' activities. In any case, MHLNs should have capabilities to ensure they can provide trauma-informed, age-appropriate crisis response care.

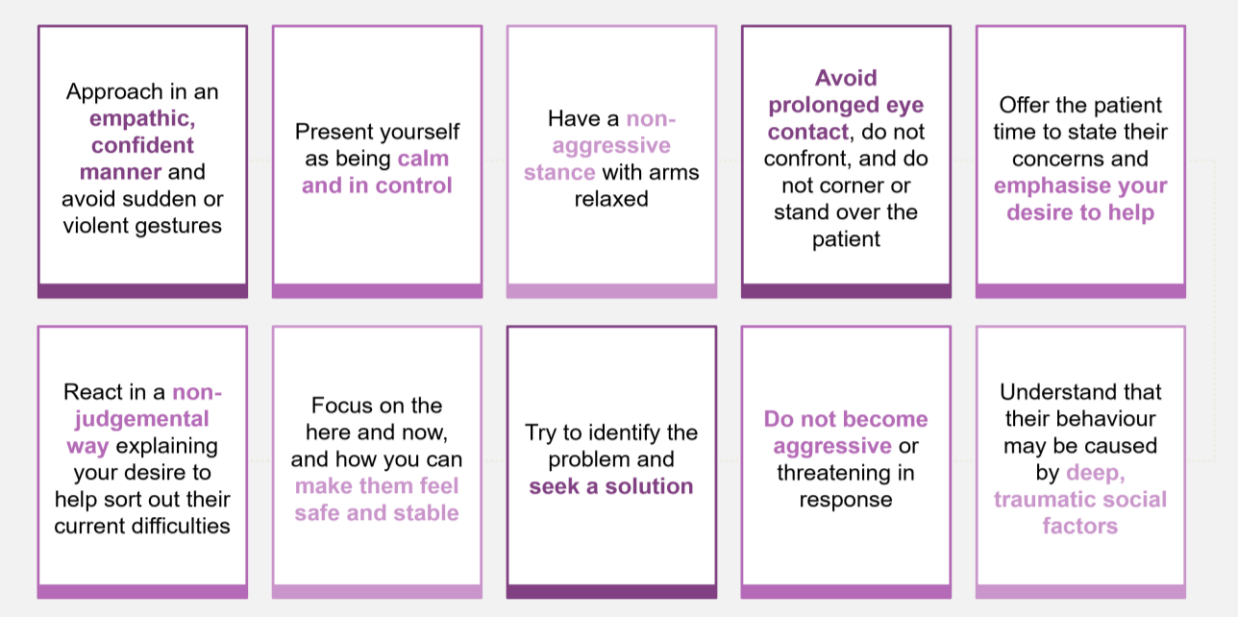
4.3.2 Presentation at an ED should be a non-judgemental, accessible process for a child during a mental health crisis

Empathetic, non-judgemental, and professional attitudes are critically important for the effective management of children in a mental health crisis.[4] A critical attitude on the part of the clinician is likely to result in an escalation of the child's symptomatology. It is important the young person feels heard and has a range of options to communicate how they are feeling and their levels of distress in a way that is flexible and trauma responsive. This includes having the option to be assessed alone and in private if they are uncomfortable around a parent or carer.

ED staff should receive education and ongoing training to be trauma-informed (e.g. appropriate, respectful language when communicating with children and families in distress). The initial approach to a child with mental health concerns should be de-escalation, de-stressing and other strategies that focus on engagement and stabilisation. This could include:

[4] Mental Health for Emergency Departments – A Reference Guide. NSW Ministry of Health. Amended March 2015.

Figure 7 | Ways of engaging safely with children presenting in a mental health crisis



These mechanisms will be particularly important for vulnerable cohorts of children who have previously struggled to access safe care in ED settings. This should include considering ways to support the safety and wellbeing needs of Aboriginal and Torres Strait Islander children and families, children from neurodiverse backgrounds, children from ethnolinguistically and culturally diverse (ELD) backgrounds, and children that identify as LGBTQIA+.

Upskilling of ED staff by Health Service Providers (HSP) and Community ICAMHS

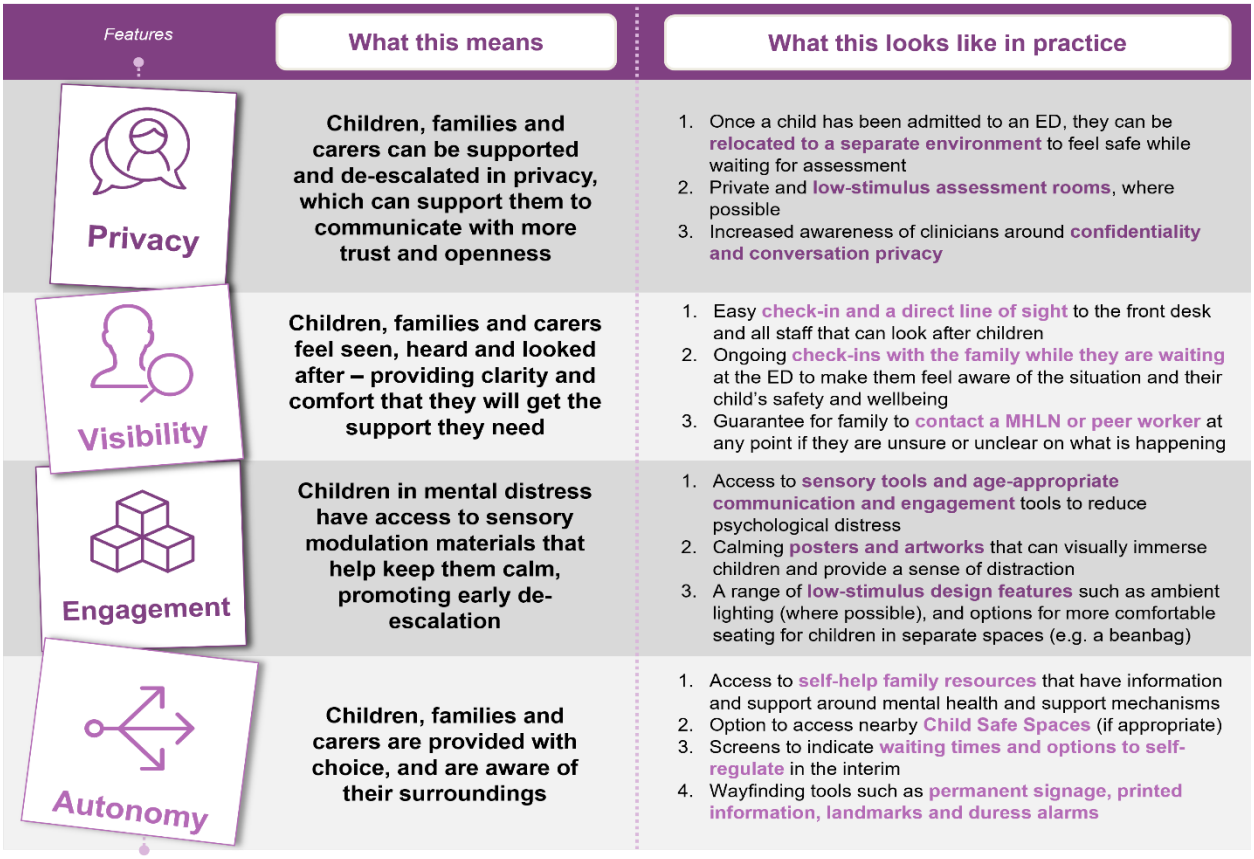
Upskilling ED staff across WA represents a significant challenge for the ICA public mental health system, but involves a large degree of planning and implementation. This will particularly focus on upskilling the large amount of staff in regional EDs, which are predominantly adult-focussed settings. At a local level through HSP leadership, Community ICAMHS can support the development of resources and training for ED staff to ensure they are equipped to respond to the needs of children in a mental health crisis, and their families and carers, in a way that is trauma-responsive, culturally safe and recovery-focused.

