ACT Government | Canberra Health Services

Adult Community Mental Health Services Model of Care

Mental Health, Justice Health Alcohol and Drug Services

November 2023

Contents

Approvals

Position	Name	Signature	Date
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5.5	October 2017	MHHJADS Governance Committee	CHS	Implementation of model
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*Once this document has been approved please remove the DRAFT watermark.

Executive Summary

ACMHS are committed to providing quality assessment and treatment in a community setting for people with mental illness or disorder that is complicated with significant functional impairment, risk and complex needs.

ACMHS has developed a MoC that ultimately seeks to ensure delivering the right service to the right person at the right time. The ACMHS MoC seeks to improve treatment and care outcomes through the provision of accessible, integrated, high quality, safe and person-centered services.

To do so, the ACMHS MoC identifies the focus of care, principles of care and components of care to better meet the needs of people requiring ACMHS, and to better support the staff delivering care.

The focus of care outlines the priority needs group of people requiring access to secondary mental health services within a stepped-care framework.

The principles of care outline the overarching nature of service delivery, as underpinned by recovery- oriented philosophy, contemporary mental health service standards and legislation and cultural competency regarding diversity and complex comorbidity.

The components of care outline the functions of service delivery, as underpinned by improving access, responsiveness, efficiency and quality outcomes across ACMHS. The core functions and the essential components of care for the ACMHS MoC are:

A distinct access, assessment and triage service to promote greater access and consistency in service responses to requests for care;

An acute response and intensive in-home treatment service which provides an alternative to inpatient admission and in-reach into hospital settings to facilitate discharges;

Clinical management and care coordination with a focus on a strengths-based approach to recovery;

An assertive community outreach service to engage more actively with people with complex needs, and;

Psychological therapies, psychosocial and other specialty interventions to more specifically target individual requirements.

The benefits of this model will be fulfilled via a more standardised, consistent and assertive approach to community based care as a safe and effective alternative to hospital treatment.

To ensure sustainability of the ACMHS MoC implementation, there are significant priorities including operational, corporate and clinical governance, workforce planning and development, change leadership, evaluation, continued innovation and fuller integration with both the primary healthcare and community agency sectors.

As a result of the ACMHS MoC the analysis, planning, consultation and implementation of any possible changes to workforce, infrastructure and locations, training, culture and operational procedures are not in scope for the purpose of this current document. These factors will instead be addressed after the endorsement of the key facets proposed in the AMCH MoC.

1. Purpose of the ACMHS MOC

1.1 ACMHS Context

ACMHS are specialist community based mental health assessment and treatment services for adults in the ACT experiencing moderate to severe functional impairment due to serious mental illness/disorder with associated complex needs and risk.

ACMHS provides a range of interventions including triage, assessment, crisis intervention, ongoing treatment, care coordination, case review and planned exit from the service. ACMHS provide services across a range of locations, including community health centres, outreach into people's homes and other community settings, as well as inreach into hospital settings. ACMHS has a significant partnership with Canberra Hospital and North Canberra Hospital based mental health services to ensure integrated person-centered care pathways across inpatient and community treatment settings.

ACMHS is an integral part of Mental Health, Justice Health and Alcohol and Drug Services (**MHJHADS**) within Canberra Health Services (**CHS**), and further integrates with community agencies, primary health and other government agencies within the broader Mental Health sector.

1.2 Purpose of the Model of Care

ACMHS has identified factors such as high clinical loads, waiting lists and congested care pathways that reduce the capacity of ACMHS to respond effectively to community demand and to support and retain a satisfied specialist workforce.

In order to address these concerns an external consultant team with substantial experience in community mental health service development was commissioned to inform a process of redesign for ACMHS. Their remit was to redesign ACMHS to improve effectiveness and efficiency based on contemporary and evidence-based service delivery models. The consultancy group developed a framework for recovery-oriented community care and a higher-level plan for its implementation.

The redesign framework promotes timely access to high quality treatment and care based on a thorough biopsychosocial assessment of individual needs and the promotion of integrated care pathways that ensure people receive prompt assistance from whichever service is best able to meet their needs and support their recovery. This includes transitioning the care of people to the primary health or community agency sectors, where appropriate. The efficiency gains aim to increase ACMHS capacity and to reduce emergency department presentations, reduce the risk of relapse and improve longer-term recovery outcomes.

In order to increase effectiveness, efficiency and capacity the following major changes were recommended:

1. Greater embedding of recovery principles and best practice, evidence-based interventions in all facets of service delivery to better meet community expectation of a contemporary mental health service;
2. More efficient access and care flow pathways to provide people with a more seamless journey through the care continuum;
3. Increased standardisation of procedures, processes and practices to promote more internal consistency in service delivery;
4. Greater clarification and delineation of the roles and functions of service elements to reduce duplication and functional inefficiencies;
5. Greater specialisation within service elements to target interventions more appropriately to the different needs of service users;
6. Enhanced integration with other internal and external services to provide better coordinated and more holistic care; and
7. Better utilisation of technologies to support care delivery systems, reduce administrative burden on staff and promote more direct clinical contact.

The fundamental principles encapsulated in these recommendations have been refined and expanded upon in the ACMHS MoC. To do so the ACMHS MoC establishes the description and definition of the:

- Focus of Care regarding priority group of people requiring ACMHS
- Principles of Care for all aspects of service delivery
- Components of Care or service functions
- Sustainability enablers for the ACMHS MoC implementation
- Evaluation of the expected benefits.

2. Focus of Care

2.1 Key Access Criteria

Access and ongoing care within the ACMHS prioritises people who are:

- Adults, and
- experiencing mental illness or mental disorder, with
- significant psychosocial functional impairment, and/or
- high risk of harm to self or others or of misadventure, and have
- complex needs and intervention requirements.

2.1.1 Adults

18-64 years will be the age range for majority of people requiring ACMHS. Flexibility will be maintained in terms of eligibility for service based on age, for example a 17-year-old may be developmentally suitable for adult services or a person over 64 years who does not have issues of aging that impact on their physical or mental functioning. Furthermore, a person younger than 64 years may have issues of aging that require older persons services as opposed to ACMHS and similarly a 22 year old might be developmentally better suited to a service for young people. Close collaboration and partnership with Child and Adolescent Mental Health Service (**CAMHS**) and the Older Persons Mental Health Service (**OPMH**) will ensure streamlined care pathways to deliver appropriate age-related mental health services based on the needs of the individual.

2.1.2 Mental Illness and Disorder

The National Standards for Mental Health Services (**NSMHS**; 2010)[i] define mental illness as:

"*A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders…or the International Classification of Diseases. These classification systems apply to a wide range of mental disorders…In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system and there is a separate, but linked, national strategy. Similarly, dementia is treated primarily in aged care settings. Both are considered important in terms of their co-morbidity with mental illness."*

The *Mental Health Act 2015*[ii] defines Mental Illness as:

"A condition that seriously impairs (either temporarily or permanently) the mental functioning of a person in 1 or more areas of thought, mood, volition, perception, orientation or memory, and is 11haracterized by—

(a) the presence of at least 1 of the following symptoms:
- *(i)* delusions;
- *(ii)* hallucinations;
- *(iii)* serious disorders of streams of thought;
- *(iv)* serious disorders of thought form;
- *(v)* serious disturbance of mood; or

(b) *sustained or repeated irrational behaviour that may be taken to indicate the presence of at least 1 of the symptoms mentioned in paragraph (a)."*

In the *Act* Mental Disorder is defined as:

(a) *" a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion; but*
(c) *does not include a condition that is a mental illness."*

However, the presence of a mental illness/disorder alone does not indicate priority access to the ACMHS. Instead, access to specialist mental health services through the ACMHS is driven by functional impairment and complexity of needs or complexity of the service response required that is associated with mental illness/disorder.

2.1.3 Functional Impairment

Mental illness/disorder may result in significant psychosocial functional impairment. People with mental illness/disorder may experience a range of cognitive, behavioural, emotional and physical symptoms that impact on their capabilities in a number of areas. It may impact on their work, study, interpersonal relationships, recreational activities, social interactions, mobility, self-care and other activities of daily living. Functional impairment can complicate the treatment and care of mental illness/disorder; create engagement difficulties; and lead to barriers to service provision.

People with mental illness/disorder who are experiencing functional impairment might also be considered to be experiencing psychosocial disability. The NSMHS (2010) describes Disability as:

"A concept of several dimensions relating to an impairment in body structure or function, a limitation in activities (such as mobility and communication), a restriction in participation (involvement in life situations such as work, social interaction and education), and the affected person's physical and social environment."

2.1.4 Risk

Some people may present with high risks that cannot be effectively or safely managed within a primary health setting or by community agencies alone. High risk of harm to self or others, and/or risk of misadventure can be mitigated though an integrated and comprehensive multidisciplinary mental health service. ACMHS partners with community agencies, primary health, acute inpatient mental health services, AFP and ACTAS to provide an integrated service response for people who pose high risk to themselves and to others.

People with mental illness/disorder who are at risk may be subject to involuntary detention and treatment under the *Mental Health Act 2015.* When the Act does not require the person to be in a hospital or inpatient setting, the person's treatment, care and support remains the responsibility of ACMHS.

2.1.5 Complexity of Need

People with mental illness/disorder, significant functional impairment and/or high risk may often have complex care requirements and needs that are refractory to more commonly available interventions and/or cannot be adequately addressed or safely met by other services. This often involves increased experiences of suffering and distress. Assessment and treatment may be complicated due to severity of symptoms, treatment resistance, comorbid substance abuse, homelessness, disability, lack of insight or engagement and other obstacles to recovery.

Some examples of more complex needs that may require support under the ACMHS MoC framework include:

- persistent debilitating symptoms of mental illness/disorder that have not responded to low intensity interventions (e.g. intractable symptoms of major depression that have not been ameliorated through common psychological or pharmacological treatments)
- complex comorbidities including alcohol and drug misuse, or intellectual disability
- chronic psychosocial disability with associated vulnerability to abuse, neglect or exploitation
- requirements of vulnerable groups, particularly those who experience poorer health outcomes and require increased access to health services such as people of Aboriginal and Torres Strait Islander backgrounds
- high levels of distress and emotional dysregulation which are often associated with a trauma history and can manifest in self-injurious or suicidal behaviour.

