

# SERVICE MODEL FOR ADULT MENTAL HEALTH CENTRES

September 2020

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## Glossary of key terms used in the paper

In general, the terms used in this paper should be understood to align with definitions provided in the Fifth National Mental Health and Suicide Prevention Plan. The following terms are highlighted.

**Warm transfer** – the Centre actively communicates with the service to which the individual is connected to provide essential information about their needs before transferring them. Support is maintained for the individual by the Centre until they are received by the service.

**Clinical governance** – Clinical governance is defined as the system by which the governing body (bodies), managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents.

**Episode of care** - the package of care and evidence-based treatment provided by a Centre, for individuals with a specific mental health need. An episode of care is delivered by members of a multidisciplinary team over a set time period.

**Peer support worker** – Workers who have a lived experience of mental illness and/or suicide and who provide valuable contributions by sharing their experience of mental illness and/or suicide and recovery with others. Peer workers may have lived experience as a consumer or as a carer.

**Care navigator** – a person who works collaboratively with consumers and carers to assist them in finding the most appropriate treatment, care or supports.

**'Front of house'** – the location where the public is received and may wait for services. Front of house services are provided in these public areas.

**Local Hospital Networks (LHNs)** – entities established by state and territory governments to manage single or small groups of public hospital services, including managing budgets and being responsible for performance in a defined geographical area. LHNs also commonly manage other health services such as community-based health services.

Some jurisdictions have their own local names for LHNs. For example, in New South Wales they are known as 'Local Health Districts', in Queensland they are known as 'Hospital and Health Services', in South Australia they are known as 'Local Health Networks', and in Tasmania they are known as 'Tasmanian Health Organisations'.

**Co-morbidity** – other conditions that occur at the same time as mental illness. This is often physical illness or poor health but also includes use of alcohol and other drugs. Both are very common in those with mental illness or mental disorders.

**Alcohol and Other Drugs (AOD)** – this term most often refers to excess use of alcohol and misuse of illicit or prescribed drugs.

## Introduction

As part of the 2019-20 Budget, the Australian Government announced it will invest \$114.5 million over five years to undertake a trial of eight Adult Mental Health Centres (the Centres), with one to be established in each state and territory. Through the 2019 Mid-Year Economic and Fiscal Outlook process, funding has been brought forward to enable the South Australian Centre to be established in mid-2020, and to enable the remaining seven Centres to be established from 2020-21, with service delivery to commence in 2021-22.

This paper has been prepared to support consistency in the establishment and implementation of the Centres. A Technical Advisory Group was established to advise the Department on the initiative. The paper outlines the key assumptions underpinning the model of service, explores how individuals with different needs might access services from the Centres, and proposes services that would be needed in-house as well as on referral. It also considers workforce, flexibilities allowed in the model, and essential safety and quality issues. The paper has also been revised, as appropriate, to reflect feedback received through a national consultation process.

The Centres are designed to provide a welcoming, low stigma soft entry point to engagement and assessment for people who may be experiencing distress or crisis, including people with conditions too complex for many current primary care services but who are not eligible for or awaiting care from state or territory public community mental health. They are also intended to trial approaches to offering immediate, short and medium term episodes of care and service navigation to connect people to ongoing services. They will assist adults seeking help in times of crisis, or as needs emerge, to have access to on-the-spot care, advice and support provided by a variety of health professionals – without needing a prior appointment.

The Centres are intended to complement, not replace or duplicate, mental health services already provided in the community. They are not designed to offer longer term care but will be based on an episode of care model, delivering packages of evidence-based care and family support to cover the short to medium term, which could last from a few weeks to several months based on clinical judgement and individual need. Centres are to provide an accessible, responsive service that meets immediate needs and provides expertise in assessment of needs, linkage and support, and care. Centres should also provide integrated mental health and AOD services.

Through the trial, the Centres are to be commissioned in all states and territories except South Australia through funding to the corresponding Primary Health Networks (PHNs). As part of their commissioning processes, PHNs will undertake further consultation, at a local level, with consumers, carers, Local Hospital Networks (LHNs) or their equivalent and other local stakeholders to co-design and shape services to meet the particular needs of the area, within the framework presented by this model. Whilst, over time, the Centres may meet a range of special needs within the region, a key imperative will be ensuring the model of care offers a culturally safe response to the needs of Aboriginal and Torres Strait Islander people, in line with the principles of the Gayaa Dhuwi (Proud Spirit) Declaration.<sup>1</sup>

## Summary of the key elements of the model

The model of service will seek to address key gaps in the system by:

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<sup>1</sup> Available from [http://natsil.mh.org.au/sites/default/files/gayaa\\_dhuwi\\_declaration\\_A4.pdf](http://natsil.mh.org.au/sites/default/files/gayaa_dhuwi_declaration_A4.pdf)

- Providing a highly visible and accessible entry point to services for people experiencing psychological distress, where all feel safe and welcomed;
- Offering assessment to match people to the services they need;
- Providing on the spot support, care and advice without needing referral, prior appointments or out of pocket cost. Every interaction should be with the intention of therapeutic benefit; and
- Offering an episode of care model based on short to medium term multidisciplinary care, aimed at improving psychological wellbeing for people with moderate to high levels of mental health need, whose needs are not being met through other services.