It is noted that Community ICAMHS will likely not have the capacity or required governance to provide supervision and ongoing training of ED staff across WA. Further HSP planning is required to determine how might Community ICAMHS provide the required expertise and learning resources that can be rolled out and implemented by HSP-leadership or leadership and development teams within tertiary settings. It is also recommended that this training be co-delivered with people with lived experience.

4.3.3 ED waiting rooms and other spaces can be enhanced to be a safer and more welcoming space for infants, children and adolescents in crisis

While EDs across WA range in size and scale – all children in a mental health crisis deserve the right to feel safe, visible, welcome and included when attending an ED. Waiting rooms should have a range of dedicated features and spaces to cater for diverse young people with different backgrounds and experiences.[5] This includes creating dedicated, low-stimulus spaces specifically for infants, children and adolescents in a mental health crisis – either as a section of the ED waiting room, or allocating separate spaces to help children (and their families) in crisis regulate and feel safe. While there are some limitations that constrain the ability of EDs to implement a range of design features that would often be seen in community-based services, there are a range of opportunities for EDs to move towards a lower-stimulus environment designed to provide support and stabilisation in a calm and welcoming space for children in a mental health crisis.[6,7,8] A more supportive ED environment can be created through architectural design focusing on privacy, visibility, engagement and autonomy (Figure 8).

Figure 8 | Safe, welcoming, and inclusive physical design features for EDs



[5] Note, in EDs that are not paediatric hospitals, this requires dedicated, separate child-friendly spaces and design features.
[6] Liddicoat, S. Improving hospital ED design for mental health presentations. Swinburne University of Technology, 2022.
[7] Qi Y, Yan Y, Lau SS, Tao Y. Evidence-Based Design for Waiting Space Environment of Paediatric Clinics. 2021.
[8] Rose, K. Designing for better mental health in the emergency department. HMC Architects, 2020.

Re-designing ED physical environments across WA

Similar to Section 4.3.2, the opportunity to improve the physical design of ED waiting rooms and other spaces represents a significant undertaking for HSPs in collaboration with local staff and communities. At a local level, children, families and carers should be involved in the re-design process to ensure EDs are more accessible, culturally appropriate, safe, welcoming and inclusive. It is recommended that in addition to training of ED staff, HSPs undertake a review of major EDs across WA to identify tangible opportunities to improve the physical space, in line with Figure 8 above. This may include a phased approach including a trial ED site before expanding the initiative to other EDs across WA.

4.3.4 Child and carer peer support workers will play a critical role in supporting the journey of children in crisis and their support persons in the ED

There is extensive literature that suggests embedding peer support workers in EDs to support children identified as a mental health presentation and their journey from first point of access to discharge could have significant benefits, if implemented effectively.[9] The uniqueness of peer support workers (rooted in principles of relationship, mutuality, shared power and equality) can help to reduce distress in children, families and carers in an ED environment. Figure 9 indicates a range of ways in which peer support workers may play a critical supporting role in the experience of children, families and carers across the duration of their time in ED.

Figure 9 | Practical ways peer support workers can improve the experience of children in a mental health crisis, and their families and carers

However, there are a number of barriers to providing peer support in an ED setting that require further planning at a community level, in collaboration with peer workers. These include the ED

[9] Minshall, C., Roennfeldt, H., Hamilton, B., Martel, A., Hill, N., Stratford, A., Buchanan-Hagen, S., Byrne, L., Castle, D.J., Cocks, N., Davidson, L. and Brophy, L. (2020). Examining the role of mental health peer support in emergency departments. Melbourne: Melbourne Social Equity Institute, University of Melbourne.

workplace culture, the medicalised or predominately clinical approach to care, time pressure, risk orientation, and lack of knowledge amongst EDs regarding mental health and personal recovery.[10] Further, the peer workforce generally faces challenges around difficulty accessing training and education[11], peer management and leadership roles[12], and peer supervision.[13] Enablers of good peer support include greater exposure to peer work practice, peer workers being embedded within multidisciplinary teams, mutual respect for peer and traditional staff, and understanding of the peer role. This is particularly important in an ED where individuals work shifts and key personnel, such as registrars, are routinely rotated.[14]

Figure 10 outlines some critical success factors that would be required to effectively support peer workers in creating a less distressing, more recovery-focused experience for children presenting to an ED in a mental health crisis.