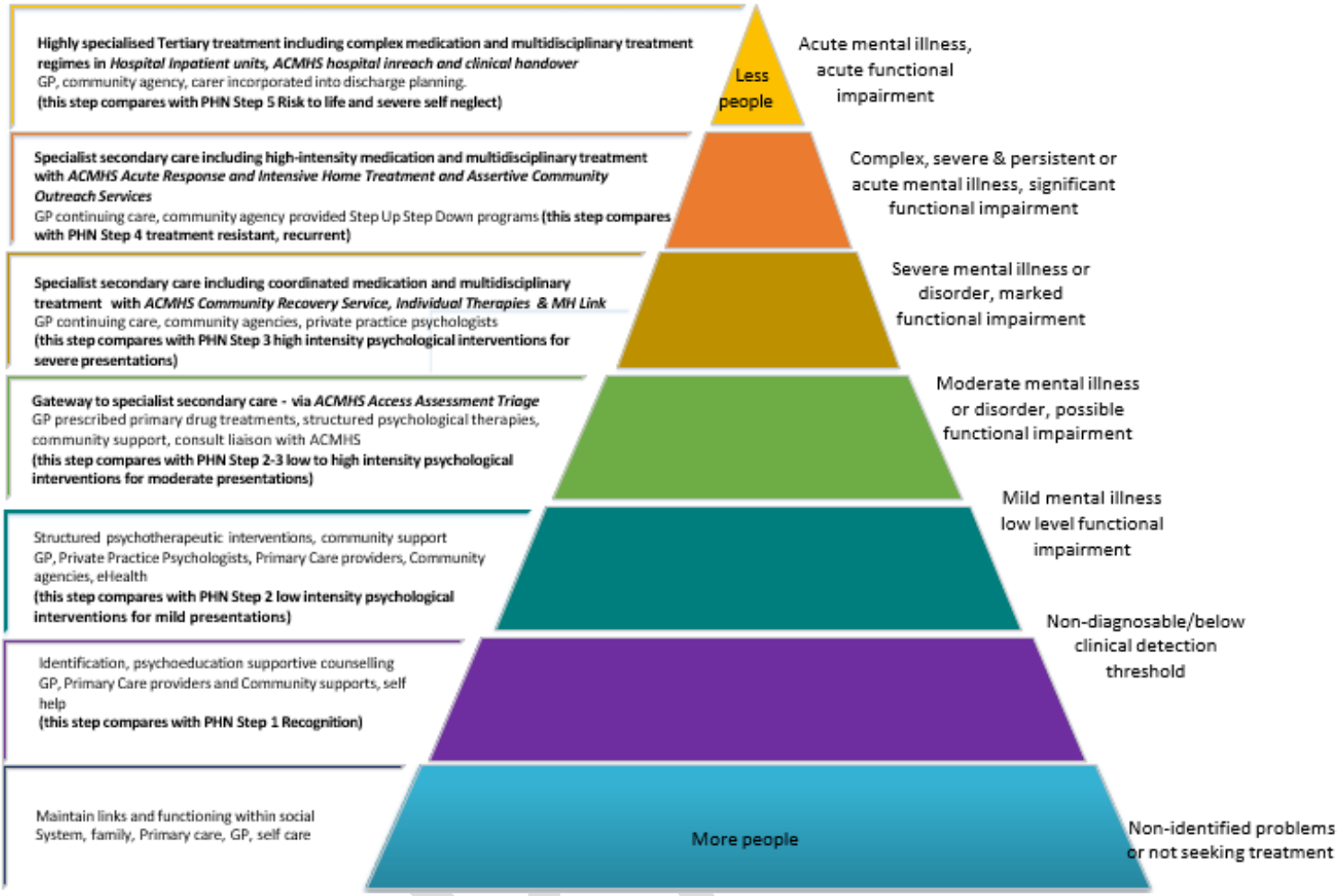
People with needs that cannot be met within the ACMHS may progress to inpatient care. Conversely, those people whose needs can be met by services lower on the Stepped Care Approach (e.g. care provided by General Practitioner (**GP**), private practitioner or community agency) will be transitioned to those services.

2.2 Stepped Care Approach

Whilst all people who experience mental health concerns require timely access to high quality treatment and support, not all will require specialist mental health services, particularly at the acute end of the care continuum. According to the National Institute for Health and Care Excellence (NICE) Guidelines 2011 *Stepped Care Model for People with Common Mental Health Disorders*[iii] all people should be able to access entry level mental health triage and primary health care. This is followed by a 'step up' for those with mild to moderate mental illness/disorder accessing primary health care services in combination with more structured psychological services. Higher steps on the care spectrum include specialist mental health service management for more severe and/or complex mental health presentations.

Specialised care within the ACMHS is prioritised for the key access criteria previously described. The Stepped Care model, represented in figure 1, provides a high-level view of where people who need ACMHS might fit along a spectrum of mental illness/disorder in the general population. The larger steps in the triangle represent larger numbers of people in the community and likewise the smaller steps represent smaller numbers of people in the community requiring that step of the care continuum. Peoples may require access to different steps, going up or down, at different times. ACMHS covers a subsection of these steps and works with other agencies to provide suitable care pathway options for different levels of individual needs at any one time.

FIGURE 1 Stepped Care Model for Adult Community Mental Health Services



(Adapted from Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services, 2015; NICE 2011 *Stepped Care Model for People with Common Mental Health Disorders; and Project Report on the Redesign of the ACMHS MoC O'Halloran et al 2015*[iv]*)*

For the purposes of this model, Primary and Secondary health care is as defined in the ACT Health Services Plan 2022 - 2030 [v] as follows:

- Primary health care is usually the first point of contact for patients and generally a referral is not required to access the service. Primary health care services include GPs, ambulance services, Aboriginal medical, community pharmacy, community agencies which provide health services, private community-based services, dental services, child and family health, self-help organisations.
- Secondary health care is usually not the first health care contact for the person, it may require a referral to provide services or is provided in a hospital setting, and includes Specialists, Hospital inpatient services, Ambulatory care clinics.

ACMHS are considered secondary health care services as they are specialist mental health treatment providers usually accessed once primary health care treatment and care avenues can no longer meet the treatment and care requirements of the person.

The ACMHS explicitly operate within a stepped care approach to match the most suitable level and intensity of service to the individual needs of the person. This ensures the appropriate allocation of resources to meet service demand as well as providing more targeted, personalised interventions for the most vulnerable people. The Stepped

Care model requires integration between secondary and primary levels of care to ensure the system is dynamic and responsive, enabling people to 'step-up' to specialist services, but also to 'step-down' to primary health care and other services. Therefore, ACMHS works closely and collaboratively with the local primary health network, known as Capital Health Network (**CHN**) to optimise access to GPs including bulk-billing services and to adopt best-practice and shared -care arrangements for people experiencing mental illness/disorder.

2.3 Key Exit Criteria

It is the objective of the ACMHS to support a person's recovery such that they are able to experience a better quality of life in the community. A person may reach a point where specialist mental health services are no longer required into the future or for certain periods during their life.

The ACMHS work collaboratively with the person and others involved, ensuring that transition from the service is safe and successful. This process includes sharing information that will assist the person's recovery into the future, such as relapse prevention strategies and information on how to re- access the ACMHS in the future, if required.

ACMHS supports the Carers Recognition Act 2021[vi] and will ensure that transitions from ACMHS will be done in a considered fashion and in consultation with the person and their family, carers and Nominated Person. A clinical handover will be provided to the health professional (usually a GP) providing ongoing care.

Once someone is no longer meeting all key access criteria the length of transition out of ACMHS is based on individual recovery requirements, treatment target consolidation timeframes, transition of care needs, collaborative agreement and planning with the person, involvement of family or carer supports and transition of care to a GP and community sector agencies.

Exit from ACMHS does not occur when a person is admitted to an inpatient mental health facility. The ACMHS episode of care will continue as in-reach into the hospital setting to maintain continuity of care and to assist the person in a seamless integrated care pathway on discharge from hospital back into the community.

The main criteria to indicate a suitable transition of a person out of ACMHS are:

1. The person is not subject to a mental health order under the *Mental Health Act 2015*; and
2. The person has recovered to the extent that frequent ACMHS contact is no longer required; and
3. The person has treatment and/or support structures external to ACMHS able to meet the person's ongoing needs, and where relevant a clinical handover has been provided; and
4. A Recovery Plan inclusive of early warning sign recognition, relapse prevention strategies and a Discharge Plan inclusive of information on how to re-access ACMHS in the future, have been developed and communicated with the person, carer, guardian and Nominated Person; or
5. A person has moved outside of the ACT permanently or is doing so for a substantial period of time. Every effort should be made to ensure people leaving the ACT have appropriate follow up care organised; or
6. Is voluntary and expresses a preference (including by way of an ACD) to receive care in another setting or receive no care at all. Every practical effort should be made to ensure the person receives appropriate care including providing a comprehensive clinical handover to the preferred health practitioner (and other services) where these exist; or
7. A person continues to have significant symptoms and functional impairment and/or require more frequent contact but whose needs can be adequately met by other services. In these cases, it must be demonstrated that no further significant benefit is expected to be gained from specialist care over and above what can be expected in the primary care sector.

People who meet these criteria should be transitioned from the ACMHS wherever possible. This not only increases the capacity of ACMHS to provide access pathways to new referrals, but it also validates the autonomy and recovery journey of a person.

Transition planning commences at the time of acceptance into the service through careful consideration of the barriers that are preventing the person's needs being met by lower levels of the stepped care model and then structured goal-setting and problem-solving is applied to overcome these challenges.

3. Principles of Care

The Vision and Principles of Care encapsulate the nature of all aspects of service delivery under the ACMHS MoC to best meet the needs of people in contact with ACMHS, and are underpinned by national and territory expectations and frameworks that include the National Safety and Quality Health Service Standards (**NSQHSS**)[vii], National Standards for Mental Health Services (**NSMHS**) 2010, MHJHADS Governance Framework 2015, National Framework for Recovery-Oriented Services 2013[viii], legislation including the *Mental Health Act 2015* and *Human Rights Act 2004*[ix], the *ACT Charter of Rights for People who Experience Mental Health Issues*, and the CHS values of reliable, progressive, respectful and kind.

3.1 ACMHS MOC Vision

The overarching vision statement for the ACMHS MoC is:

'Optimising recovery through excellence in community mental health care.'

These words represent key elements that the ACMHS strive to achieve:

Optimising recovery – Making the most of every opportunity to collaboratively engage a person in strengths based quality of life goals that engender hope, maximise self- determination, and improve functioning and social inclusion.

Excellence – providing specialist mental health assessment and treatment which is supported by evidence and best practice, that is well-governed and delivered by highly-trained staff who constantly strive for integrity and quality outcomes in their daily practice.

Community mental health care – offering multidisciplinary intervention and support to a person in their own home or community, including as an alternative to hospital admission.