The service model will need to address the following four service elements:

- Respond to people experiencing a crisis or in significant distress, including people at heightened risk of suicide, providing support that may reduce the need for emergency department attendance;
- Provide a central point to connect people to other services in the region, including through offering information and advice about mental health and AOD use, service navigation and warm referral pathways for individuals, and their carers and family;
- Provide in-house assessment, including information and support to access services; and
- Provide evidence-based and evidence-informed immediate, and short to medium term episodes of care, including utilisation of digital mental health platforms.

## Assumptions underpinning the service model

- Centres will welcome adults experiencing emotional distress, crises, mental ill health, and/or addiction, and their families and carers through a 'no wrong door' approach that is consistent with the *Mental Health Statement of Rights and Responsibilities*.
- Centres should offer a holistic approach to care, addressing a broad range of social, physical and emotional needs, supported by best practice in evidence-based and evidence-informed care. This should include integrated care for people concerned about AOD use which coexists with mental ill health, other comorbidities or dual disabilities, and culturally appropriate best practice.
- Centres should plan and deliver services that are co-designed to meet local needs in a way that is person-centred and prioritises self-determination, choice and agency.
- Centres should be required to provide or facilitate core functions within an agreed framework, in a way which complements and does not duplicate existing services, including acute or long term services.
- Centres must adhere to the principles of the Gayaa Dhuwi (Proud Spirit) Declaration in the development and delivery of services to ensure culturally safe services for Aboriginal and Torres Strait Islander people are included as part of the broader model.
- Centres must be safe and inclusive to all who present, including members of LGBTI communities and people from Culturally and Linguistically Diverse (CALD) backgrounds.
- Young people aged 12-25 years old should be given information about care and support available from youth specific services such as headspace and other services targeting the needs of young people, if this is the most appropriate way to meet the needs of the individual.
- Centres should have some flexibility for regional variation, over time, to address other cultural or local population needs and to make optimal use of already available services. This includes opportunity for the development of innovative approaches to complement core services provided through Centres.
- Centres should be promoted as supporting people at times of crisis and distress, and not in terms of language of mental illness.

- Centres will connect people to pathways to less urgent longer-term care where this is in the person's best interest. The Centres are not expected to provide services of an ongoing nature, but will have capacity to provide short to medium term targeted care and support.
- Centres should promote optimal use of digital mental health and AOD services, including integrating digital forms of support into care plans and supporting their use.
- A quality framework should support the model of service, including by ensuring the risks of supporting individuals who may be experiencing high distress are managed, and attending to appropriate ongoing support, supervision and training for all staff, including peer support workers.

## A highly visible and accessible entry point for individuals and those providing support to them

The physical environment of the Centres should be calm, safe, friendly and welcoming to individuals experiencing emotional or psychological distress and to family and carers who support them. Centres should feel welcoming and safe to all who present, including Aboriginal and Torres Strait Islander people, people from diverse cultural backgrounds and LGBTI people. In addition, it is important that the Centres provide a safe entry point to integrated care for people who present concerned about their AOD use. Centres should be in a location easy to reach by public transport. They should be relatively close to a major hospital and/or to other health services, so a close relationship with crisis teams can be developed, and to facilitate their role of offering an alternative to emergency department attendance, where appropriate.

Centres must be open extended hours in order to be available to people when they are experiencing distress. Centres should enable access to support and advice seven days a week, and after hours, including through provision of a digitally based contact point for people experiencing distress at times the Centre itself is not physically open. Opening hours may be adjusted in response to demand experienced through the trial and to complement availability of other regional services.

Centres will have a "front-of-house" function where people can seek information and assistance navigating services by visiting the Centre, and potentially also by digital means through telephone or internet. A digital presence for the Centre may also include provision of computers on site and assistance accessing a range of digital information and mental health services. This could include low intensity on-line services such as Head to Health or other self-help or clinician supported digital interventions for mental health and/or problems related to AOD use.

Whilst people are waiting for services at the Centre, staff, including peer support workers, will be available to check in with them, and provide support if needed. People seeking information or resources rather than services, including family members or carers, will be welcomed at the Centres and supported to get the information they need. It is intended that support and interventions will be provided over a short timeframe for most people so that long wait times and waiting lists are avoided. It is recognised that for some people there will not be readily available services to which they can be referred, and in these circumstances targeted medium term care may be appropriate, particularly whilst waiting for longer term or specialist care.