Figure 10 | Critical success factors for embedding peer workers into EDs to support children, families, carers, and other staff[15]

4.3.5 Establish strong working relationships with other parts of the ICA public mental health system to foster integration, connection and follow-up support

To create a more connected, integrated, and seamless experience for children, families and carers, EDs should nurture strong working relationships with other parts of the ICA public mental health system. This will ensure children attending an ED in a mental health crisis are receiving the immediate support they need to feel safe and stable, but also are connected to

[10] Ibid.
[11] Byrne, L., et al., Taking a gamble for high rewards? Management perspectives on the value of mental health peer workers. International Journal of Environmental Research & Public Health, 2018. 15(4): p. 746.
[12] Byrne, L., A. Stratford, and L. Davidson, The global need for lived experience leadership. Psychiatric Rehabilitation Journal, 2018.
[13] Byrne, L., et al., 2018 (1).
[14] Minshall, C., et al., 2020.
[15] Minshall, C., et al., 2020.

follow-up supports to promote recovery and wellbeing in the longer-term. These ways of working will benefit how children, families and carers access crisis care, how they are supported in these settings, and how they are transitioned onto other settings with structured follow-up supports.

These are outlined below in Table 2.

Table 2 | Ways of working to create a more seamless and connected ED journey for children, families and carers

Area of improvement	What this will achieve	Required relationship and ways of working
Access to care EDs can support children in a mental health crisis to access Child Safe Spaces in the community at point of triage, if safe and appropriate.	Child Safe Spaces provide a lower-stimulus, less clinical alternative to EDs, and provide a community-based setting for children to receive immediate de-escalation and stabilisation support.	1. Child Safe Spaces should be located nearby or attached to major EDs, to facilitate ease of access. 2. There will need to be co-developed procedures for when and how children could access a Child Safe Space, depending on their presentations.
Expert support ED clinicians can access the telehealth component of ACRTs for specialist child and adolescent mental health crisis response expertise.	ED staff, particularly those in regional or general EDs, can access expert advice and support if required to effectively support an ICA-specific mental health presentation.	1. All ED staff to be aware of telehealth component of ACRTs at a local level. 2. Community ICAMHS will need to communicate the availability of this service to EDs in their area-based network.
Assessment Assessment is informed by past assessments undertaken by other mental health services, including Community ICAMHS and/or local community-based mental health services.	This will embed a 'tell your story once' approach, reducing the chance of re-traumatising children by having to re-explain information about their past supports, rather than focusing on their current needs.	1. MHLNs and other ED staff should access prior assessments and any other information from past interactions, including if the child has previously attended an ED, or information collated from a multi-disciplinary team where the child is under the care of Community ICAMHS. 2. The MHLN and/or ED physicians should look to contact the child's care coordinator, if relevant and possible. 3. ED staff should have access to Community ICAMHS databases, with appropriate restrictions and permissions in place.
Follow-up care – ACRTs If a child being discharged from ED is still displaying acute mental health symptoms and could benefit	Children, families and carers are provided with crisis support following discharge from an ED to ensure the	1. ED physicians can identify if the child would benefit from follow-up support from an ACRT, and communicate this with the child and their family.

Area of improvement	What this will achieve	Required relationship and ways of working
from ongoing intensive support to avoid imminent deterioration of their mental health and a repeated crisis, they could be supported to access community-based care from an ACRT.	family feels safe, supported and stable.	2. EDs will liaise with the local ACRT and provide a summary of the child's presentation, their current situation and immediate needs. 3. The ACRT will engage with the family either prior to discharge or shortly following it to communicate the range of supports they can offer and plan for next steps.
Follow-up care – Community ICAMHS When a child is being supported to transition away from the care of an ED[16], it must be informed by a clear plan including outreach support and linkages to other services, including an automatic referral onto Community ICAMHS.	Ensures that children experiencing acute mental health issues will have guaranteed, timely access to mental health supports in the community, providing continuity of care closer to home.	1. ED physicians can submit a referral to a local Community ICAMHS Hub for the child to receive ongoing care. 2. This would be embedded within the child's safety plan prior to discharge, and communicated to the child, family and carer. 3. ED will liaise with the local Community ICAMHS and provide a summary of the child's presentation, their current situation and support needs.

[16] Note, in the instance where a child needs to be transitioned from an ED to a paediatric inpatient ward (e.g., PCH), this Model of Care assumes that existing transfer protocols would remain in place.