3.2 ACMHS MOC Principles of Care

1. **ACMHS service provision is:**
2. **Recovery-oriented and person-centred**
3. **Integrated, multidisciplinary and evidence-based**
4. **Embracing of diversity and complexity**
5. **Timely, accessible and responsive**
6. **Committed to Supported Decision Making**
7. **Committed to safety, quality and harm reduction**

3.2.1 Principle 1. Recovery-Oriented and Person-Centred

Service provision is hope-inspiring, strengths-driven, and collaborative and assumes people with severe mental illness/disorder can lead fulfilling lives and contribute meaningfully to their communities and society more broadly. The ACMHS aims to:

- Foster a culture of hope, empowerment and inclusion, that builds on the person's strengths and resources, as well as those of their family and community, to encourage the person to take the lead in their recovery.
- Promote autonomy and self-determination, valuing respectful and therapeutic relationships, and listening to the expertise gained from lived experience.
- Recognise each person's unique life context and individualise treatment plans with reviewable goals and targets
- Enable a holistic approach to treatment, care and support informed by evidence and individual need, emphasising physical, social, occupational as well as psychological and emotional well- being.

- Work towards improvements in broader functioning, including self-management, daily living skills, physical health, housing, improved relationships, community participation, education and employment
- Recognise family systems, acknowledging the roles that family and carers play and, in collaboration with the person, involve families, carers and Nominated Persons in treatment and care decisions, consistent with person-centered care and the practice of supported decision making. As part of the approach to service delivery, staff will provide education to families and carers, supporting them to address their needs, and suggesting links with supports, whenever appropriate
- Recognise the importance of drawing upon a person's social networks and systems within a community setting to enable a person and their social network to heal, recover and strengthen together as vital to the success and sustainability of providing recovery-based services in the community
- Deliver services in the least restrictive manner and promote the use of Advance Agreements, Advance Consent Directives (ACD) and the appointment of a Nominated Person
- Respect and enable the full human rights of the person, including the right to legal capacity, communication and participation in treatment, care and support on an equal basis with others
- Work collaboratively with relevant agencies to ensure people have access to a range of service delivery options. Links to other agencies are made as early as possible in the process
- Work to end discrimination and increase community awareness and understanding of people affected by mental illness/disorder
- Employ and support a peer workforce and acknowledge the lived experience of mental illness/disorder within the multidisciplinary team
- Ensure staff are provided with the training, tools and support needed to develop a recovery- focused approach for each person, including maintaining staff wellbeing.

The ACMHS MoC aims to move away from solely diagnosis-based treatment pathways or service- defined needs of a person. It will instead move towards individualised approaches to care that consider a person's unique situation and goals, and an approach that supports collaborative decision making for treatment options wherever possible.

People with mental illness/disorder who have contact with ACMHS have a direct line of input into service provision through collaborative care planning and formal consumer feedback processes. ACMHS take a Listening and Learning approach whereby all feedback is considered in the context of gap analysis and service improvement opportunities. Systemic advocacy and strategic service consultation is achieved through the employment of MHJHADS consumer consultants and embedding Mental Health Consumer Network representation in ACMHS governance.

3.2.2 Principle 2. Integrated, Multidisciplinary and Evidence-Based Practice

ACMHS are a fundamental component of an integrated mental health services within MHJHADS, providing screening, assessment and a range of clinical and psychosocial interventions for adults living within the community. ACMHS operates as central coordinators in the care continuum of MHJHADS services for adults with a mental illness/disorder. They are pivotal in facilitating effective access, engagement and care within a recovery-oriented service. ACMHS aid a seamless transition between services enabled by collaboration, quality clinical handover and a person-centred focus at all times.

The ACMHS also performs an essential role within the care continuum of the broader health care sector and works in collaboration with the person, their family, carers, Nominated Persons and in partnership with primary care services, community agencies and government services. The ACMHS not only utilises existing mechanisms and relationships to coordinate care, but firmly embeds stakeholder involvement into the design of procedures that reflect genuine service integration.

Integration with community agencies, primary care and other government agencies underpins all aspects of ACMHS service delivery and needs to be prioritised at every point of the care continuum for successful ACMHS MoC implementation and sustainability.

3.2.2.1 Multidisciplinary

As a specialist secondary mental health service, the ACMHS values a workforce that is strong on diversity and multi-disciplinary principles, ensuring a range of training, skills, knowledge and experience for the provision of comprehensive services and interventions.

The ACMHS have staff from different health professional backgrounds and clinical support roles including peer workers, to provide a range of interventions which are holistic, discipline specific and evidence based. Multidisciplinary approaches enable access to the range of interventions required, multifaceted treatment formulation and comprehensive clinical review. ACMHS service components ensure the quarantined time for discipline specific individual intervention when needed in conjunction with general clinical management and assessment.

The ACMHS MoC signals a deliberate shift in the ethos of treatment and treatment delivery in ACMHS towards a higher priority for and concentration on clinical psychosocial interventions. Workforce development will be integral to ensure ACMHS clinicians have the required competencies to deliver high-quality psychosocial interventions. Work practices within ACMHS teams will enable clinicians with recognised psychosocial intervention competencies to focus on their core discipline skills.

3.2.2.2 Evidence-based

The ACMHS provide treatment and care that is efficient, effective and supported by best practice evidence; ensuring professional development opportunities and specialist training and other supports are available to all ACMHS staff. The approach to all service elements is to embed:

- High quality clinical practice guidelines for mental health conditions that includes evidence- based pharmacological and psychosocial therapies and interventions
- Standardised processes for access, triaging, screening and assessment processes
- Best practice clinical and assertive case management models
- Transparent and accountable processes for establishing and evaluating recovery outcomes.

The ACMHS MoC does not seek to prescribe what evidence based best practice is suitable to individualised treatment pathways, instead clinical practice guidelines developed internationally and locally should be referred to when formulating individual treatment approaches to optimise recovery outcomes.

3.2.3 Principle 3. Embracing Diversity and Complexity

ACMHS acknowledge and respond to the diversity and complexity of people accessing ACMHS through the promotion of informed, flexible and adaptive practices. On both an individual and broader community level, ACMHS also seeks to reduce the stigma and marginalisation of people with mental illness/disorder who have diverse and complex needs.

3.2.3.1 Aboriginal and Torres Strait Islander People

The historical and contemporary context and conditions, within which Aboriginal people live, including the loss of country, have made it difficult to attain and sustain good health and wellbeing for many.

Aboriginal and Torres Strait Islander peoples regard social and emotional well-being holistically. Therefore the interplay of psychological, environmental, economic, biological and social factors that influence mental wellness and illness are considerable for Aboriginal and Torres Strait Islander people. The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 [x] sets out guiding principles that ACMHS uphold including recognition that experiences of trauma and loss have intergenerational effects and racism, stigma, environmental adversity and social disadvantage have negative health impacts.

ACMHS is committed to the ACT Aboriginal and Torres Strait Islander Agreement 2019-2028[xi] in closing the gap for health outcomes for indigenous Australians by improving access, cultural competency and clinical outcomes for Aboriginal and Torres Strait Islander people with mental illness/disorder. ACMHS is committed to developing a culturally sensitivity workforce, to understanding specific therapies that have an evidence-base for Aboriginal and Torres Strait Islander people and to increasing access to information developed specifically for Aboriginal and Torres Strait Islander people.

3.2.3.2 Culturally and Linguistically Diverse (CALD) Backgrounds

Providing services to people with CALD backgrounds requires sensitivity to the cultural, gender and spiritual needs of people and their families by:

- Delivering services that are sensitive to the social and cultural beliefs, values and practices of those from CALD backgrounds
- Recognising culture as a protective factor where a strong connection between culture and positive wellbeing exists. This includes acknowledgement of the influence culture has on explanatory models of mental illness/disorder, including its causes and the manner in which it presents
- Supporting ongoing training for staff to maintain and improve cultural competency and reinforce sensitive practice
- Communicating with people in language that is easily understood, free from medical jargon and using interpreters whenever and wherever required
- Increasing access to written materials in languages other than English.

3.2.3.3 Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual (LGBTIQA+)

People of diverse sexuality, sex and gender have significantly poorer mental health and higher rates of suicide than other Australians[xii]. Sexuality, sex and gender diversity is in itself not a causal factor for mental illness/disorder, however the discrimination and exclusion that people who identify as LGBTIQA+ experience relates to higher rates of depression, suicidality, substance misuse, and psychological distress in this community[xiii].

The ACMHS provide safe and supportive care for LGBTIQA+ people and strives to be sensitive to a person's sexuality, sex and gender diversity. Awareness regarding family of choice is also important when identifying carer support systems. Individualised care plans and risk assessments are developed with consideration of these factors in order to address the specific issues that have a high prevalence amongst LGBTIQA+ people. The ACMHS promotes inclusive language and practices, staff education and training to increase competency and understanding of LGBTIQA= mental health concerns. ACMHS also strives to build integrated partnerships with LGBTIQA+ agencies and stakeholders.

3.2.3.4 Comorbidity

The ACMHS supports the ACT Drug Strategy Action Plan 2022-2026 [xiv] and acknowledges the key issue of comorbidity and the critical importance of specifically addressing the needs of peoples with disorders of substance misuse as well as mental illness/disorder. This involves the use of de- stigmatising, evidence-based and integrated pathways to appropriate care and treatment. The core skills of working with substance misuse and mental illness/disorder is to enhance motivation and engagement; identify risk factors; and develop relapse-prevention strategies, all of which are essential capabilities of the ACMHS staff. More complex issues are addressed through consultation and collaborative work with other alcohol and drug services to ensure access to specialist intervention when required and the integration of treatment efforts.

ACMHS comorbidity strategy is to:

- Improve referrals, care pathways and coordination between services to facilitate earlier detection and treatment of people with or at risk of developing comorbidities
- Focus on what services and interventions are needed at any point in time to best support individuals rather than identifying which diagnosis takes precedence
- Promote the use of screening tools, and staff development to ensure best practice assessment, treatment and care to appropriately respond to people with comorbidity.

Service coordination required when people present with a combination of mental health and alcohol/drug issues and this is described below in Table 1.

TABLE 1 MENTAL HEALTH AND ALCOHOL AND OTHER DRUG (AOD) INTERVENTION MATRIX

	Severe Mental Illness	**Moderate Mental Illness**	**Mild Mental Illness**
Severe AOD problem	Joint treating team of Specialist MH and Specialist ADS	Joint treating team of Specialist MH and Specialist ADS OR Primarily ADS treating team inclusive of basic MH care from ADS with Specialist MH input and consult liaison	Primarily ADS treating team inclusive of basic MH care from ADS
Moderate AOD problem	Joint treating team of Specialist MH and Specialist ADS OR Primarily MH treating team inclusive of basic AOD care from MH with Specialist ADS input and consult liaison	Joint treating team of Specialist MH and Specialist ADS OR Primarily MH treating team inclusive of basic AOD care from MH with Specialist ADS input and consult liaison OR Primarily ADS treating team inclusive of basic MH care from ADS with Specialist MH input and consult liaison	Primarily ADS treating team inclusive of basic MH care from ADS
Mild AOD problem	Primarily MH treating team inclusive of basic AOD care from MH	Primarily MH treating team inclusive of basic AOD care from MH	Basic MH and AOD support services and self-help

(Adapted from ACT Comorbidity (Mental Health and Alcohol, Tobacco or Other Drug Problems) Strategy 2012-2014 Health Directorate[xv],)

ACMHS works with individuals to address both areas of mental health and substance use as both conditions are typically not mutually exclusive and interact with each other. Therefore, ACMHS have work practices that ensure:

- Alcohol and drug use history and current behaviour will be captured as part of all comprehensive mental health assessments to increase identification of these issues at the earliest point of intervention
- A timely and evidence-based response is provided to all persons identified as having an alcohol or drug use issue
- Collaborative work with other alcohol and drug services.