## Assessment

Those requiring more than information or assistance navigating available services will need to be provided with a biopsychosocial assessment of their needs. Current projects, such as the Department of Health's Initial Assessment and Referral Project<sup>2</sup>, will be useful in considering a consistent approach to assessing need and connecting people to the services best able to respond to that need.

An initial brief review of needs should be undertaken at the point of accessing the Centre to identify whether individuals need urgent support, and to determine what the main focus of support is likely to be. In particular, all staff involved in initial intake, or who play a role in supporting clients while waiting, should be trained to recognise an individual who may need urgent support and who should be 'fast-tracked' to a clinician. Clients of the Centre should not be required to go through two stages of assessment, nor tell their story more than once within the Centre. It is expected that the clinician who first sees the person will make clinical judgements on the most appropriate interventions and in many cases also be the professional to deliver the episode of care. At times they will need to seek the particular expertise of other team members. It is expected that a number of clinicians at the Centre will have experience and expertise across mental health, AOD and physical health, given the prevalence of these problems amongst the population likely to present.

For those presenting with significant distress and acute needs which require urgent medical attention beyond the capacity of the Centre, protocols will be developed with the LHN for urgent review and referral. This may include immediate communication with, or warm transfer to, emergency or acute services where this is needed. Immediate support will be provided by staff at the Centre to help de-escalate symptoms and ensure people and their families feel safe. The Centre may form an agreement with the local acute mental health service for prompt in-reach support.

The assessment and referral process will determine the level of service a person requires, and care to be provided. It will inform development of a care plan where appropriate, and identify those individuals who would benefit from service navigation. Centres will ensure that the physical health needs of people with more severe mental illness are assessed, and that drug and alcohol comorbidities or risks of substance misuse are routinely assessed. Where substance use is a significant component of the presentation, professionals with competency in identifying and managing substance misuse issues, including addiction specialists, should be involved or consulted in assessment processes and subsequent treatment plans. Where physical health needs are prominent (e.g. people with co-occurring chronic illness), the Centre should assist in organising an early appointment with local primary health services. It is anticipated that some Centres may develop local arrangements for medical services and other services able to be billed to Medicare to be provided in-house, within the clinical governance of the Centres as outlined below. The assessment process will also consider non-health factors which would both impact and be impacted by distress levels including a lack of adequate, stable safe housing, domestic and family violence, low socio-economic status, a history of trauma, and past experience of high levels of discrimination and stigma.

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<sup>2</sup> The Initial Assessment and Referral Project, is an initiative of the Australian Department of Health and aims to provide advice to Primary Health Networks (PHNs) on establishing effective systems for the initial assessment and referral of individuals presenting with mental health conditions in primary healthcare settings

## Core services to be provided by Centres

To provide the elements of the service model, there are a number of services which all Centres would be reasonably expected to provide 'in-house', using available funding and through the most efficient mechanism of service delivery that meets the local need. In addition there are a number of important services and supports upon which the effectiveness of the model depends, which Centres are expected to either offer in-house, or offer through seamless referral pathways and partnerships with other agencies.

Core services to be provided '**in-house**', **using funds available to the Centres**, to address the key four elements of the service model, must include the following:

### **1. Responding to people experiencing a crisis or in significant distress:**

- Immediate support to reduce distress for people experiencing crisis or at risk of suicide presenting to the Centre in person or connecting with the Centre digitally, to help them feel safe before ongoing management within the Centre, or arranging warm transfers to other services where appropriate (see also flexibilities); and
- Support for communities and individuals experiencing significant distress associated with times of natural or other disasters.

### **2. Providing a central point to connect people to other services in the region:**

- Information for individuals, families, friends and carers on locally available mental health, AOD and suicide prevention services, and related social support services;
- Support and advice for families, friends and carers to assist them in their role, and acknowledge their social and emotional support needs; and
- Service navigation, supporting clear and seamless pathways, including access to digital self-help services, and providing a point of contact and follow-up.

### **3. Provide in-house assessment, including information and support to access services:**

- Biopsychosocial assessment and initial review to ensure people are matched to the services they need, including assessment of physical health needs, problems related to AOD use, and other social factors or adversity which might impact on their mental wellbeing.

### **4. Evidence-based and evidence-informed immediate, and short to medium episodes of care:**

- Initial information provision, comfort and, if necessary, management of symptoms, including, where possible, those related to alcohol and drug use;
- Short to medium term support and care, based on an episode of care model, whilst individuals are recovering or are waiting to be connected to longer term or more appropriate services and support, including regular contact and follow-up with individuals at heightened risk of suicide and their families and carers; and
- Digital mental health services and information, including promoting access to on-line therapies (such as those offered through Head to Health) and clinician-supported digital interventions for mental health and problems related to AOD use.