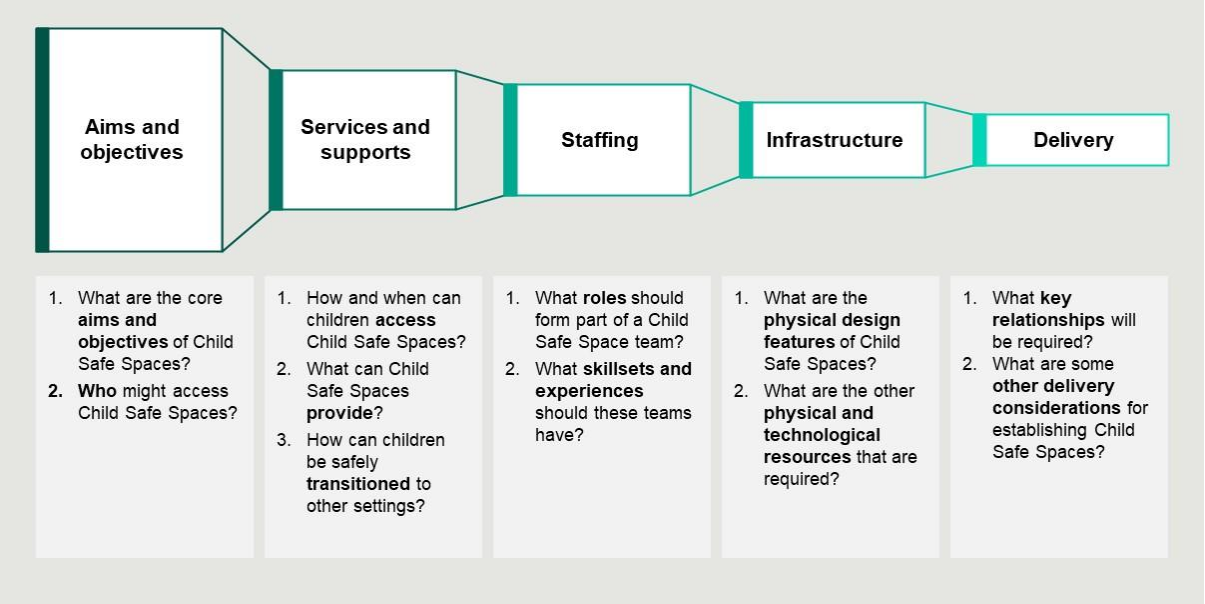
5 Child safe spaces

5.1 Overview

This model will provide safe alternatives to EDs through the development of peer-led Child Safe Spaces in the community that can provide immediate safety, respite and stabilisation. Child Safe Spaces will be a welcoming, low-stimulus environment for children, families and carers, acting as a less-intensive alternative to local EDs in instances where there is no immediate physical health concern, and the child and their family can be safely supported in the community. **This will be led by a primarily non-clinical workforce to engage and support individuals who require non-judgemental support, but with an appropriate number of clinical staff with the capability to undertake assessments, deliver short-term interventions and ensure clinical governance**.

This section outlines the key functions of Child Safe Spaces, which should be developed at a more operational level through further planning and implementation at a local level. It covers five key sections, outlined in Figure 11 below.

Figure 11 | Components of the Child Safe Spaces model



5.2 Aims, eligibility and target cohort

5.2.1 What are the core aims and objectives of Child Safe Spaces?

Child Safe Spaces in the community will be developed as an alternative to EDs for children in a mental health crisis that can be safely and effectively supported in the community. Child Safe Spaces have two overarching aims, with a number of related objectives, outlined in Table 3 below.

Table 3 | Aims and objectives of Child Safe Spaces

Aims	Objectives
1. Provide immediate support to assist children in a mental health crisis	Help children experiencing a mental health crisis to gain relief quickly and to resolve the crisis situation when possible
	Provide appropriate, child-centred, compassionate mental health care and support, avoiding unnecessary law enforcement involvement and ED admission
	Provide a safe environment for staff and children to enable positive engagement
	Provide immediate, brief support and advice to families and carers of children experiencing a mental health crisis
2. Support children, families and carers to access follow-up mental health supports, ensuring continuity of care and recovery	Increase knowledge of local supports and services, and how to access these services for children, families and carers
	Support individuals to engage with appropriate services and treatment to address the underlying factors contributing to their distress when they wish to be

5.2.2 Who might access Child Safe Spaces?

Child Safe Spaces will aim to provide short-term support to **children aged 0–17[17], and their families, who are experiencing a mental health crisis and require immediate respite and stabilisation support**, **as a less intensive alternative to presenting to an ED**. This should be treated as a broad definition and be as open and inclusive as possible, but limited to children and families who require urgent mental health support in the community. This acknowledges that there is a broad spectrum of risk in terms of crisis and suicidal behaviour – and that Child Safe Spaces will provide a safe, peer-led space staffed by peer workers and a small contingent of supporting clinicians and/or mental health workers for children and adolescents experiencing suicidal crisis or general mental health distress. This acknowledges the importance of a non-clinical workforce to engage and support individuals who require non-judgemental support, who can work closely with an appropriate number of clinical staff to undertake assessments, deliver

[17] While Child Safe Spaces will cater to children aged 0 – 17 to achieve a 'no wrong door' policy, it is expected that particular focus will be on supporting the needs of children aged 8 and above.

interventions and ensure clinical governance. Note, while Child Safe Spaces are a genuine alternative form of crisis response support in the community, it does not provide the same intensity of support as EDs or ACRTs. Therefore, a more fulsome and broad description of this target cohort has been introduced to acknowledge these differences. Examples of a child who may access Child Safe Spaces as an alternative to ED include but are not limited to:

- A child who is experiencing mental health issues has become increasingly distressed, but has walked into the ED and does not feel safe.
- 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 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'.
- An adolescent who has recently become street-present and is experiencing worsening mental health issues, and requires non-judgmental support to keep them stable and avoid becoming over-stimulated.
- A child recently presented to the ED and did not have a positive experience. A few weeks later, they are experiencing a mental health crisis but would prefer to speak to a non-clinical peer worker that can listen to them in a non-judgmental manner.
- A child previously diagnosed with borderline personality disorder that is currently receiving care from Community ICAMHS is feeling very overwhelmed in their home environment, and is looking for a low-stimulus environment that will prevent them from becoming at risk of self-harm.

Child Safe Spaces are not the most appropriate place for children if they are in a medical and/or psychiatric emergency, are displaying violent behaviours and cannot be safely de-escalated, or require intensive clinical support. The safest place for a child experiencing a medical emergency due to mental ill-health is in an ED. Alternatively, if the child requires crisis response support but an outreach option is deemed to be safer for the child and their family, ACRTs can become involved and provide more intensive crisis response support. If children or families determine they require ongoing support, Child Safe Spaces' peer workers will link children back to mental health Community ICAMHS teams, GPs or other care providers – so to ensure continuity of care.

5.3 Care and supports

5.3.1 How and when can children, families and carers access Child Safe Spaces?

Children should be able to attend Child Safe Spaces through a broad range of pathways, with limited barriers to access

No formal referral is required to access a Child Safe Space; it can be accessed in the following ways:

- Children requiring immediate mental health assistance can access the space as a 'walk-in'.
- Families and significant others of children in a mental health crisis who have expressed a desire for immediate assistance can bring their child in for support.
- A Community ICAMHS worker can assist children to present for immediate support.
- Other child and youth community-based social mental health, alcohol and other drug, health, or social services, all of which can support children to access the Child Safe Space.
- Police and paramedics can bring children in need to the space as an alternative to EDs or police lock ups.
- The ED can facilitate transfer of the child to the space if they require immediate support, but no physical threat or risk of harm is present.
- ACRTs may provide immediate de-escalation support, and then support access to a local Child Safe Space if further immediate support would be of benefit to the child and their family.

Children are able to access a Child Safe Space on an ongoing basis as required; however, it is not intended to provide ongoing accommodation. If it is observed that a child is accessing the Child Safe Space on a regular basis, staff are encouraged to explore options with a view to engaging the child in alternative services that will better meet their needs.

