



Behavioural Health Clinic – An Innovative Allied Health-Led Model Responding to Paediatric Emergency Department Social Behavioural Presentations

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Background

A paediatric **Social Behavioural Crisis (SBC)**, refers to paediatric Emergency Department (ED) presentations involving acute behavioural dysregulation. Typically including neurodevelopmental (diagnosed, undiagnosed or underdiagnosed), mental health, substance misuse, trauma exposure and/or inadequate service access. These children and families frequently present to ED's in extreme distress, with limited understanding of what supports are available, or how to access them. At Princess Margaret Hospital (PMH) and Perth Children's Hospital (PCH), a 55% increase in SBC presentations was recorded between 2014 and 2022 Fig(1).

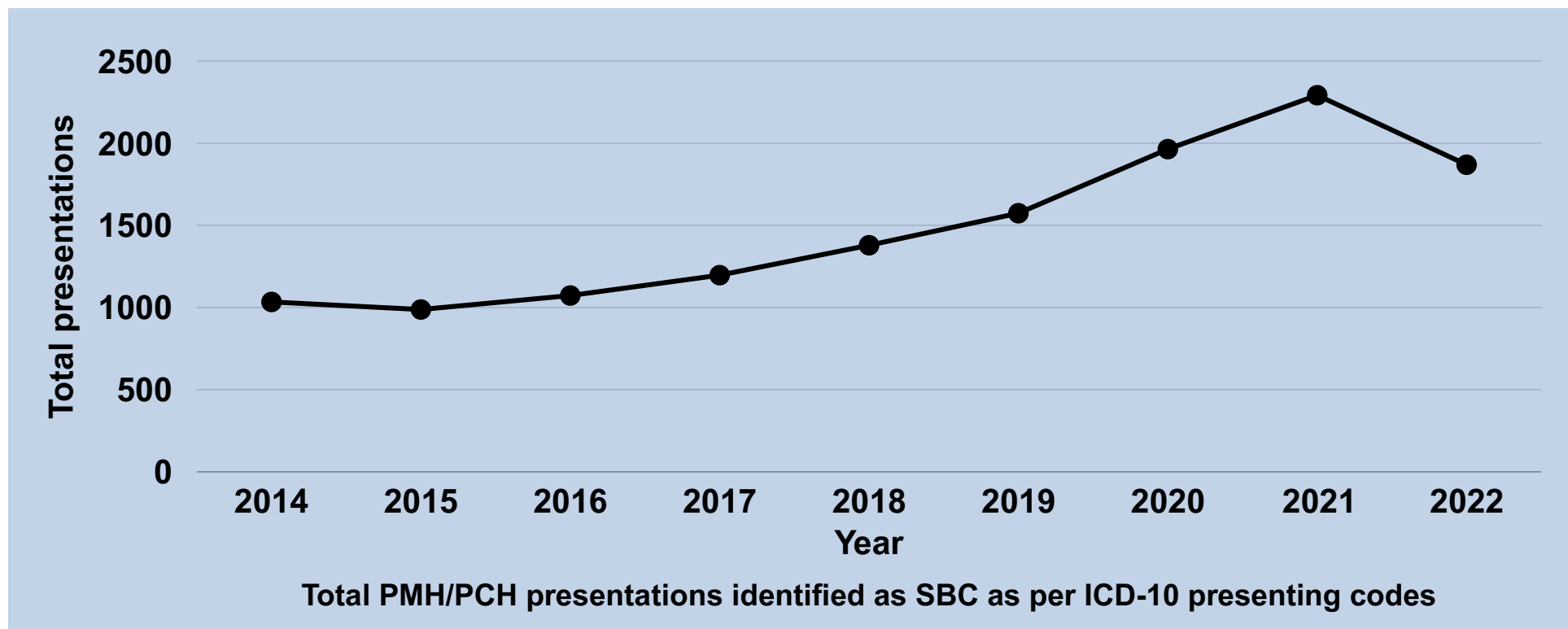


Fig (1)

Existing ED pathways, lack relational assessment and continuity and are therefore unable to meet the emotional, behavioural, and psychosocial needs of this cohort. Frequently resulting in reactive or fragmented responses. SBC presentations are becoming increasingly common in ED's across Australia and internationally. Western Australia lacks a defined care pathway for this patient group.

The Behavioural Health Clinic Model

The Behavioural Health Clinic (BHC) was established in response to this service gap. The BHC is a trauma informed, allied health led rapid response clinic, piloted at PCH. Providing short-term intervention to families referred after ED presentation.

The clinic aims to

- Stabilise families in crisis
- Reduce caregiver distress
- Facilitate access to community supports
- Reduce frequency of behavioural escalations
- Reduce unnecessary ED presentations

Led by Senior Social Work with Occupational Therapy as indicated, the clinic offers parent/s up to four outpatient sessions. Child involvement in sessions is by assessment. Appointments are ideally scheduled within 7 days of ED discharge. Sessions are facilitated in a non-clinical outpatient setting at PCH. Clinicians work relationally and flexibly, responding to each family's unique concerns.