Centres will also ensure that the following core services, which are essential to the integrity of the model, are available to people who present to the Centre, either on an '**in-house**', '**in-reach**' or **referral basis**. Most of these services would be provided under the clinical governance of the Centre, particularly where funded on an in-reach or in-house basis:

- Medical assessment, including initiation or continuation of medication management where appropriate; and assistance with physical health needs from GPs, or psychiatrists;



- Structured psychological therapies such as cognitive behaviour therapies, including services provided through Medicare Benefits Schedule (MBS) arrangements;
- Assistance with accessing care coordination services;
- Local outreach, either physically or via digital services, to meet the needs of vulnerable groups and the needs of people who are unable to easily access services delivered through the Centres;
- Specialised suicide prevention follow-up services, such as the Way Back Support Service;
- Family therapies and family peer support and education services;
- Assistance identifying and managing comorbid substance misuse from addiction specialists;
- Integrated vocational support services such as Individual Placement and Support (IPS);
- Connection to services that assist with referral to the NDIS and related information;
- Assistance managing stressors associated with high levels of distress, including financial problems, civil and criminal legal issues, family support, accommodation instability and social isolation;
- Connection to specialised domestic violence supports;
- Culturally safe services for Aboriginal and Torres Strait Islander people;
- Connection to peer-led services such as peer networks, support groups, or phone lines;
- Connection to group programs as a means of building social supports; and
- Other services which are essential to the integrity of the model, depending on the particular geographic, cultural and service needs of the region (see flexibilities below).

The mix of additional services which the Centres provide in-house may vary from location to location, and will depend on arrangements negotiated with LHNs and other local services to ensure complementarity and to focus available Centre funding on addressing gaps. Some Centres may focus on providing a platform for in-reach services to be offered, including services from GPs, psychiatrists or other MBS funded providers.

## What services are out of scope for the Centres?

To ensure demand management, and ensure capacity for new people to present, Centres will not generally provide longer term or ongoing mental health care or support services.

Centres are not funded to provide:

- Services for people who cannot be managed safely within the acute care centre environment;
- Acute reception of police or ambulance referrals;
- Pathology, radiology or pharmacy services;
- Ongoing, long term psychosocial support or recreational services;
- Direct financial support;
- Residential or bed-based services, including short-stay services;
- Services targeting children and young people which could be provided more appropriately by headspace or other specialised children or youth mental health services;
- Disability support services provided through the NDIS;
- Other services which are provided by other agencies in the area (see referrals below).

## The role of the Centres in providing care to people with moderate to high levels of mental health need

The Centre's role in relation to supporting people with moderate to severe levels of mental illness should focus on providing an episode of care which aims to support the individual and to assist them to navigate the health, mental health, and broader social services which they need over the long term.

Centres may include a short to medium term service offer for people with moderate to high levels of need, where there are no available services appropriate to their needs to which they can be referred, or whilst they are waiting to be connected to longer term care. However, if Centres are to continue to be accessible, and have capacity to deliver immediate support, they will need internal protocols to assist in demand management. The Centres are expected to have a limited role for those with enduring, long term needs.

An appropriate role for Centres for supporting people with moderate to high levels of mental health need should include:

- Provision of immediate care for people with moderate to severe mental illness who present in distress or suicidal crisis;
- A full biopsychosocial assessment of their mental health and other needs including co-occurring substance use or physical health issues which may influence their needs;
- Provision of short to medium term care according to an episode of care model, for people for whom there is no other service available. This should deliver a limited package of services through a multi-disciplinary team arrangement designed to address their mental health and related needs;
- Warm referral to more specialised services and longer term psychosocial support where individuals require ongoing, long term care;
- The provision of continuing assistance with care navigation to individuals who are experiencing moderate to severe levels of psychological distress, to ensure they are not left without services; and
- Connecting family and/or other carers with services that can support them in their roles.

Centres should not provide ongoing long term care, nor replace the role of state/territory community mental health services in providing services to people with acute needs. In some circumstances, individuals may present who are the clients of existing services, including state/territory community mental health services. Whilst immediate care should be provided, Centres should support these individuals to reconnect with their regular services.

The evaluation of the trial of Centres and the ongoing monitoring of the role they play in this area will be useful to inform adjustment of the model of service to appropriately meet the needs of this group in a way which does not duplicate the role of other services, yet which helps to address the gap in services for people with more complex needs.

## The role of the Centres in providing care to people who present with significant levels of distress or suicidal crisis

Centres are intended to help address the service gaps which currently exist for people experiencing high levels of distress or suicidal crisis. In addition to providing a safe place to present for people experiencing high levels of distress, or who are at heightened risk of suicide, the Centres will also offer continued contact and follow-up support through an

episode of care model until these individuals are either in recovery, or connected through warm transfer to services to meet their ongoing needs.

Precedents through initiatives such as the Safe Haven services, have shown this can successfully divert people from less appropriate emergency department attendance, and promote better outcomes, where urgent emergency department care is not required. These services rely on good cooperation with emergency departments and community-based front line services and acute mental health services to support throughput and ensure safety for clients and staff.