Access – Child Safe Spaces operating hours

Child Safe Spaces will operate at extended hours including evenings, with the aspiration to be expanded to 24/7 operation over time depending on community need. Consideration could be made as to the benefits of ensuring Child Safe Spaces have as much coverage as possible, and where this cannot be achieved, opening hours could better reflect availability when other services and supports are less likely to be accessible, such as in the evenings or on weekends.

Child Safe Spaces will adopt a trauma-informed 'no wrong door' approach to ensure children can access the level of support they need

An important principle of all Child Safe Spaces is a 'no wrong door' approach, which aims to ensure all children are welcomed and able to access support of some level within the space. The role of a Child Safe Space is to welcome, listen and understand a child's needs.

As mentioned in Section 5.2.2, the target cohort of Child Safe Spaces should be treated as a broad definition and be as open and inclusive as possible, but limited to children and families who require urgent mental health support in the community. This also acknowledges the existence of more intensive crisis response services that may be more appropriate, including both ACRTs and EDs. To deliver on a no wrong door approach, in the situation where a child does not require immediate or crisis support from a Child Safe Space but could benefit from accessing other services, staff can support the child and their family in identifying and accessing alternative supports and services such as community centres, drop-in hubs, hostels or social services. Although children in a medical and/or psychiatric crisis should be admitted to an ED, Child Safe Spaces should liaise with a nearby ED immediately to facilitate access to crisis support as soon as possible.

Further, children who at first display challenging behaviours due to severe mental ill-health could significantly benefit from access to a highly empathetic mental health or social worker that could de-escalate the child's situation safely, and therefore should not be seen as unsuitable to access the service. Child Safe Spaces should develop a procedure to facilitate alternative engagement and referral options for children when the facility is full.

5.3.2 What can Child Safe Spaces provide to support children in a mental health crisis, and their families and carers?

A meaningful 'first point of contact' to reduce distress and set the direction for a positive engagement

Children in a mental health crisis will attend a Child Safe Space because of its capability to be a genuine crisis response alternative to EDs, providing a peer-led lower-stimulus environment that makes them feel safe, welcome and included. Therefore, the 'first impression' upon their connection to and arrival at a Child Safe Space is critical to promoting positive engagement with

the child, and improving opportunities to de-escalate their current situation. Upon arrival, children should be warmly greeted by a peer worker who starts building trust and rapport, and helps children and families to feel safe and welcome. Components of a safe, relationship-driven model include[18]:

- reassurance that the child has come to the right place
- not having to undergo a formal assessment or triage process
- a peer worker sensitively enquiring to understand what a child or family member might be needing from the safe space
- children feeling comfortable and in control with when and how they share their experience with a suicide prevention peer worker
- the child having the ability to define the role or presence of their carers or loved ones in the space
- clear information about what the safe space involves, including what support is available (and what is not), managing capacity (including any waiting times), staff roles and the expectations of children and families.

This first impression is important to understand the child's situation and needs, and should allow the child and family members to tell their story. It should not create a barrier between the child and the staff member.

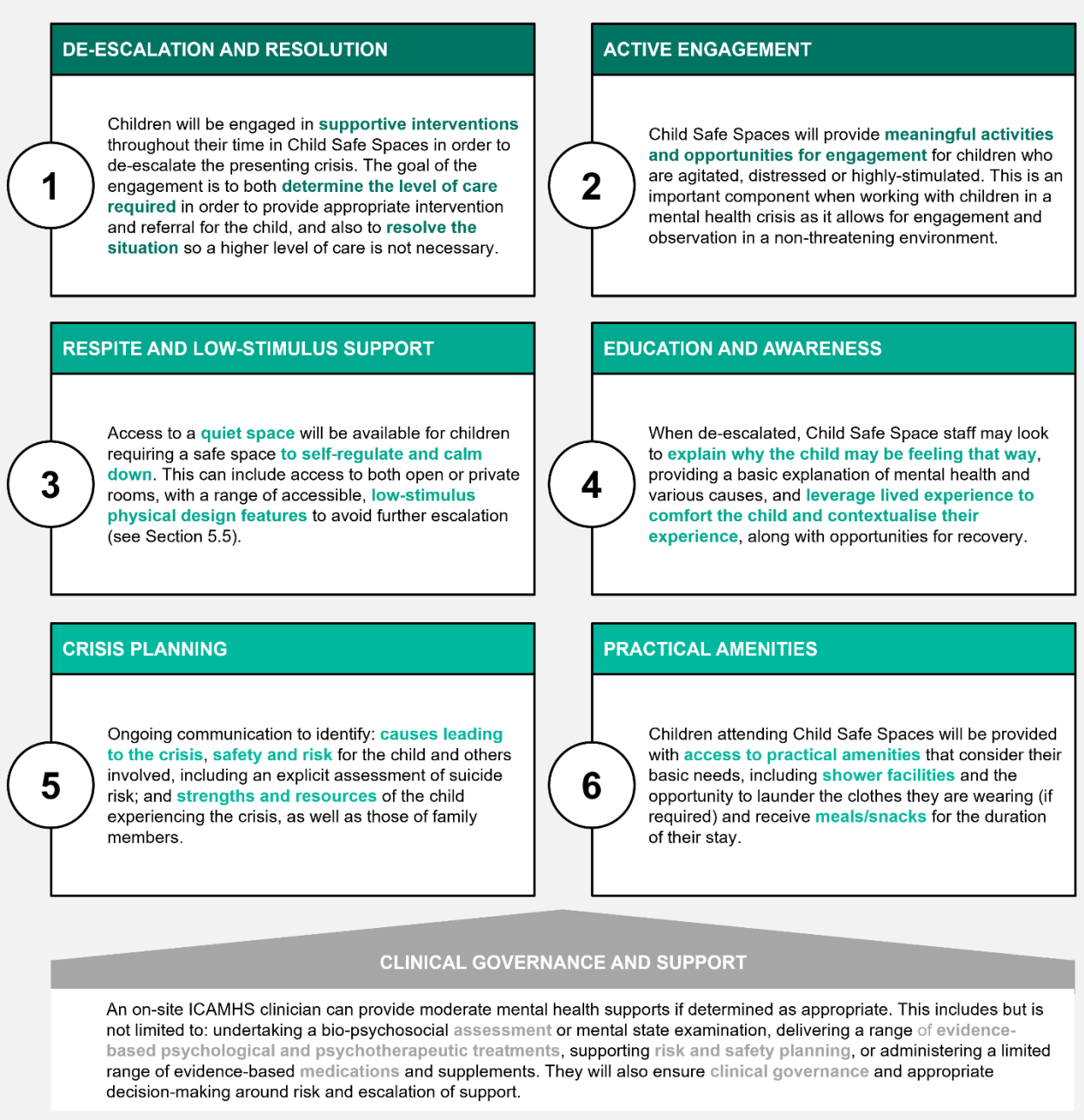
Child Safe Spaces will provide immediate access to holistic supports that meet the needs of children, and their families and carers