3.2.3.5 Physical illness

Mental Health conditions are associated with lower life expectancy and a greater burden of physical disease[xvi] . Factors affecting the higher burden of physical health concerns for people experiencing mental illness/disorder include barriers to accessing physical health care, unhealthy lifestyles, the direct impacts of chronic mental illness/disorder (for instance cognitive impairment due to schizophrenia), treatment-related complications (e.g. sedation, weight gain, insulin resistance) and non-adherence or inconsistent approaches to mental and physical health interventions[xvii].

ACMHS recognise the importance of treating a person holistically, particularly in relation to improving the physical health of people experiencing mental illness/disorder by:

- Ensuring physical health is considered an integral part of all comprehensive assessment and recovery-planning processes
- Promoting access to quality physical healthcare through collaborative relationships with other health providers, particularly GPs
- Considering the physical health impacts of proposed pharmacological treatments and thoroughly exploring alternatives or limiting use of such treatments wherever possible
- Promoting positive healthy lifestyle strategies, particularly those which may counteract or minimise any negative impacts of pharmacological treatments on physical health
- Addressing the social determinants of health as part of someone's health care.

3.2.3.6 Disability

As cited in the Disability and Health Inequalities in Australia Research Summary[xviii], people classified as having a disability have, on average, poorer mental health than people who had experienced the death of spouse in the previous year. Fifteen per cent of young adults and adolescents with disabilities have poor psychological health compared with 8 per cent of their non-disabled peers. About one quarter of people with an intellectual disability sought professional help for a mental health issue (e.g. from a GP, psychiatrist, public mental health service) in the past year compared with 11 per cent of the general population. People with intellectual disabilities are more likely to have been diagnosed with depression than the general community (30.4 per cent compared with 19.9 per cent). Nearly 25 per cent of people with severe or profound disabilities have a high level of psychological distress compared with 5 per cent in the general population.

ACMHS recognise the importance of being an accessible service for people with disability and work collaboratively with disability services and National Disability Insurance Agency to ensure ACMHS clinical input is complimentary to a package of care and support options for the person. Additionally, the MHJHADS Mental Health Intellectual Disability team are included as consultants to the ACMHS treating team when needed.

3.2.3.7 Family/Domestic Violence

Family and domestic violence (including physical, psychological, emotional, economic, social and sexual abuse) is associated with a range of health problems and is the single biggest health risk to Australian women aged 15 to 44 years of age[xix]. Family and domestic violence can occur in a range of different interpersonal relationships, circumstances and settings. For example, it can also impact on men and those in same sex relationships and have serious long-term physical and psychological impacts on children and young people.

Family and domestic violence significantly impacts the health and well-being of individuals including: physical injury, anxiety, and depression, increasing the likelihood that people will engage in harmful practices including substance abuse and self-injurious behaviour[xx]. Experiences of family and domestic violence can result in poorer recovery, and be the cause or trigger for a mental illness/disorder or relapse, respectively. Findings and Recommendations from the Review of Domestic and Family Violence Deaths in the ACT[xxi] also identifies the importance of assessing risk of family and carers.

ACMHS acknowledges the important role it has in identifying and responding to family and domestic violence, as well as monitoring the safety of people engaged with services. Sensitivity in managing and responding to incidents and

disclosures of violence is achieved in ACMHS through a non-judgemental, knowledgeable, and empathic approach to such situations. This is enhanced by a strong therapeutic relationship with the person and collaboration with other key stakeholders wherever possible including family, carers, community agencies and domestic violence services.

Research indicates that disclosure of family and domestic violence to health professionals is more likely to occur if open enquiries are made around this issue[xxii]. Hence, screening for domestic violence has been incorporated into the ACMHS assessment and recovery-planning processes.

3.2.3.8 Stigma and Marginalisation

ACMHS also works with the community to reduce stigma and marginalisation by:

- Promoting a person's access to mainstream health services and support agencies
- Providing education to promote facts and challenge misinformation and preconceptions
- Capitalising on opportunities to raise community awareness of mental health issues
- Leading by example with careful use of language and diagnostic labels.

3.2.3.9 Trauma Informed

Trauma-informed approaches are an integral part of recovery-oriented services[xxiii], and as such are embedded within the ACMHS MoC. Trauma is a broad term and includes experiences of personal lived- experiences as well as cultural, inherited (intergenerational) history and collective trauma. All clinical practices and interventions within the ACMHS are trauma-informed by:

- Being attentive and responsive to the impacts of trauma on mental health and recovery.
- Ensuring policies and daily practices do not contribute to re-traumatisation
- Recognising that unresolved trauma may impact on a person's feelings of safety and trust. It may also lead to a reliance on harmful coping strategies, such as substance use or self- injurious behaviours
- Appreciating the complexity of recovery that comes and the need for both evidence-based clinical interventions and support to overcome functional and other barriers in order to achieve better health outcomes
- Ensuring all ACMHS staff are trained in trauma-informed practice.

3.2.3.10 Children of People with Mental Illness (CoPMI)

There has been growing recognition within adult focused mental health services of the need to have greater sensitivity and responsiveness to the needs of children living with parental mental illness/disorder. They may be vulnerable to developmental, behavioural and mental health problems which may greatly undermine their participation in education and socialisation, and therefore impact on future life opportunities. Children may also be in roles of young carers and require suitable help and support.

However, a compelling body of evidence also demonstrates the efficacy of early intervention strategies and targeted support of CoPMI families, in mitigating the risk to children by reducing the impact of parental mental health and social adversity commonly associated with mental health issues.

ACMHS promote better mental health outcomes for children and young people by widening the clinical scope of adult mental health clinicians to include children and young people in the routine mental health assessments of adult parents accessing ACMHS. This ensures the service views families holistically, validates people in their parenting role and identifies appropriate support links and to intervene accordingly, including where there may be child at risk issues.

To better meet the complex needs of children and parents, a CoPMI clinician is embedded in ACMHS and ACMHS promotes the collaboration with GPs, Maternal and Child Health, Children and Young Peoples Services and the Integrated Multi-agencies for Parents and Children Together (IMPACT) Program.

3.2.4 Principle 4. Timely, Accessible & Responsive

In keeping with Standard 10.2 of the *National Standards for Mental Health Services 2010*, the ACMHS are committed to being accessible to individuals and to meeting the needs of the community in a timely manner. Access to the ACMHS refers to the availability, proximity and responsiveness of all components of service delivery to:

- More readily assess and address mental health crises in the context of that person's daily life, surroundings, supports and preferences for home treatment
- Developed and successfully implemented coping skills in the environment in which they are
- likely to be used, such as a person's home or the community
- Establish therapeutic relationships with less power imbalance and more positive benefits when the person is in their own home rather than in a more clinical setting such as a hospital
- Deliver cost-effective community services in comparison to more expensive inpatient care.
- Responsiveness also refers to providing GPs with timely advice and mental health information to support them to care for people in the primary health sector.

3.2.4.1 Virtual Care Program

Virtual Care aims to connect clinicians and any other persons(s) responsible for providing care to a patient and carer(s) remotely with the use of technology. Where clinically appropriate, virtual care is a safe, effective and valuable tool to support many MoC and offers benefits through improved access, availability, efficiency and quality healthcare. Building on the current Covid Care@Home Service provided by CHS, this model aims to support the ongoing challenges of a demand for accessible health care. Once fully operational, it is intended that this program will support the ACMHS MoC.

3.2.5 Principle 5. Committed to Supported Decision Making

ACMHS promotes the capacity of people with a mental illness/disorder to determine, and participate in, their assessment and treatment, care or support.

In order to encourage and facilitate people in making their own informed decisions about their treatment and care, ACMHS staff:

- Assess a person's decision-making capacity on a decision-by-decision basis, and presume that a person has decision-making capacity unless there is clear evidence to the contrary
- Respect the individual decision making style of the person
- Respect and value the autonomy and dignity of the person
- Take the time to support the person to make the decision in the manner or language that best supports the person to make the decision, and by enabling assistance from the person's formal or informal decision supporters (including Nominated Persons)
- Give effect to the person's preferences and choices under an Advance Agreement and Advance Consent Direction, if the person has impaired decision-making capacity
- Facilitate the creation of Advance Agreements, Advance Consent Directions and the appointment of Nominated Persons.

3.2.6 Principle 6. Committed To Safety, Quality and Harm Reduction

The management of safety, quality and harm reduction is a core function and responsibility of all CHS services and employees.

ACMHS contributes to safety, quality and harm reduction by:

- promoting a culture of governance and leadership, and continuous quality improvement, including engaging in research activities
- increasing capacity and maintaining management workloads for quality care
- incorporating the feedback, views and opinions of people, their families and carers to improve services and ensure quality care

- sharing information about risk with people and services involved
- providing the necessary training and education for all staff
- providing clinical supervision to allow opportunities for reflective practice
- promote data driven quality improvement initiatives.

ACMHS also have a responsibility to manage and reduce the harmful risks associated with mental illness/disorder wherever possible, both for the protection of the individual and in some cases, staff and the broader community. These risks include but are not limited to: self-harm and suicide; threats of verbal or physical aggression to others; as well as risks to a person's emotional wellbeing, financial, occupational, social or reputational status and potential impacts on their interpersonal relationships. This requires ACMHS to have a continual focus on:

- assertive service engagement to strengthen support systems as protective factors
- embedding ongoing risk assessment and monitoring processes in clinical and operational service policies and procedures
- contextualising harmful behaviours when linked with mental illness/disorder
- providing psychosocial and pharmacological interventions to reduce psychological distress related to increased risk and to support recovery
- working within the principles and requirements of the *Mental Health Act 2015* to promote an alliance with treatment
- prioritising work health and safety of all stakeholders and involved parties
- regular communication of risks to relevant stakeholders and involved parties to provide a coordinated and collaborative response, including family, carer and Nominated Person collaboration.