Protocols for this function of the Centre will need to be refined in partnership with the LHN and emergency departments to:

- Ensure swift identification of those individuals who are experiencing a crisis, and provision of immediate support and comfort to them and their family or carers;
- Identify and refer individuals whose needs cannot be met appropriately in the Centre. This may include the care of individuals who are at risk of harm to themselves or others;
- Identify individuals experiencing heightened distress who are intoxicated or under the influence of licit or illicit drugs, and swiftly decide whether or not their needs can be appropriately and safely met at the Centre;
- Have in place clear arrangements for crisis support and transport to emergency departments when urgent referral is needed; and
- Centres will also need to have capacity to discretely provide care for individuals in heightened distress, in a way which protects their privacy and does not impact on other clients of the service.

In some locations there may already be services in place nearby which offer a safe and person-centred, friendly alternative to presenting to hospital. In these circumstances, Centres may wish to partner with these services, rather than duplicating the service, and focus available funds on other aspects of the service model to better address service needs in consultation with LHNs and other key stakeholders.

## Referrals

Smooth referral pathways, which are seamless for people requiring support will be essential to the effective operation of the Centre's model. This must include capacity for warm transfers, particularly for people experiencing high levels of distress who require long term care, to enable new entries to the service. Through warm transfers, the Centre actively communicates with the service to which the individual is referred to provide essential information about their needs before transferring them. Support is maintained for the individual by the Centre whilst they are waiting for an appointment with the agency to which they have been referred.

Services to be provided on referral, where it is not possible to provide these services in-house or through using the Centre as a platform, may include:

- GP management of ongoing physical health issues;
- Private MBS funded psychiatry or psychological services;
- headspace services or child mental health services;
- Other services commissioned by PHNs, including psychological services, Aboriginal mental health services, or services targeting the needs of hard to reach groups;
- Services providing mental health or broader support services for Veterans;

- Warm transfers to state or territory government funded acute and emergency care, and public and private hospitals;
- Public and private specialist mental health services;
- Services meeting particular needs such as perinatal depression, eating disorders, or early psychosis;
- Specialised support networks and or physical health support services;
- Social support services, including housing, employment, child and family support and income support;
- Community legal assistance services or forensic mental health support services;
- Specialised Alcohol and Other Drug services (where ongoing support is needed as opposed to integrated support for co-occurring mental health and substance use conditions at the Centre);
- Disability support services, including support through the National Disability Insurance Scheme and Information, Linkages and Capacity Building (ILC) programs; and
- Peer support groups, and peer led safe spaces.

## Partnerships and protocols

Close partnerships will be formed with the services described above as appropriate to enable an integrated approach to individuals who may require transfer from one service to the other. In particular, clear protocols will be developed for the interface between the Centres, the PHN and the LHN and its emergency departments to enable a seamless transfer of patients when needed. It is anticipated that some people who present in crisis at the Centre may have existing care arrangements with LHN mental health services.

As part of this it is expected that protocols developed with local services will provide clarity on what sort of presentations are likely to require emergency department attendance, and which individuals experiencing distress can be appropriately supported within the Centres.

As many individuals presenting to the Centre may already be clients of other services, including public and private specialist mental health services, protocols for communicating with and if appropriate providing shared care with these services will also be important. Each Centre will also need to have good systems with other local providers for referral and coordination of care. It will be important that services are not duplicated and that information is shared among providers (with consent) to minimise the need for repeated explanation by consumers and carers. The use of My Health Record should be considered to facilitate communication and coordination. In general, wherever possible, efforts to co-locate services at the Centre should be pursued to support a 'one stop shop' approach. This is most likely to avoid fragmentation and retelling of stories.

## Workforce – a multidisciplinary team approach

To deliver the core functions of the Centre, it is expected that Centres will establish multidisciplinary teams, supported by appropriate clinical governance – both within the Centre and where there are shared care arrangements. Services provided will need to be recovery focused, trauma informed and person-centred. The core workforce may be supplemented by practitioners providing services funded through MBS items.

A multidisciplinary team approach allows the opportunity for clinicians and peer support workers, and/or staff with dual expertise across mental health and AOD, or with expertise in delivering digital mental health services or particular cultural expertise, to utilise their particular skill sets while also functioning as an integrated team with shared clinical review and team support.

However, not everyone presenting to the Centres will require multidisciplinary care. Individuals with high levels of distress, or complex needs will most benefit from having access to a small team whilst they are in the care of the Centre (e.g. mental health nurse, psychologist and peer worker). On the other hand, many individuals with lower levels of distress will prefer to receive, and may only need support from one professional. Similarly, it would not be efficient to expect Centres to establish an extended multidisciplinary care team in-house, including specialists, to meet the needs of all clients.

Centres should seek to establish partnerships with GPs, emergency department staff and other external professionals, including MBS funded private service providers, to enhance a multi-disciplinary team approach to meeting needs, without duplicating available services. There may also be shared employment arrangements with LHNs, including possible secondments, and potential for sessional in-reach services to enhance the spread of skill and expertise within the team.