Child Safe Spaces will provide a broad range of supports as a genuine alternative to EDs for children in a mental health crisis, focusing on providing immediate support to de-escalate the child's current situation and any physical harm. If a child has been brought into a Child Safe Space by a family member or carer, that person will also be provided with immediate, brief support. **This will be led by a small contingent of peer workers that facilitate safe, supportive interactions, with clinical support from a clinician or mental health worker that could be from a range of professional backgrounds.** This workforce profile is critical to establishing a relationship-driven model focused on engagement, trust and stabilisation – but also supports the capacity of the non-clinical workforce to be supported by clinical governance and capabilities that may be critical to preventing further risk or harm.

The core supports offered by Child Safe Spaces are outlined in Figure 12 overleaf.

[18] Roses in the Ocean, 'Report: A Safe Spaces Narrative. Emerging outcomes of Safe Spaces co-design'. Beacon Strategies, 2021.

Figure 12 | Core immediate supports provided by Child Safe Spaces



Note – scope of supports available

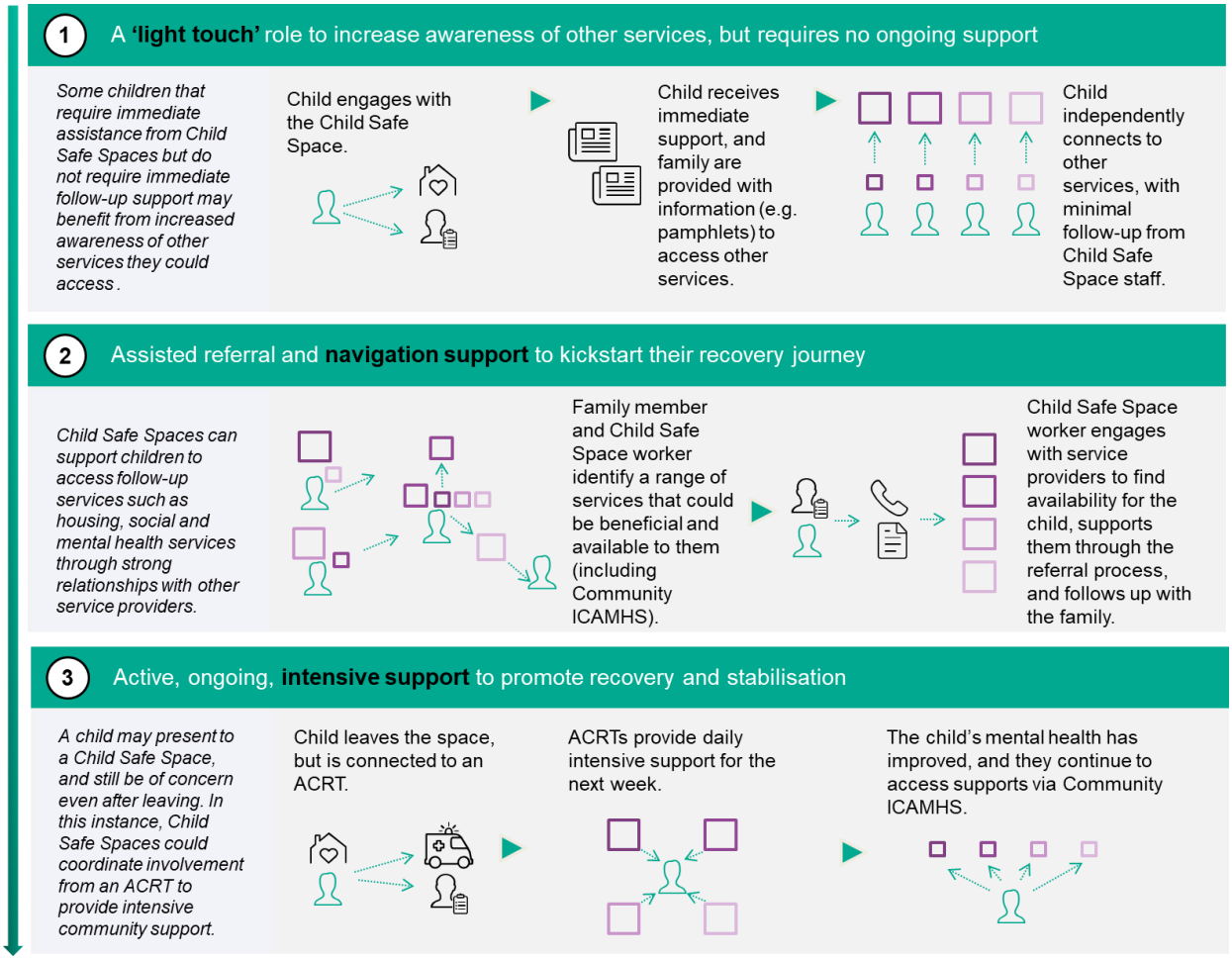
Child Safe Spaces will not provide **intensive** clinical treatment or therapies, as they are intended to be a peer-led environment for children experiencing mental distress, rather than a comprehensive multidisciplinary clinical team with specialised capabilities. If children or families determine they require immediate and intensive clinical support, Child Safe Spaces' peer workers will link children back to more intensive crisis response services, such as ACRTs or an ED.