4. Components of Care

The ACMHS MoC organises service delivery into seven core functional components that provide integrated healthcare pathways, as shown in Figure 2. The delineation of service components in this way aims to increase capacity of ACMHS to uphold the focus of care and principles of care, including responding effectively to community demand, and to effectively support and retain a satisfied specialist workforce.

FIGURE 2 ACMHS SERVICE COMPONENTS

Access Assessment and Triage A distinct access, assessment and triage team to promote greater access and consistency in service responses to access requests
Police Ambulance and Clinician Early Response A tri-service mental health co-response capability which works in partnership with ACT Policing and ACT Ambulance Services to provide a timely mobile response to people experiencing mental health crisis.
Home Assessment & Acute Response An acute service that provides a rapid mental health community response to referrals provided by the AMH
Intensive Home Treatment Provides an intensive in-home treatment team which provides an alternative to inpatient admission, inpatient access functions and in-reach into hospital settings to facilitate discharges
Community Recovery Service Clinical Case management and care coordination with a focus on a strengths-based approaches to recovery
Assertive Community Outreach Service An assertive community outreach service to engage more actively with people with complex needs
Mental Health Link Functions as a partner with consumers and carers to provide consultation liaison services and to streamline existing supports for MHJHADS adults in the areas of detention exit program, transitional, residential, and clinical sub-acute accommodation as well as coordinating a brief intervention program and offering neuropsychology services.
Individual Therapies Psychological therapies, psychosocial and other specialty interventions to more specifically target individual requirements

4.1 Access Mental Health (AMH)

In keeping with contemporary best practice evidence, the ACMHS MoC proposes a centralised AMH component of care to assist people to access the right service at the right time. A centralised access process aims to provide an identified service entry point to undertake 24hr triage and a thorough mental health assessment that more effectively link people with the services that most appropriately meets their needs.

The access function is critical to identify and mitigate potentially life-threatening risks for people calling the service. In order to fulfil the access role, a clinician is expected at a minimum to undertake mental health screening of presenting issues, needs, risks and initial planning with the person.

Following mental health screening, based on mental health triage response rating[xxiv], it may be determined that further assessment is required or that the person be provided with resources and alternative referral options available within CHS and the broader community. At this point the AMH can coordinate resources to respond to the person's need in the community as well as possible hospital diversion if required. If further assessment is required, people will then receive follow up assessment by the AMH, or by the Home Assessment and Acute Response Team (**HAART**) if triaged as urgent. The assessment forms the basis of a Recovery Plan for treatment goals and multidisciplinary interventions for people who require ongoing specialist mental health services.

The priority presentation for the AMH are adults who may self-refer or be referred by others. People may present to the service via a number of different means such as telephone, faxed referral, email communication, 'walk in' (e.g. presenting to a community health centre without appointment) or through contact with emergency services. Additionally, referrals from other program areas within MHJHADS should also go through the AMH, including referrals from inpatient facilities, specialist mental health services (such as Forensic Mental Health Services) and young people transitioning to adult services from the CAMHS. This ensures a consistent response and effective monitoring of trends, needs and ACMHS service demands.

Centralising access assessments will develop triage as a specialist area within the mental health service continuum and increases standardisation of assessment processes which promotes equity of access.

Due to this, referrers and the general community experience received will be a more consistent service response. Centralising access assessment workflows, that includes facilitating referrals to external agencies where appropriate, also increases capacity in other service components, such as community recovery teams, to attend to their core business.

The AMH service operates 24 hours a day, 7 days a week, including public holidays. In consultation with the person being assessed and the referrer, the AMH function offers appointments in a range of locations (e.g., Community Health Centres, the person's home) according to three considerations:

- provision of an accessible and acceptable service
- management of risk and safety of the person, staff and others
- minimising travel times for both the assessor and the person being assessed.

4.2 Police, Ambulance, Clinician Early Response (PACER)

PACER is a tri-service mental health co-response program operating in partnership with ACT Policing and ACT Ambulance Services (ACTAS) to provide a timely mobile emergency response to people experiencing mental health crisis. PACER was designed to improve the inter-agency cooperation and collaboration to deliver a more streamlined early intervention response for people experiencing mental health crisis. PACER consists of a Police Officer, Ambulance Paramedic and mental health clinician working together to respond to, assess and help people experiencing a mental health crisis in the community.

PACER delivers first line care with consideration for the least restrictive methods, the mental health needs of the person in crisis, the role and responsibilities of the emergency service agencies and the demand on the hospital emergency department. PACER operates extended hours/7 days a week/365 days a year.

The three key program aims of PACER are to:

Improve health outcomes for mental health consumers and maintain their dignity by utilising a health platform to deliver acute mental health services to the community.

Provide least restrictive care by reducing the use of restrictive measures such as the use of emergency apprehension provisions under the Mental Health Act 2015.

Reduce demand on police, ambulance, emergency departments and acute inpatient services by providing mental health assessment, treatment, care and support in the community.

PACER works closely with other ACMHS and CHS Services/Teams in the Stepped Care Model including AMT, HAART and Inpatient Units. HAART as a team provides clinicians and operational and clinical governance to both the Rapid Response and PACER acute services.

4.3 Home Assessment and Acute Response Team (HAART)

The HAART is a highly mobile and intensive service focused on providing a rapid mental health response to referrals provided by the AMH. HAART provides brief interventions in a person's home or other community environment, when a person is experiencing an acute exacerbation of a mental illness/disorder and/or severe psychological or emotional distress. HAART as a team provides clinicians and operational and clinical governance to both the Rapid Response and PACER acute services.

Acute treatment responses are provided where there is a marked deterioration in a person's mental health resulting in significant functional impairment and/or concerns of increase risk of harm to the person or others to the point that they are risk of needing inpatient care. Increased service contact and more intensive community based management is required to reduce further deterioration.

Referrals to HAART are accompanied by a clinical assessment or triage response rating that identifies suitability for the service by establishing that the referred person is:

- Experiencing an acute exacerbation of their mental illness/disorder
- Able to safely receive care within a community setting
- Assessed as likely to require inpatient admission but where earlier and intensive support could possibly avert admission and/or escalation of circumstances necessitating an admission
- Appropriate for discharge from an inpatient setting but requires intensive support to provide for a safe transition back to the community.

HAART operates extended hours, 7 days a week, 365 days a year and the treatment, care and support options that are provided include:

HAART interventions are recovery-based and tailored to the individual to address the needs identified in the initial assessment or discharge plan.

- Pharmacological and brief intervention therapies (e.g. solution-focused therapy)
- Early intervention rapid response and ongoing assessment and review
- Assisting the person to develop skills relating to crisis/stress management and de-escalation techniques, including the opportunity to practice these with clinicians in situ
- Intensive treatments provided through high frequency contact
- Provision of information about treatments options to promote choice and informed decision- making

- Symptom management, including medication review and administration, management of side-effects and monitoring of efficacy
- Attention to the wellbeing of carers and families by providing support and psychoeducation and linking with appropriate support agencies
- Assistance to maintain community supports, particularly where their absence may significantly destabilise a person's recovery (e.g. loss of accommodation)
- Early preparation and planning to step-down from HAART once an acute episode has resolved. This will include regular communication with a person's GP, case manager or other health professionals
- Facilitating timely access to mental health inpatient units, residential SUSD, crisis accommodation, and psychosocial support services as required
- Fulfilling functions as required under the *Mental Health Act 2015* in relation to involuntary assessment, treatment, care or support provisions.

4.4 Intensive Home Treatment

The Intensive Home Treatment (IHT) team provides continued acute response for up to 2 weeks and is focused on averting admissions wherever safe and appropriate to do so, and if not coordinates acute mental health admissions. IHT operates on an extended roster, 7 days a week, 365 days per year.

IHT is also involved in supporting people to transition from acute inpatient services back to the community where complex multidisciplinary intervention can continue in a person's home as an alternative to ongoing hospitalisation.

Referrals to IHT are accompanied by a clinical assessment or triage response rating that identifies suitability for the service by establishing that the referred person is:

- Recovering from an acute exacerbation of their mental illness/disorder
- Able to safely receive care within a community setting
- Assessed as likely to require inpatient admission but where earlier and intensive support could possibly avert admission and/or escalation of circumstances necessitating an admission
- Appropriate for discharge from an inpatient setting but requires intensive support to provide for a safe transition back to the community.

IHT interventions are recovery-based and tailored to the individual to address the needs identified in the initial assessment or discharge plan.

- Pharmacological and brief intervention therapies (e.g. solution-focused therapy)
- Early intervention and ongoing assessment and review
- Assisting the person to develop skills relating to crisis/stress management and de-escalation techniques, including the opportunity to practice these with clinicians in situ
- Intensive treatments provided through high frequency contact
- Provision of information about treatments options to promote choice and informed decision- making
- Symptom management, including medication review and administration, management of side-effects and monitoring of efficacy
- Attention to the wellbeing of carers and families by providing support and psychoeducation and linking with appropriate support agencies
- Assistance to maintain community supports, particularly where their absence may significantly destabilise a person's recovery (e.g., loss of accommodation)
- Early preparation and planning to step-down from HAART once an acute episode has resolved. This will include regular communication with a person's GP, case manager or other health professionals
- Facilitating timely access to mental health inpatient units, residential SUSD, crisis accommodation, and psychosocial support services as required
- Fulfilling functions as required under the *Mental Health Act 2015* in relation to involuntary assessment, treatment, care or support provisions.

4.5 Community Recovery Service (CRS)

The CRS provide a recovery-focused, strengths-based approach to clinical case management to improve wellbeing and enhance functioning in the community for adults who:

- Are experiencing complex mental illness/disorder or psychological distress which is associated with significant functional impairment and/or significant risks
- May be subject to a Psychiatric Treatment Order under the *Mental Health Act 2015*
- Have multidisciplinary treatment needs that cannot be met elsewhere in the community or less intensive service
- Require regular service contact over a medium to longer-term episode of care.

For new referrals, AMH will undertake a comprehensive needs assessment and determine whether the CRS is the most appropriate service to meet the person's needs. For internal MHJHADS transition of care to CRS, AMH will be the first point of contact then a comprehensive clinical handover discussion will occur to seamlessly transfer care. CRS teams operate weekdays from community health centres.

The person will be allocated an individual clinical manager and a treating medical officer. Regular follow up and engagement is determined by the assessment outcomes, formulation of treatment needs and personalised recovery goals. CRS may involve the specialities of other ACMHS and MHJAHDS teams, plus external support providers, to assist the person towards recovery beyond what can be achieved solely through CRS contacts.