**Table 1 – Possible Multidisciplinary Team Members**

<b>Core function</b>	<b>Skills or competencies</b>	<b>Possible multidisciplinary team members</b>
Providing a central point for connection  Service navigation	<ul style="list-style-type: none"> <li>• Knowledge of local services</li> <li>• Knowledge of digital services</li> <li>• Capacity to identify and provide reassurance to individuals in distress</li> <li>• Skills in care navigation</li> </ul>	<ul style="list-style-type: none"> <li>• Peer Support Workers</li> <li>• Mental Health Nurses</li> <li>• Occupational therapists</li> <li>• Allied Health Professionals</li> <li>• Care Navigators</li> </ul>
Providing an option for intervention and support to reduce the need for emergency department attendance	<ul style="list-style-type: none"> <li>• Ability to de-escalate high levels of distress</li> <li>• Capacity to identify individuals requiring acute emergency department care</li> <li>• Medical skills, including knowledge of medication</li> </ul>	<ul style="list-style-type: none"> <li>• Psychologists</li> <li>• Social Workers, Occupational Therapists or other Allied Health Professionals with mental health competency</li> <li>• Mental Health Nurses</li> <li>• Medical Staff (GPs and/or Specialist Psychiatrists and Registrars)</li> <li>• Peer Support Workers</li> <li>• AOD Professionals or staff with dual competency</li> <li>• Aboriginal Health Workers</li> </ul>
Assessment (noting a single professional would be likely to undertake an individual assessment, but may seek support and advice from other team members)	<ul style="list-style-type: none"> <li>• Skills in using the Initial Assessment and Referral (IAR) tool or similar model</li> <li>• Competency as a mental health professional</li> <li>• Ability to assess physical health needs and or AOD support needs</li> <li>• Ability to assess suitability for digital support and treatment options</li> </ul>	<ul style="list-style-type: none"> <li>• Mental Health Nurses</li> <li>• Psychologists</li> <li>• Social workers, Occupational Therapists or other Allied Health Professionals with mental health competency</li> <li>• Aboriginal Health Workers</li> <li>• AOD Professionals and GPs</li> </ul>

Core function	Skills or competencies	Possible multidisciplinary team members
<p>Providing care and support for individuals, families and carers (noting a single professional may meet the needs of some individuals, whilst a team approach to care could be required for people with complex needs)</p>	<ul style="list-style-type: none"> <li>• Skills and training in providing interventions or psychosocial support</li> <li>• Competency as a mental health professional</li> <li>• Competency in providing AOD support</li> <li>• Competency in providing or supporting digital treatment options</li> </ul>	<ul style="list-style-type: none"> <li>• Psychiatrists and Registrars</li> <li>• Addiction specialists</li> <li>• GPs</li> <li>• Social Workers, Occupational Therapists or other Allied Health Professionals with mental health competency</li> <li>• Psychologists</li> <li>• Mental Health Nurses (scope for Nurse Practitioners)</li> <li>• AOD Professionals</li> <li>• Peer Support Workers</li> <li>• Aboriginal Health Workers</li> <li>• Transcultural Health Workers</li> <li>• Vocational Support Workers</li> </ul>

Given the role of Centres in offering an option for intervention and support to reduce the need for emergency department attendance, staff will need to be available who have received specialised training and who are experienced in supporting people at risk of suicide or who are experiencing significant levels of distress. In addition, all staff who provide “front of house” functions and support initial intake of people should be trained in ways to help support individuals experiencing distress, and to identify people requiring urgent care. It is anticipated that the Centre manager will have both clinical and operational expertise. Staff should have appropriate support or supervision arrangements in place.

## Flexibilities

In general, Centres will be required to provide a reliable model of service consistent with the national framework and branding, and offer a minimum central suite of services as outlined earlier in this document. However flexibilities will be allowed to address regional variation including the following:

- Adjusting any service offering to ensure that the Centre is complementing and not duplicating existing services in the region;
- Addressing particular cultural needs of the region, such as the needs of Aboriginal and Torres Strait Islander people, and the needs of people from diverse communities within the region including LGBTI people;
- Potential to adapt or share workforce in areas of reduced availability, for example sharing scarce professionals such as psychiatrists and mental health nurses with hospitals or other state or territory government services;
- Some Centres may wish to offer opportunity for external entities to provide services using the Centres as a service platform, to offer more of an in-house service offering and make best use of resources;
- Flexible approaches to providing access over extended opening hours may be utilised to make the best use of limited workforce, and complement other services in the region. Centre opening hours may vary in this respect; and
- Making arrangements with professional training programs to utilise and where required, offer supervision to students and junior professionals in training, including

those at Probationary and Registrar levels, and those preparing for peer support worker roles.