Inclusion criteria

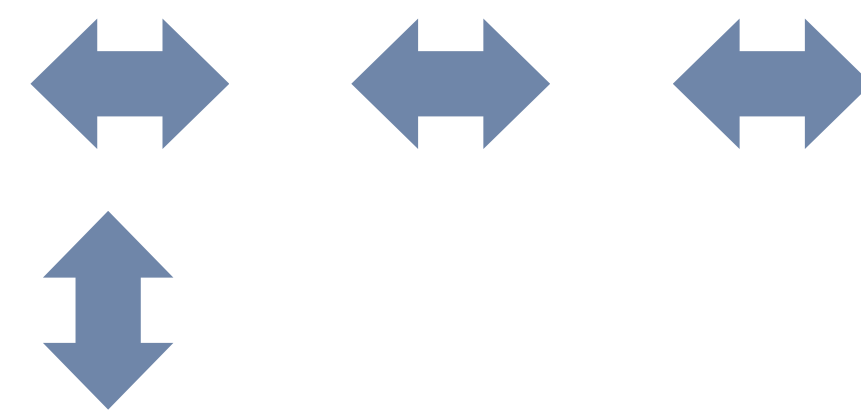
Children aged 9–16 living in the Perth metropolitan area, where behaviours of concern are the primary presenting issue and the child has minimal or no current engagement with support services.

Referral pathway

PCH ED SBC Presentation ----> **ED Social Work assessment & referral to BHC** ----> **First session within 7 days of ED presentation** ----> **Up to 4 sessions for parent/s, child involvement on assessment** ----> **Discharge & handover to community team.**

Effectiveness of the BHC is measured through caregiver pre and post clinic surveys, attendance to sessions and ED utilisation data.

Interventions & Therapeutic Frameworks



Therapeutic approaches

- Trauma-informed
- Family systems theory
- Attachment theory
- Circle of Security
- Polyvagal theory
- ABC Model
- Grief and loss theory
- Psychodynamic theory
- Person centred theory
- Neurodevelopmental trauma
- Stress response cycle

Direct work

- Behaviour exploration
- Family system and attachment repair
- Trauma informed parenting support
- Grief and loss counseling
- Psychoeducation on neurodiversity and co-regulation
- Safety planning
- Single session therapy
- Reflective space for caregivers
- Support to identify stress cycles and emotional triggers
- Strategies to engage in relational repair

Indirect interventions

Multi agency liaison ----> Care coordination ----> Advocacy for improved service access across sectors ----> Referrals to mainstream supports ----> Post clinic summaries to stakeholders to support continuity of care.

Implementation

PCH ED data audits

In a 60-day snapshot (2024), 73 of 264 PCH ED Social Work (SW) referrals were behavioural in nature. Of these, 47 involved severe aggression with parent safety concerns. Most had a neurodivergent diagnosis, but few were linked to paediatricians or disability supports. The patients average ED stay was 7 hours.

PCH ED data analysis between January - March 2024, captured psychosocial complexity and presence of mental health acuity of SBC presentations responded to by ED SW Fig(2). Note - Child and Adolescent Mental Health Services (CAMHS), Child Protection & Family Services (CPFS).

Month	January 2024	February 2024	March 2024
Total SBC patients seen by SW	40	36	48
Total SBC patients seen by SW and CAMHS Crisis Connect	10	9	23
Children in care of CPFS	15	13	19

Fig (2)

Consumer reference groups

Young people and families played a central role in the clinic's design and evaluation. Engagement sessions highlighted frustration with ED environments and traditional crisis responses.

What consumers told us

"Your plan for such a clinic seems a great idea, and long overdue..."
Parent

"There is a lot going on in the ED, the lights are too bright and doesn't feel safe, a non-clinical room would feel better."
Young person

"The idea of chatting with clinicians with the child present is one of the kindest and positive ways of progressing."
Parent

National benchmarking

A national benchmarking review highlighted significant service gaps across paediatric hospitals in Australia in responding to behavioural health crises. Findings strongly supported a preventative; relational model.

Outcomes

During the 12-month pilot (2024–2025), 27 families were referred to the BHC. Twelve completed all sessions, seven partially engaged (<4 sessions), seven did not engage, and one was transferred to PCH Adolescent Medicine Team.

Of the 19 families who completed or partially completed the program, most faced significant psychosocial complexity. **47%** had histories of **FDV** or **parental substance use**, **42%** intergenerational **trauma**, and **32%** had recent **CPFS** involvement or **parental mental health** concerns. Fig(3) and Fig(4) provide further data analysis. Note - Child Development Services (CDS).