Integral activities delivered by CRS include:

- Coordinating a recovery plan based on the person's goals in collaboration with the person and others (e.g. family, carers, Nominated Persons, community agencies, GPs etc) with ongoing review of progress
- Pharmacological and psychosocial interventions to address multiple complex clinical needs
- Assistance towards improvements in broader functioning, including self management, daily living skills, physical health, housing, improved relationships and community participation, education and employment
- Care coordination with the primary healthcare and community sectors, as well as assisting access supports through the NDIS where eligible
- Assessing for and actively assisting the person to address comorbidities, including drug and alcohol issues and physical health problems
- Ongoing risk assessment (e.g. self-harm, suicide, violence or aggression) and mitigation
- Pharmacotherapy prescription (or GP Liaison regarding prescription), administration, observation, monitoring
- Ongoing review of mental state, recognition of early warning signs of relapse, relapse prevention and crisis management planning
- Supporting the person to be the driver of their own mental health care through mechanisms such as the creation of Advance Agreements, Advance Consent Directions and the appointment of Nominated Persons, as specified in the *Mental Health Act 2015*
- Fulfilling functions as required under the *Mental Health Act 2015* in relation to involuntary assessment, treatment, care or support provisions.

Some people, who experience persistent mental illness/disorder, may require clinical management for an extended period. However it is intended that most people, with time, will be able to transition to a lower level of care. The clinical manager will have worked with the person to put in place the strategies needed to support the person to continue to achieve Recovery goals at the suitable time for transition out of ACMHS.

4.6 Assertive Community Outreach Service (ACOS)

The ACOS is a highly specialised and intensive a multidisciplinary team-based service which provides treatment and care for people who have highly complex needs including barriers to treatment and care engagement. The service is available over extended hours and assists people who require a prolonged period of assertive and frequent contact to engage the person in recovery. The ACOS provides care beyond the more routine pharmacological, psychological and other psychosocial interventions typically delivered in CRS. The complexity of presentations requires a more flexible and adaptive approach to supporting a person's recovery. This includes significant collaboration and negotiation with a number of external agencies due to the multiple social determinants of health factors present for people accessing ACOS.

It is anticipated that most referrals will come from inpatient or community mental health settings. The AMH provides a centralised access point for any external referrals.

The ACOS will provide care for adults who:

- Are experiencing complex mental illness/disorder or psychological distress which is associated with significant functional impairment and/or significant risks
- Have a history of multiple mental health inpatient admissions and/or long periods of admission and/or frequent presentations to emergency departments
- May be subject to a Psychiatric Treatment Order under the *Mental Health Act 2015*
- Are either unable or unwilling to engage with services and
- Are vulnerable and with multiple complex needs including:
    - frequent relapses
    - history of poor alliance with treatment including medication
    - poor response to previous treatment
    - significant ongoing risks requiring more assertive management
    - requiring high frequency contact (e.g. more than 3 'routine' home visits most weeks) with a mental health service over an extended period (e.g. 2 years)
    - a chaotic, disorganised, unstable lifestyle, complicated by issues such as homelessness, legal or financial difficulties
    - comorbidities including substance abuse, physical health problems, intellectual disability or personality vulnerabilities.

ACOS aims to deliver treatment over a sustained period to enable the person to improve in social and other areas of functioning, require less hospital admissions and engage more actively in treatment.

The person is allocated a key worker within the team but the entire team will be aware of each individual's needs to ensure continuity of care given the extended hours component of the team and the team-based approach to biopsychosocial interventions. A structured holistic, flexible and intensive treatment plan is developed in collaboration with the person, family, carer and Nominated Person and aimed at addressing both short-term and longer-term goals. Treatment includes:

a) thorough and ongoing risk assessments inclusive of crisis and risk management plans
b) monitoring medication and promoting a broader treatment alliance
c) strategies for early identification and treatment of mental health and physical health deterioration
d) a focus on rehabilitation and improving functioning in activities of daily living, social inclusion and interpersonal relationships
e) identification and assertive treatment of comorbidities particularly physical illness and alcohol or drug problems. Collaboration with partner agencies including GPs and other services to manage comorbidities
f) setting goals that enable the person to transition to less intensive care settings Supporting the person to be the driver of their own mental health care through mechanisms such as the creation of Advance Agreements, Advance Consent Directions and the appointment of Nominated Persons, as specified in the *Mental Health Act 2015*
g) Fulfilling functions as required under the *Mental Health Act 2015* in relation to involuntary assessment, treatment, care or support provisions.

4.7 Mental Health Link Team

Mental Health (MH) Link provides highly specialised treatment and care through a range of multidisciplinary services primarily for individuals with severe mental health needs experiencing challenges in accessing treatment and care. MH Link provides in reach consultation liaison services to support the transition of adult consumers from MHJHADS acute and rehabilitation inpatient care areas to community living. MH Link also supports community adult consumers to step up to sub-acute therapeutic residential accommodation.

MH Link functions as a partner with consumers and carers to bring together government and community services and to streamline existing supports for MHJHADS adults in the areas of custodial, transitional, residential, and clinical sub-acute accommodation. MH Link offers a homeless outreach services team (HOT) to provide transitional care for adult MHJHADS consumers who have no fixed address, helping them to secure accommodation and access community social and medical services after they discharge from inpatient care areas.

MH Link works in collaboration with teams across the stepped care spectrum to deliver care and treatment to enable the person to improve in social and other areas of functioning, require less hospital admissions and engage more actively in treatment.

MH Link provides the following programs:

4.7.1 Clinical Sub Acute Supported Accommodation (Step up, Step Down residential programs)

Provide consultation liaison and work with both inpatient and community stakeholders to facilitate intake into Step-Up Step-down houses and associated recovery programs.

4.7.2 Homeless Outreach Team (HOT) Service

Provide transitional care for adult consumers who have moderate to severe mental health care needs and who are experiencing primary homelessness by linking in with services and then either stepping up to CRS or down to a GP.

4.7.3 In Reach Consultation and Liaison

Provides support to patients presenting with barriers to discharge by supporting the transition of adult consumers from MHJHADS acute and rehabilitation inpatient care areas to community living through consultation and liaison with treating teams and stakeholders.

4.7.4 MH Supported Accommodation

Provide consultation liaison to facilitate supported short and longer-term accommodation houses, partnering with consumers, carers and NGO's.

4.7.5 Neuropsychology

Provides neuropsychological support and assessments for individuals being treated under MHJHADS for a range of thinking skills such as attention, memory, language, planning and reasoning. The service aims to support people with mental illnesses, genetic conditions, brain injury or disease through improving cognitive skills and assisting with the planning and organisation of day-to-day activities.

4.7.6 Brief Intervention Program

Coordinates the provision of up to four brief psychological sessions, drawing on a roster of clinicians from across the MHJHADS division.

4.7.7 Partnership

MH Link partners with Wellways, Woden Community Services, STRIDE and the ACT Corrective Services community housing initiative to support consumers to connect with the community and to enable psychosocial recovery. MH Link also partners with the Way Back Support Service which provides community support post suicide attempt.

4.7.8 Therapies Team

ACMHS recognises that various evidence-based approaches are utilised as part of assessment, treatment and care throughout ACMHS. Whilst all ACMHS teams utilise diversity and expertise of a multidisciplinary team, the interventions provided in the Therapies Team component maximise access to discipline specific therapies and assessments that are delivered in a more concentrated and structured manner than is typically possible within other ACMHS services. This service component enables access to individual psychological, psychosocial and other specialist interventions that are a core component of a multimodal approach to the treatment of major mental illness/disorder. The interventions must draw upon the individual expertise of clinicians who are assessed as suitably experienced or qualified to deliver specific therapies and specific assessments. The interventions are also limited to those which are not easily accessible to the person in the community. The team is also integrated with group programs delivered through the existing Adult Mental Health Day Service such that they complement each other for delivery of specific programs.

The team provides psychosocial and other interventions that include:

- specific assessments (such as occupational therapy or functional assessments; family assessments),
- specific therapies (such as Cognitive Behaviour Therapy; Family Therapy; and Dialectical Behaviour Therapy).

The quarantined time away from crisis or case management functions enables structured approaches to therapy informed by a substantial body of evidence based best practice guidelines that are consolidated in various clinical practice guidelines that are endorsed and disseminated by various health representative organisations (e.g., National Institute for Health and Care Excellence (**NICE**); National Health and Medical Research Council). Clinical Practice Guidelines and research demonstrating therapy efficacy are used to inform the interventions planned by the team. The clinical plan will be discussed with the person as part of the development of the Recovery Plan.

Priority will be given to people who are high service users such as those people who have frequent presentations to emergency departments or hospital admissions. Involvement of the Therapies Team is expected to make a significant difference to their clinical care and lead to a reduction in their emergency presentations or hospital admissions. For example, this might include people with trauma backgrounds or Borderline Personality Disorder who require higher intensity and more specialised interventions to help manage psychological distress and associated harmful behaviours. This service is also available to people whose needs cannot be provided by any other service or means (e.g., unable to access these types of services through the private health sector or NDIS).

The Team also provides consultation and liaison services to help inform the care for people under the care of other ACMHS teams. For example, this may include information, education or support to a clinician who may be involved in the care of a person who, for a variety of reasons, is not able to engage in more intensive therapy.

Therapies are mostly an adjunct of treatment and care when a person is clinically managed or participating in a group delivered by other service components or programs. Shared clinical decisions and robust communication is essential to effective person-centred approach to treatment, therefore requiring an integrated approach to Multidisciplinary Team (**MDT**) reviews between the Therapies Team clinicians and other service components and programs.

The Therapies Team component also has a role in the provision of consultation liaison to support clinicians elsewhere deliver effective assessment or clinical management.

4.8 Components of Care Comparison

The ACMHS MoC Components of Care are differentiated as key functions of service delivery not only by the nature of the service provided but also across a spectrum of the presentation of people requiring service contact and by length and frequency of service contact. The high-level comparison can be shown in Figure 3, which also includes reference to inpatient care and primary health care as higher and lower steps on the Stepped Care model.