Flexibilities in focusing investment would be determined through a process of mapping existing services, negotiations with local state or territory government service providers and other stakeholders to focus on gaps and avoid duplication. This should build on and utilise mapping exercises, and knowledge acquired for joint regional mental health planning purposes. For example, if the LHN already funds an alternative mental health service or safe space for people experiencing crisis who otherwise would present at hospital, the Centres may instead focus on enhancing other complementary aspects of the service model, and partner with the LHN service in offering seamless referral pathways for consumers.

Centres are encouraged to explore partnerships with other agencies for the development of innovative service options to complement the Centre's core functions.

## Integration and planning

Each individual Centre will be established within a service landscape, which is likely to be unique. The mix of state and territory government, non-government and PHN funded mental health and social support services, which may be available, will vary. This makes it very important that Centres should be carefully planned, mapping available services to ensure core functions are provided in a way which makes the best use of available resources.

In general to achieve appropriate integration and planning, Centres will need to:

- Map available services;
- Consult with other agencies, services, and consumers and carers about service gaps and needs;
- Ensure appropriate information is shared between the Centre and other agencies about roles and relationships;
- Share experience and learning across Centres in different jurisdictions;
- Negotiate pathways and protocols for integrating services;
- Identify risk of service duplication, or confusion to consumers about overlapping service intent; and
- Consider opportunities for co-design and co-commissioning.

## Safety and quality

A comprehensive safety and quality framework will be required as part of the implementation of the Centres. This should include the following:

- Compliance with relevant safety and quality standards, including the *National Standards for Mental Health Services 2010*;
- Implementing appropriate confidentiality and privacy arrangements in accordance with relevant legislation, whilst ensuring appropriate information sharing is in place between services involved in a care pathway to support quality care;
- Clinical governance to ensure that staff are appropriately credentialled, well supported and trained to provide care to people experiencing crisis. Protocols must be in place to guide review of the care provided and for responding to critical incidents and complaints;
- There should be clear lines of accountability within the Centre;
- Protocols to ensure the safety of staff and clients in the event that an individual presents a risk to themselves or others;

- Protocols with other relevant organisations, for example LHNs and their services, to ensure that offering alternative services to those offered in acute settings does not result in a delay in providing urgent services or otherwise risk the safety and wellbeing of individuals;
- After hours arrangements that include provisions to ensure staff and clients are not at risk and are equipped to discretely manage the care of individuals who are intoxicated or exhibiting anti-social behaviour associated with drug use (e.g. arrangements in place with police, minimum after hours staffing levels);
- Consideration in general of safety and quality priorities outlined in the Fifth National Mental Health and Suicide Prevention Plan;
- Cultural safety considerations to ensure that Aboriginal and Torres Strait Islander people receive quality responses and equality of care;
- Support for carers which is timely, responsive, appropriate and accessible, in line with the *Carer Recognition Act 2010*; and
- Support for the appropriate use of the *Privacy Act 1988* and the Australian Privacy Principles, so information can be shared by practitioners as part of effective collaboration with consumers and carers.

## Pathways to care

Pathways to care and support within the Centre will be different, depending on whether individuals seek information or connection to other services, in-house assessment and treatment services, or are experiencing significant distress or crisis. Pathways should also be in place to ensure family and carers seeking information, and potentially emotional support, are appropriately supported. A possible, broad pathway to care is outlined in Attachment A.

This pathway presumes the following broad elements:

- Initial contact – by phone, on-line, walk-in or referral from other services;
- Initial brief assessment of needs to identify whether need is for information for self or others, for mental health services or for crisis support;
- Provision of immediate support and assessment if appropriate;
- Provision of short to medium term care targeted to need to enable support until the individual is connected to longer term care;
- Liaison and referral with agencies to whom the individual is referred; and
- Review and, if required, follow-up.

## Phased implementation

The Centres will be a new addition to the existing regional service landscape, and will face a number of local implementation challenges in addressing service gaps including:

- Planning services to complement, and not duplicate available services in the region;
- Managing demand in a way which enables access to immediate support and advice for all who present, whilst also providing short to medium term episodes of care for those for whom services are not available;
- Building a skilled multidisciplinary team in the context of likely workforce shortages;
- Identifying and where possible meeting unmet special local or cultural needs whilst also having a standard suite of services;
- Offering after hours services, including a level of crisis support, in a way which is sustainable from a duty of care, workforce and budget perspective; and
- Developing partnerships needed to offer a range of services and referral pathways.



To allow time to address these challenges, a phased approach to implementation of Centres is proposed. These phases are likely to include:

- An establishment phase, which will be informed by consultation, needs assessment, local service mapping and existing joint regional mental health planning processes before opening for service delivery. This should include establishing a mission and culture, agreeing principles underlying the model of care, and providing initial inter-disciplinary training and supervision;
- An embedding phase, where a basic core suite of information, services and referral pathways is established and delivered, and partnerships are developed. This may, for example, involve focusing on provision of core in-house services such as the capacity to provide immediate information, advice and support and service navigation; and
- A full implementation phase, through which additional partnerships to support in-reach services or more specialised support to address local need is offered.