Data for 12 (+7) partially completed patients			
Average age	10.5	Average days between ED & referral	15.6
Age range	6 - 16	Total prior SBC presentations before BHC referral	16
Aboriginal/TSI	0	Total SBC ED presentations between referral and program	1
Current NDIS	8	Total SBC ED presentations during program	4
CDS active	9	Total SBC ED presentations post program (to April 2025)	1
CDS waitlist	1		
Private Paed/Psychiatrist	8		
CAMHS active	4		

Fig (3)

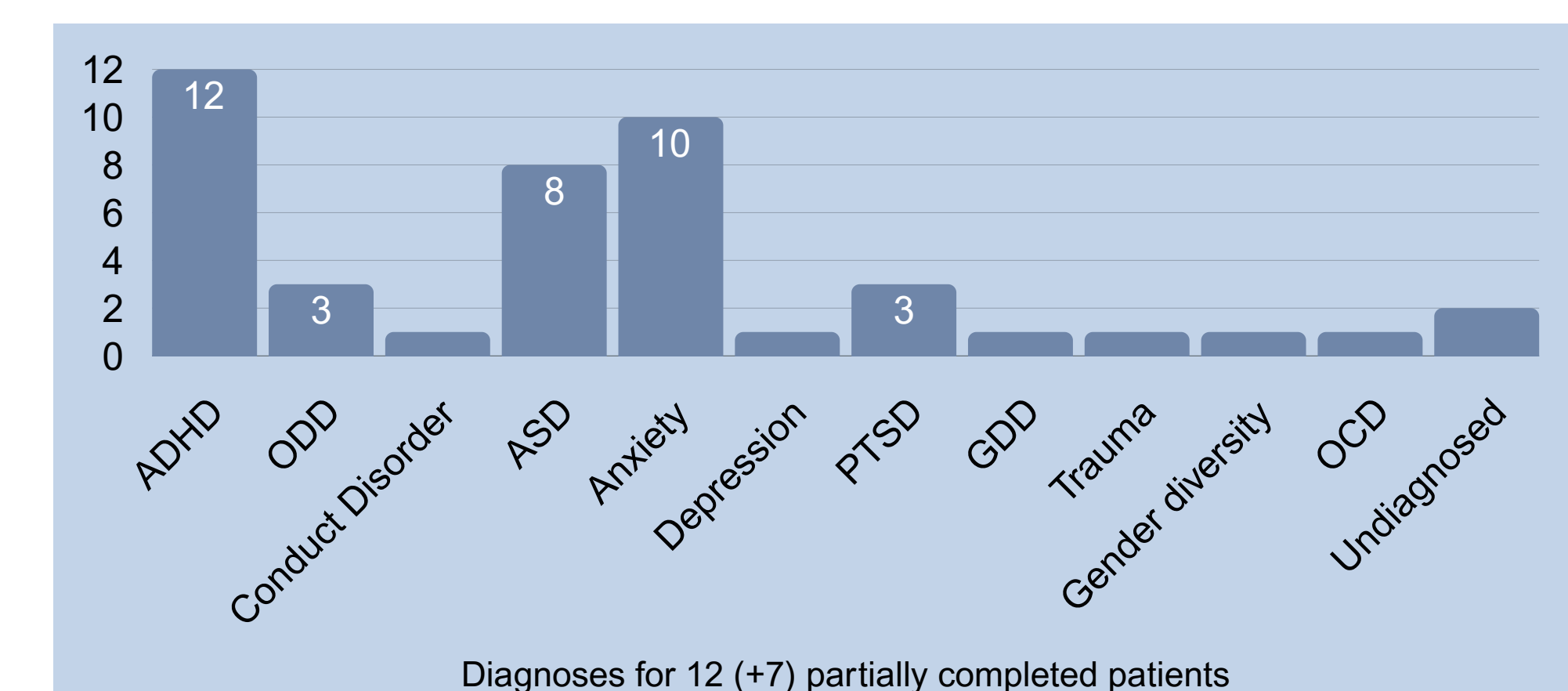


Fig (4)

Caregiver Feedback

Pre/post surveys reflected improvements in family functioning, care coordination, and carer confidence, with reduced familial distress.

"I feel more confident as a parent and as a spouse."

"The service my son and I received was so beyond helpful..."

"Our child has improved greatly as they are now getting the treatment and the medication they need."

"Great advice on how to manage my son's challenging behavior..."

"She provided to us a place to share, with all the confidence..."

"The clinic helped in so many ways.. we will forever be grateful.."

Conclusion

The BHC does not replace specialist medical, mental health, or disability services. However, it offers a vital therapeutic space where young people and caregivers can explore behavioural concerns, access timely support, and develop a coordinated care plan. This approach supports improved functioning for the child and strengthens the family system.

Future directions include expanding the model to incorporate additional disciplines, increase service capacity, trial planned admission pathways, and determine the most effective long-term service location.

References

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