5.3.3 How can children be safely transitioned to other settings?

Child Safe Spaces can play a flexible coordination and referral role that is broad, inclusive, and tailored to the child's needs and circumstances

Child Safe Spaces will play a critical role in supporting children, families and carers to access follow-up supports, ensuring continuity of care and recovery. This role should be highly tailored to the individual needs of children, families and carers. While some children and families may only require (or be willing to receive) light touch coordination and support, others will require, and be ready for a more 'hands on' coordination role. This concept is outlined below in Figure 13.

Figure 13 | Types of coordination and referral support that Child Safe Spaces staff could offer



Support – duration of stay

The possible length of stay will vary for each child, determined by their presenting issue(s), immediate and ongoing needs. Assuming that Child Safe Spaces operate at 24/7 capacity, in a limited number of circumstances, children will be able to stay at the space for up to 24 hours. The 24-hour period will allow for stabilisation, assessment of ongoing treatment and social support needs and referral.

5.4 Staffing

5.4.1 What roles should form part of a Child Safe Space team?

Child Safe Spaces' staffing profile will be a peer-led model (with some clinical support) to provide a lower-intensity, trusting, safe environment for children in crisis

Child Safe Spaces should predominantly be staffed by peer workers or other non-clinical mental health workers (e.g. Aboriginal Mental Health Workers (AMHW) in some instances) who have demonstratable experience of working with children with acute and complex mental health issues, and the skills and lived experience to understand those presenting with suicidal crisis. To compliment this contingent, each Child Safe Space will be supported by an ICAMHS clinician that can oversee clinical governance and risk, as well as support engagement and de-escalation activities with moderate mental health supports as required (see Figure 12).

The scope of services provided by Child Safe Spaces is largely focused on engagement and de-escalation, which in itself requires strong relationship-building between staff and individuals. Children are accessing these spaces to feel safe and promote recovery from distressing mental health situations, not medical crises. Therefore, a peer-led model in these spaces reflects a focus on emotional trust and rapport, rather than reflecting a specialist clinical facility such as a hospital or other institution.

Individuals with lived experience and those from similar backgrounds who are most able to relate and build rapport with children and families struggling with mental health will be critical to the success of Child Safe Spaces.

To provide oversight and day-to-day management of Child Safe Spaces, it is recommended that a service manager with relevant experience and shared values (see below) be employed to support the scope of practice of peer workers.

5.4.2 What skillsets and experiences should these teams have?

Soft skills such as non-judgmental support and shared values are critical for all roles within Child Safe Spaces

Soft skills and shared values of staff will be as important as technical capabilities in providing inclusive care that is non-threatening and makes children in a mental health crisis feel safe and supported. Some of the skills and values that Child Safe Spaces staff should possess are outlined below in Figure 14.

Figure 14 | Soft skills and values of Child Safe Spaces staff

By recruiting staff who possess soft skills and share similar values with children, families and carers who access Child Safe Spaces, the service will be able to establish a reputation within the community as a trusted and approachable provider of safe and effective mental health crisis support. This will be critical to increasing the number of people who access support and kickstart their recovery journey, as well as minimising harm in those in a mental health crisis and subsequently reducing pressure on local EDs.

Staff will be open-minded, inclusive, empathetic and have demonstratable experience working with diverse people including those who are neurodiverse, LGBTQIA+, Aboriginal and Torres Strait Islander, and ELD. Recruitment should be focused on employing a workforce who can meet all the needs of children, families and carers.

Staff should represent the diversity of those who might access the service, including Aboriginal and Torres Strait Islander, LGBTQIA+ and ELD groups

To ensure Child Safe Spaces are delivered and supported by staff who can meet the needs of children, families and carers, these spaces need to employ a workforce that reflects the diversity of the community it serves. Child Safe Spaces, where possible, need to employ a diverse range of people including those who are LGBTQIA+, Aboriginal and Torres Strait Islander, and ELD. This should also consider recruitment of AMHWs and cross-cultural peer workers who provide greater capacity to support children and families from vulnerable backgrounds and cohorts. Children and families who can see themselves reflected in the staff of the service will be much more likely to engage and trust the service with their recovery and be willing to access these spaces in the future, if required.

5.5 Delivery environment

5.5.1 What are the physical design features of Child Safe Spaces?

A warm and welcoming environment that promotes de-escalation, inclusivity and safety

When children, families and carers enter a Child Safe Space, they will walk into a warm and welcoming physical environment that underpins a low-stimulus, recovery-focused experience. This requires consideration of the configuration and layout of the physical environment, aesthetic and sensory experiences, facilities and amenities, and the inclusiveness of the environment to children from diverse backgrounds, cultures, genders and abilities.[19]

The ideal environment is immediately welcoming upon entry, without the need to enter via a reception area or complete any paperwork, and no barriers that exist between staff and guests. The physical environment of Child Safe Spaces will be predominantly 'open plan', and not include 'treatment type rooms'. However, quiet spaces will be available, so to enable children to find an environment that meets their needs, and engage privately with a peer worker or supporting clinician comfortably and privately. This could mean a child talking to a peer worker in a quiet space, or even to rest and recuperate in a comforting environment, or engage in supportive activities in a self-directed way in a 'central living room'. It is recommended that the open space also have access to WiFi, computers and phone chargers.

Features within Child Safe Spaces should include both safety considerations as well as practical low-stimulus design features. Green space, dim lights, neutral colours, natural lighting and available refreshments will create the right low stimulus, welcoming environment.

To embed culturally safe and inclusive design, Child Safe Spaces should consider:

- including Aboriginal and Torres Strait Islander, LGBTQIA+ and ELD children in the facility design process
- having an Acknowledgement of Country plaque featured at the entrance to the facility
- display culturally appropriate and relevant art throughout the space
- in certain regions, there should be an abundance of culturally appropriate signage around the facility to promote connection to language and culture.

5.5.2 What are the other physical and technological resources that are required?

Child Safe Spaces should be situated in a safe and accessible location, tailored to community need

Child Safe Spaces will form as a legitimate alternative to EDs to support children in a mental health crisis in the community. While the exact number and location of Child Safe Spaces across the regions is to be determined through further planning from HSPs, selecting the right location is critical in ensuring the safety and accessibility of a Child Safe Space.