A process of iterative review between phases, including continuing consultation with key stakeholders, will help to shape the role of Centres to deliver a basic suite of services and locally appropriate additional services to optimally complement existing regional services.

## Evaluating the service model provided through the trial

In broad terms, the following outcomes for consumers and carers are expected from each Centre funded through the trial:

- People requiring support in the area, or those attending the Centre, will recognise the Centre as an accessible entry point to the mental health care system for the services and information they need.
- People will be able to access through the Centre, or be connected to by the Centre, the particular mental health and related services they are assessed as needing.
- People will receive immediate advice and care which will reduce their level of mental and emotional distress.
- Individuals experiencing high levels of psychological distress or in crisis will receive the care they need from the Centre, resulting in a reduction in the number of non-urgent presentations to local hospital emergency departments.

An evaluation framework for the trial is being developed, with the assistance of the Technical Advisory Group, to support monitoring and review of the effectiveness of the model of service in achieving these outcomes, and to inform future expansion of the initiative.

Centres should collect outcomes data to inform an iterative, ongoing evaluation of service effectiveness to ensure the needs of the local community are being met.

## Patient pathways within the Centre

<b>Initial contact and intake</b>	By phone, on-line, walk-in, or referral from other service (e.g. GP, hospital, state/territory service)		
<b>Initial brief assessment of needs</b>	<b>Information for self or others</b>	<b>Mental health service needs (non-crisis)</b>	<b>Crisis services (alternative to emergency department)</b>
<b>Immediate support and assessment if appropriate</b>	Connect with information and services.  Support and advice for families, friends and carers	Assessment undertaken to identify level of need and/or referrals required, using Initial Assessment and Referral decision tool, or similar. Initial support provided. AOD use and physical health assessed. GP advised patient is receiving services.	Immediate support to de-escalate and; <ul style="list-style-type: none"> <li>• Support in-house</li> <li>• Supported transfer to home/carers</li> <li>• Warm transfer to acute OR</li> <li>• Full assessment following stabilisation as per non-crisis.</li> </ul>
<b>Short to medium term care and episode of care according to need</b>	Support to access digital information and treatment services relating to mental health and/or AOD needs	Support and short to medium term therapeutic care, based on an episode of care model, whilst individuals are waiting to be connected to longer term services and support if needed.  For some individuals this short term support may be enough to resolve distress, supplemented with digital treatment services or family support.	Support and short term targeted therapeutic care, based on an episode of care model, including while waiting connection to longer term support.  Regular contact and time limited follow-up with individuals at heightened risk of suicide and their families and carers, including by digital means.
<b>Service navigation and referral</b>		Service navigation to assist them to connect to services and supports.  Warm referral to relevant services.	Service navigation and option of review  Warm referral to relevant services  Referral to Way Back or other follow-up services if risk of suicide
<b>Review</b>		Follow-up and review.	Follow-up and review.
<b>Enablers</b>	Partnerships, clear protocols with state/territory services, multi-agency care planning, skilled workforce, clear roles, supported pathways.		

## Adult Mental Health Centres Principles

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The Australian Government is funding a trial of eight Adult Mental Health Centres across Australia. The Adult Mental Health Centres will be developed and operate at the local level under the following operational principles. The Centres will:

1. Offer a highly visible and accessible 'no wrong door' entry point for adults and their families to access information and services which are designed to empower, support and improve their psychological and physical health, and social and emotional wellbeing.
2. Provide information and services which can assist those providing support to people in need.
3. Provide a welcoming, compassionate, culturally appropriate and safe environment that is inclusive for all people accessing services or supports that are trauma-informed, person-centred and recovery-focused.
4. Provide access across extended hours to best practice on the spot advice, support and care for immediate, short term, and where appropriate, medium term needs delivered by a multidisciplinary professional health care team providing discipline specific and interdisciplinary care including a suitably trained peer support workforce, nursing and allied health and specialist medical care, without prior appointments or a fee.
5. Assist people in need to find, access and effectively utilise digital forms of help including information, support and therapies.
6. Support people to connect to pathways of care through integration with longer term existing community mental health services where these are accessible and appropriate, local Primary Health Network commissioned services, or GPs and state and territory funded services, as required.
7. Provide an option for intervention and support that may reduce the need for emergency department attendance.
8. Explore opportunities for the development and utilisation of innovation to complement defined core functions, and to meet gaps in the provision of mental health services in the region.
9. Implement appropriate confidentiality and privacy arrangements in accordance with relevant legislation.
10. Operate under robust effective governance frameworks that support connectivity to other supports and services, and conduct local evaluation activities, to ensure transparency and accountability and maximising service quality.

The establishment and implementation of the Adult Mental Health Centres trial will be nationally evaluated to generate new evidence and to guide any future expansion of this initiative.