FIGURE 3. ACMHS SERVICE MATRIX

Not requiring ACMHS, suitably managed without ACMHS by Primary Health, private psychologists, community agencies, counselling centres, self help, social systems (NB these services would still be involved in the ACMHS and inpatient columns)	**Access Mental Health (AMH)**	**Community Recovery Service (CRS)**	**Mental Health Link (MH Link)**	**Therapies Team**
	First contact point with assessment and referral follow up as per triage rating	Moderate intensity (weekly, fortnightly or monthly) multidisciplinary interventions	Moderate to severe intensity (weekly, fortnightly or monthly) multidisciplinary interventions	Weekly structured sessions as per mode of therapy or one off specialist assessment session
	Phone or Community Health Centre	Person's Home or community health centre appointments	Person's Home, community health centre appointments, emergency departments, hospital inpatient units and custodial settings.	Community Health Centre
	Triage line 24 hrs 7 days, Assessment appointments 9am-5pm Mon-Fri *(rapid 24 hr assessment response referred into HAART)*	9am- 5pm Mon-Fri	8:30am-5pm Mon-Fri	9am-5pm Mon-Fri
	Assessment period	Long term	Short term	Shot or long term
All other presentations of mental illness/disorder	Signs of at least moderate mental illness/disorder requiring further assessment. Complexity of mental health presentation is unknown and triaged at this point.	Complex, severe and persistent mental illness/disorder with significant psychosocial functional impairment and/or risks associated with complex needs	Complex, severe and persistent mental illness/disorder with significant psychosocial functional impairment and/or risks associated with complex needs	Complex, severe and persistent mental illness/disorder with significant psychosocial functional impairment and/or risks associated with complex needs
				Requiring structured discipline specific therapy sessions or assessments

Not requiring ACMHS, suitably managed without ACMHS by Primary Health,	**Assertive Community Outreach Service (ACOS)**	**Intensive Home Treatment Team (IHT)**	**Home Assessment and Acute Response Team (HAART)**	**Police, Ambulance, Clinician Early Response (PACER)**	**Inpatient Admission**
private psychologists, community agencies, counselling centres, self help, social systems (NB these services would still be involved in the ACMHS and inpatient columns)	Moderate to high intensity (2-3 times weekly) multidisciplinary interventions Person's Home or community health centre appointment extended hours 7 days 12-24 months	High intensity (twice daily, daily, 2-3 times weekly) multidisciplinary treatment safely managed without hospital admission Person's Home or community health centre appointment extended hours 7 days 2 - 6 weeks	Rapid response acute mental health and suicide risk presentations. Assessment and management in the persons home, community centre, or other community location. Short term follow up following inpatient discharge or service contact. Mobile Service Operates extended hours 7 days 2 weeks	Emergency/Crisis service for acute mental illness Mobile Service Operates 24 hours 7 days Early Intervention	High intensity multidisciplinary treatment in contained hospital facility Canberra Hospital & North Canberra Hospital MH Units Operates 24hrs 7 days with on site 24hr medical and nursing support
All other presentations of mental illness/disorder	Complex, severe and persistent mental illness/disorder with significant psychosocial functional impairment and/or risks associated with complex needs	Acute mental illness/disorder and or suicide risks	Acute mental illness/disorder and or suicide risks	Acute mental illness/disorder and or suicide risks	Complex, severe and persistent mental illness/disorder with significant psychosocial functional impairment and/or risks associated with complex needs
	Requiring assertive service engagement strategies	Requiring acute service engagement strategies to facilitate hospital admission, to avert hospital admission, to support transition into the community	Requiring acute service engagement strategies	Requiring acute service engagement strategies	Requiring assertive service engagement strategies
			An acute exacerbation of the mental illness/disorder and/or severe psychological or emotional distress	An acute exacerbation of the mental illness/disorder and/or severe psychological or emotional distress	An acute exacerbation of the mental illness/disorder and/or severe psychological or emotional distress
					Immediate risk of self harm to others that cannot be safely managed without contained hospital environment and 24 hr medical care.

5. ACMHS MOC Sustainability

A number of factors require attention, such as sector partnerships, culture, governance and workforce development to enable the benefits of increased capacity, efficiency and effectiveness that the focus of care, principles of care and components of care aim to promote; and to avoid degradation of the ACMHS MoC over time. Ongoing involvement and oversight from people and their carers will be essential to ensure the culture of recovery-oriented service provision is maintained and expanded.

5.1 Sector Partnerships

The inclusion of service partners, peak agencies and statutory bodies is part of any model of care in order to sustain optimum service delivery. The National Health Workforce Innovation and Reform Strategic Framework highlights that a critical part of service improvement is thinking in systems terms and engaging with others across sectors and jurisdictions. Additionally, the Plan for Health Workforce of ACT 2012-17 discussion paper[xxv] linked service quality and safety and workforce sustainability to increased collaboration between organisations.

A range of committed, diverse and comprehensive community support services exist in the ACT and ACMHS works in close collaboration wherever possible to maximise care coordination and optimal referral pathways. In addition, the Mental Health Community Coalition ACT (**MHCCACT**) is the peak body for community agencies in the mental health sector and works closely with MHJHADS ensuring systemic advocacy, productive partnerships and strategic planning.

Continued committed close linkages and collaborative partnerships with community agencies and GPs are pivotal to implementing and sustaining the ACMHS MoC. For ACMHS to be responsive when needed, the community and primary sector agencies will need to be supported in their care coordination and recovery support roles with people who access ACMHS. Collaboration will be prioritised regarding risk management, seamless referral pathways, recovery planning, case review and transfer of care.

5.2 Culture

5.2.1 ACMHS Principles of Care

The ACMHS MoC is not just articulating structural change towards more clearly defined components of care, it requires significant attention to embedding and consolidating the Principles of Care and priority access criteria. This will improve the capacity, efficiency and effectiveness of community based mental health care. Sustaining the ACMHS MoC in relation to Principles of Care requires cultural change from diagnosis-based decision making and siloed approaches to care pathways that have historically occurred.

There is the continued need to further develop collaborative recovery-oriented approaches when working with people, their carers, and Nominated Persons. This approach also needs to be used when introducing a peer workforce into service delivery, encouraging inclusive attitudes and developing competencies to embrace diversity in ACMHS.

5.2.2 Creativity, Innovation, Change

The National Health Workforce Innovation and Reform Strategic Framework highlights the importance of transforming organisational cultures to foster innovation, creativity and change. Furthermore, CHS Quality and Clinical Governance Framework characterises clinical effectiveness as supported by a culture where evaluation of improvement and performance is commonplace and expected in every clinical service. Innovation, creativity and change is recognised, encouraged and rewarded within the ACMHS workforce. The positive contributions of all staff both collectively and individually are affirmed. There are clear and transparent processes regarding rewards and recognition with a common understanding of this amongst staff. Additionally, quality improvement is embedded in various processes including staff meetings, individual performance plans and service Key Performance Indicators.

5.2.3 Staff Wellbeing

The physical and psychosocial wellbeing of ACMHS staff has a direct impact on workplace culture and quality customer service. Facilitating ways where staff are able to focus on personal wellbeing in the ACMHS workplace follows the strategies outlined in the Canberra Health Services Staff Health and Wellbeing Strategy 2020-2023[xxvi], including:

- Encouraging healthy lifestyle choices and access to physical health activities
- Ensure a sense of social and cultural connection and wellbeing by ensuring staff feel they belong.
- Encouraging staff have a sense of purpose in their lives outside of work to support a spiritual connection
- Provide emotional support options for staff through Employee Assistance Program (EAP) and other professional support activities.
- Provide opportunities to increase knowledge by offering study leave, participation in clinical learning opportunities and recognizing excellence.
- Ensuring that the workplace is safe and free from harm, where support from occupational violence, family violence, equipment, manual handling training and a staff immunization clinic are available.
- Promoting a CHS smoke free environment to ensure everyone's wellbeing
- Providing financial initiatives such as salary packaging and financial counselling through EAP
- Additionally, ACMHS endeavours to
- Actively address bullying and harassment in the workplace,
- Ensure manageable workloads and clarity of roles, responsibilities and expectations
- Develop and appoint responsive and supportive managers
- Promote healthy work life balance.

5.2.4 Values

The Canberra Health Services values of Reliable, Progressive, Respectful and Kind underpin the workforce culture for effective implementation of the ACMHS MoC. In light of these organisational values an effective health service requires commitment to:

- person-centered focus and empathetic care
- utilisation of best practice approaches
- ensuring transparency, accountability, and professional competence
- working collaboratively within a multidisciplinary team alongside people and their family and support systems.

Values-based leadership within the ACMHS workforce will model commitment to embedding these values in professional conduct throughout the workplace. Values-based team building will set foundations for teamwork communication, relational goals and expectations as underpinned by Reliable, Progressive, Respectful and Kind. Being connected to a sense of

purpose and shared organisational values fosters collaborative effort to engage in workforce risk management.

5.2.5 Respect, Equity and Diversity

ACMHS is committed to upholding the provisions of the ACT Whole of Government, Respect, Equity and Diversity Framework[xxvii]. ACMHS is committed to providing a safe and harmonious work environment that enhances the achievements of both the individual's and the organisation's goals. It also upholds a culture in which diversity is respected and the contribution that people with diverse backgrounds, experience and skills make to the workplace is valued.

5.2.6 Governance And Leadership

Structured, consistent and embedded governance and leadership within ACMHS is pivotal in implementing the ACMHS MoC and for sustaining improvements. A focus on governance provides a framework which draws together initiatives, processes and systems and ways of working as described in the ACMHS MoC, and therefore staff of all levels, including clinicians, managers, team leaders and medical staff retain responsibility for ACMHS performance and quality service provision.

The ACMHS has a tiered hierarchy of organisational governance regarding decision making and endorsement of service activities which aligns with the *Governance Framework for Mental Health, Justice Health and Alcohol and Drug Services*. The specific roles and responsibilities of the ACMHS staff within this governance structure are also detailed in individual position descriptions and duty statements.

The CHS Governance Framework 2020-2023 highlights that clinical governance is the responsibility of each and every person who is involved in receiving or providing health services. The application of ACMHS MoC principles of care is a key commitment for ACMHS staff across all service components.

ACMHS Team Leaders and Managers have a direct role in supporting their staff and in overseeing daily operations. This role is pivotal in shaping the appropriate delivery of service functional components in line with priority access criteria and principles of care. Team leaders also contribute significantly to an innovative and engaged workplace culture to sustain the MoC by promoting shared and collaborative responsibility[xxviii] and driving continuous quality improvement.

The management team requires strong leadership attributes and skills to support their staff in the ACMHS workplace. At the same time, all ACMHS staff are developed and encouraged to show personal leadership within their workplace. Staff are rewarded and recognised for displaying personal leadership in their approach to championing quality initiatives, best practice, multidisciplinary teamwork and governance.

ACMHS Medical staff support staff and the management team by providing clinical and academic leadership and ensure clinical decision making and treatment remain in line with MoC principles of care and achievement of quality clinical outcomes consistent with evidence-based practice.

ACMHS Directors and Senior Managers provide senior leadership to ensure service delivery is in line with the strategic direction, organisational accountability targets and corporate governance processes.

Furthermore, MHJHADS Discipline Principals have an integral role within ACMHS to advise on and promote professional standards, competency and professional development of ACMHS staff.

The Chief Psychiatrist has a statutory function under the *Mental Health Act 2015* to oversee the provision of assessment, treatment, care and support for people subject to the Act, and to make recommendations about mental health service delivery. The Chief Psychiatrist is also responsible for setting out the functions of mental health officers, which may include ACMHS staff.