[19] Roses in the Ocean, 'Report: A Safe Spaces Narrative. Emerging outcomes of Safe Spaces co-design'. Beacon Strategies, 2021.

Consideration of location should include the physical building or venue itself, as well as other factors such as geographical location and proximity to other services, opening days/hours, and historical context of the building or site in how it has been used previously.[20]

Considerations around the ideal location of a Child Safe Space include:

- a building that resembles a regular home, cafe or lounge
- located off hospital grounds, but in close proximity to an ED and/or other services to facilitate ease of access if clinical support is required
- a permanent space, rather than a temporary or makeshift structure
- centrally located and easily accessed within a community (e.g. parking, public transport)
- safe to access at all times of day
- accessible for people of all abilities.

For Child Safe Spaces located in busy, central communities or in high-risk areas, there are several associated risks that must be considered. This should include staff ensuring that children can be safely transitioned back to another environment, such as their home, safely and effectively. Child Safe Spaces should also actively engage with children and families in a broad range of suburban communities to avoid these spaces becoming inaccessible due to reluctance of families to bring a child in a heightened state to travel into a Child Safe Space.

5.6 Delivery considerations

5.6.1 What key relationships will be required?

Child Safe Spaces will have warm connections to other appropriate and reliable supports

A key component of Child Safe Spaces is connecting children, families and carers to other services and support within their community relevant to their needs, and providing follow-up upon leaving the space. Strong working relationships with Community ICAMHS, community-based social and mental health services, and EDs will be critical to the success of Child Safe Spaces in the community.

Table 4 | Key relationships for Child Safe Spaces

Community ICAMHS ***This includes facilitating access to ACRTs***	▪ Child Safe Spaces should be directly linked to a Community ICAMHS Hub to: ○ liaise with a care coordinator if that child is currently under the care of Community ICAMHS ○ facilitate access to an ACRT, if required ○ support a direct referral to Community ICAMHS for the child if they require follow-up mental health

[20] Roses in the Ocean, 'Report: A Safe Spaces Narrative. Emerging outcomes of Safe Spaces co-design'. Beacon Strategies, 2021.

	support (this is highly likely going to be required if the child is not already receiving support).
Community-based services ***This includes Aboriginal Community Controlled Health Organisations (ACCHOs), other mental health providers, housing, government social services, local health services (i.e. GPs), education and training, financial support services, and community support groups***	▪ Child Safe Spaces will need to cultivate a range of key relationships and referral pathways with local and community-based services as part of its core business. ▪ Child Safe Spaces will act as a conduit between other services and helping connect children and families to continue their recovery journey.
EDs	▪ Clear policies and processes in place if a child presents to a Child Safe Space but is in a medical and/or psychiatric emergency and needs to be taken to a nearby ED. ▪ Clear policies embedded in ED triage system to support transfer to a nearby Child Safe Space if they could be safely supported and de-escalated in a community setting.

5.6.2 What are some other delivery considerations for establishing Child Safe Spaces?

Strong, shared governance and management processes are critical to success

Child Safe Spaces need to be underpinned by strong, shared governance approaches that ensures the safety, quality and effectiveness of supports provided, while honouring the values and principles of low-stimulus environments and a peer-led model. This includes:

- Strong governance processes and policies need to be embedded across all service components to ensure decisions are safe. Where clinical risk is involved, the ICAMHS clinician at the Child Safe Space should lead this process to support the peer worker contingent and ensure clinically safe management and escalation processes.
- Ongoing staff training in de-escalation and other trauma-informed crisis management techniques. This is critical to building a pipeline of skilled, trauma-informed peer workers and clinicians working in crisis response services, who also have adequate professional and personal supports. It is recommended that Community ICAMHS establish professional training pathways and personal support networks for all Child Safe Spaces staff.
- Maintaining the commitment to a non-clinical approach to the Child Safe Space while integrating with existing nearby clinical settings (e.g. EDs)

- Staff roles and/or capability statements referencing the responsibilities of staff pertaining to child safety, health and wellbeing, managing risk and oversight.
- Transparent complaints processes, including how to raise concerns and issues, as well as escalation pathways and who will be responsible for taking these complaints forward.
- Determining critical incident or emergency processes (e.g. duress alarms) that align with the values and principles of Child Safe Spaces.
- If possible, establishing governance and oversight mechanisms that involve generous and appropriate representation from people with lived experience.

A pilot process may be required to effectively scale up the delivery of Child Safe Spaces across WA

It is recommended that this model be implemented through a pilot process to plan, develop and establish a Child Safe Space in a metropolitan and regional setting before 'rolling out' Child Safe Spaces across WA. This is to ensure Child Safe Spaces are configured, staffed and supported appropriately as an alternative to EDs, and will require an active role in educating the community about these spaces to improve access and reduce strain on EDs. It is recommended that people with lived experience of mental health issues be involved in the design, set up and promotion of Child Safe Spaces in the community reflect the needs of children, families, and carers.

6 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 acute care and crisis response in infant, child, and adolescent mental health.

Table 5 below contains a list of the key terminology used within this Model of Care document.

Table 5 | Key terms used within this document

Term	Its intended meaning and use
ACCHO	Aboriginal Community Controlled Health Organisation
ACRT	Acute Care and Response Teams
AMHW	Aboriginal Mental Health Worker
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.
ED	Emergency Department
ELD	Ethnoculturally and linguistically diverse
Family	A child's family of origin and/or their family of choice. It may include but not be limited to a child's immediate family, extended family, adoptive family, peers, and others that share an emotional bond and caregiving responsibilities.
GP	General practitioner
HSP	Health Service Provider
ICA	Infant, child and adolescent
ICA Culturally Safe Principles	CA 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.
MHLN	Mental Health Liaison Nurse
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

Term	Its intended meaning and use
	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.
Peer support worker	A peer support worker is someone with lived experience who is there to support the child, families and carers. They may provide emotional and psychological supports; be in attendance at appointments; or be an advocate and/or champion for the child, family and carers.
People with lived experience	A child or young person who is or has lived with the impacts of mental ill-health and a person who is or has provided care to a child who is living with mental ill-health.
Service Guarantee	The Service Guarantee outlines what children, families and carers will expect to experience in their interactions with the ICA mental health system.
Staff	People who work within the ICA mental health system.

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