As part of an integrated ACMHS the MDT forms a decision-making body that will establish as a group the appropriate follow up requirements for a person or review and endorse any outcomes of the assessment and treatment. The MDT provides transparency and accountability for decision-making and also enhances practice by fostering learning opportunities, including interdisciplinary development, within a supportive peer review environment support. It also ensures a holistic view of current clinical demands and complexity which can highlight service delivery issues to management. MDTs are not defined by service location instead involve participation of all components of care involved with a person.

Based on an established commitment to equality and partnerships, opportunities are also provided to ensure people, their carers and other internal and external stakeholders are able to contribute to a range of activities which include the planning, development, implementation and evaluation of services.

5.3 Workforce Development

5.3.1 Professional Development - Training

The ACMHS MoC promotes ongoing training and development for all staff, including clinical and peer supervision, clinical reviews and multidisciplinary team meetings where each staff member is responsible for ensuring the best possible service is delivered in line with National Mental Health Practice Standards 2013[xxix].

All ACMHS staff have an individual performance plan discussion and documentation which supports their learning and professional development requirements to ensure a skilled and competent workforce. The National Health Workforce Innovation and Reform Strategic Framework 2015[xxx] emphasises the importance for services to develop an adaptable health workforce equipped with the requisite competencies and support that provides team based, inter-professional and collaborative models of care.

Workforce growth, efficiency and productivity are supported by providing staff with appropriate access to professional development opportunities. ACMHS staff will have regular access to clinical supervision, training, and multi-disciplinary and interprofessional learning in the workplace.

5.3.2 Professional Development – Supervision

Clinical supervision facilitates the professional and practice development of clinicians through a process that includes reflection, education and discussion. Clinical supervision enables ACMHS clinicians to assume responsibility for the development of their knowledge, skills, competency, practice and professionalism. It supports professional standards of practice and quality of care within a clinical governance framework. The effective use of clinical supervision is critical for providing efficient, effective and timely support to people with mental illness/disorder and their carers and is a key part of staff professional development. Individual supervision and peer supervision will provide avenues for staff to access the specialist knowledge and guidance from supervisors and colleagues.

5.3.3 Teaching Environment

MHJHADS has key partnerships with a number of teaching institutions including The University of Canberra, The Australian National University and the Australian Catholic University in providing clinical placements and teaching to medical students, nursing and allied health students. A number of these students will have placements within the ACMHS.

MHJHADS also has the responsibility for providing post graduate training to a number of disciplines including doctors, nurses and allied health professionals. These trainees provide the service with significant benefit in terms of service provision and, in the longer term, will become fully qualified practitioners able to meet the needs of the Canberra population. Our aim is to provide a setting where junior clinicians can learn from and be mentored by experienced practitioners and in turn become skilled practitioners of evidence-based care and be qualified to teach others.

MHJHADS also provides entry level employment for RN1s and HPO1s and has the responsibility to create work opportunities suitable to the entry level skill and capacity. MHJHADS values and nurtures entry level staff in effort to build and develop their experience and expertise for future succession into higher clinical employment levels.

Providing a quality learning experience takes an investment of time and resources. Adequate time, training and resources are allocated to those who supervise students and junior clinicians to ensure they have a positive learning experience. AHPRA and other professional bodies that oversee the registration and training of health professionals have specific requirements in terms of training experiences, clinical supervision and the working environment that are adhered to in order to maintain accreditation and reputational status as a provider of high-quality training.

AHPRA and other professional bodies overseeing the various disciplines have specific requirements for continuing professional development and supervision. Clinicians must adhere to these requirements in order to maintain their professional registration and thereby their employment.

Outside of registration requirements, continuing professional development is critical for keeping up to date with research and innovation in health care in order to equip the workforce to provide the highest quality health care. Supervision is important in creating room for clinicians to examine and reflect on their own practice and to seek advice from and feel supported by

their colleagues particularly when caring for complex, high needs individuals. Supervision is also important for maintaining a clinician's wellbeing in what can be a demanding environment.

Continuing professional development and supervision requirements take time but provide benefits for MHJHADS in the maintenance of a motivated and effective workforce. The ACMHS recognises the importance of these and will allocate adequate time and resources to ensure clinicians' needs in these areas are met.

5.3.4 Staff Orientation

Orientation training package should not just focus on familiarising new staff with the service components and work duties, instead ACMHS should also orientate new staff to the principles of care and culture that embeds ACMHS MoC within daily business.

5.3.5 Embedding Research

ACMHS provides a rich setting to conduct mental health research in a real world setting and has a number of prominent mental health researchers on staff who are enthusiastic supporters of research initiatives. ACMHS is committed to ongoing research because:

- Ongoing research and innovation is vital to improving the lives of people with mental illness/disorder
- Research projects have the capacity to enliven the service with new ideas and to assist staff with the maintenance of curiosity and life-long learning that is essential to providing good quality clinical care
- Research projects are a key part of training for many of the undergraduate and post graduate students who have clinical placements within MHJHADS
- Ongoing research adds to the prestige of the organisation and assists in the recruitment and retention of a skilled workforce that is essential to providing excellence in clinical care.

5.3.6 Structured Change Management Approach to Moc Implementation

The approach to change management will affect the longer term sustainability of the ACMHS MoC concepts within service delivery.

To facilitate sustainable changes the ACMHS MoC implementation needs to be methodically embarked on to ensure considered and planned change activities that:

- limit change fatigue
- maximise communication and support for people affected by the ACMHS MoC
- ensure widespread engagement in the implementation process, and
- foster strong leadership to embed the MoC into routine practice.

The implementation schedule will address the detail regarding policy and procedure development, workforce profile analysis, team structure and location change, training roll out and achievable timelines that balance urgency for change and the importance of staging and prioritising implementation tasks.

6. ACMHS MOC Evaluation

6.1 ACMHS MOC Changes and Benefits

The implementation of the ACMHS MoC aims to achieve the following changes:

1. Greater embedding of recovery principles and best practice, evidence-based interventions in all facets of service delivery to better meet community expectation of a contemporary mental health service
2. More efficient access and care flow pathways to provide people with a more seamless journey through the care continuum
3. Increased standardisation of procedures, processes and practices to promote more internal consistency in service delivery
4. Greater clarification and delineation of the roles and functions of service elements to reduce duplication and functional inefficiencies
5. Greater specialisation within service elements to target interventions more appropriately to the different needs of service users
6. Enhanced integration with other internal and external services to provide better coordinated and more holistic care
7. Better utilisation of technologies to support care delivery systems and reduced administrative burden on staff and promote more direct clinical contact.

These changes should achieve the following benefits:

- Improved access pathways to ensure the right response for the right people and the right time
- Improved definition of ongoing clinical management functions and target population to ensure increased safety and quality of care for people with serious mental illness/disorder
- Effective and appropriate community-based treatment and care to reduce need for hospitalisation
- Improved workplace culture that reflects clarity of vision and role expectations and improved staff wellbeing.

The ACMHS can evaluate the extent to which benefits have been realised through existing data capture and analysis processes.

6.2 Data Capture and Analysis

Data capture is fundamental to service delivery and will be utilised to provide information on whether the ACMHS MoC implementation is achieving the expected changes. The ACMHS MoC evaluation aims to limit the need for any additional data capture and instead capitalise on existing and clinically relevant data capture.

ACMHS has obligations under legislation, standards and policy to maintain accurate demographic and clinical information data on people accessing ACMHS. ACMHS captures all relevance demographic information data in the Digital Health Record (DHR). ACMHS captures all relevance clinical information data in the MHJHADS Electronic Clinical Record (ECR).

Data capture in both systems also functions to:

- improve multidisciplinary team information sharing
- reduce clinical handover risks

- ensure a person-centered clinical record for integrated MHJHADS services in the treating team
- ensure data integrity for reporting and service provision analysis.

De-identified data from both systems is extracted into the CHS data warehouse for national and local reporting, performance analysis, service planning, and approved research. For example, all National Outcomes and Casemix Collection data is captured in the ECR and extracted for national reporting.

All incident data is captured on the CHS Riskman system. Information in this system is extracted in the CHS Risk Register for analysis.

Staffing and Budget reports using the Oracle system are also analysed monthly.

Manual audit processes are also used in terms of clinical documentation standards, consumer and carer feedback and staff culture survey.

Analysis of service provision Key Performance Indicators and trends from data extracted from all systems enable:

- business planning and strategic planning
- operational reporting
- performance monitoring and evaluation.

These existing data reporting processes will be used to analyse, evaluate and monitor the ACMHS MoC implementation, as per the Benefits Realisation and Evaluation Plan.

6.3 Benefits Realisation

The ACMHS MoC intended changes and achievements will be analysed in the context of measurable Benefits and related metrics that can be identified through existing data capture and analysis, as shown in Table 2.

TABLE 2. EVALUATION OF BENEFITS

Benefit	Measure	Metric
Improved access pathways to ensure the right response for the right people and the right time	• Reduced presentation at Emergency Department (ED) for assessment • Increased triage and assessment in community • Reduced waiting lists for assessment by psychiatrist • Responses for initial follow up aligning to triage ratings • Reduced wait lists for treatment/clinical management • Increased internal consistency in relation to intake criteria, assessments and clinical decisions	• Number of Emergency Department (ED) presentations • National Emergency Access Targets (NEAT) for ED • OOS for community triage • Wait times between referral and assessment • Number of service contacts made within the allocated triage priority rating timeframes. • Wait time between initial assessment and treating team clinician allocation • Clinical documentation audits • Stakeholder feedback (including person, carer, other agencies)
Improved definition of ongoing clinical management functions and target population to ensure increased safety and quality of care for people with serious mental illness/disorder	• Increased internal consistency in relation to intake criteria, assessments and clinical decisions • Service contacts frequency in line with persons needs and service fidelity criteria • Reduced referral through to clinical management teams for access episodes of care • MDT adhering to treatment target reviews • TL leadership of standardised understandings • Improvements in Outcome Measures • Improvements in attaining recovery goals • Improvements in levels of functioning •	• Clinical Documentation audit • No of service contacts achieved in accordance within triage priority ratings • Occasion of service (OOS) frequency of teams • CRS and ACO referrals • TL performance plans • Outcome Measures scores (eg HoNOS) • Social determinants of health statistics (e.g. numbers of people studying or working) • Goal attainment scales • Consumer and carer satisfaction
Effective and appropriate community based treatment and care to reduce need for hospitalisation	• Enhanced capacity of ACMHS • Reduced frequency of hospitalisation • Reduced Length of Stay (LOS) in mental health inpatient units • Implement evidence based interventions • Provide recovery oriented services to ensure individual needs are catered for • Integrated care pathways within ACMHS • Reduced 28 day readmissions • Reduced 3 and 6 month re-entry to ACMHS after exit	• Staffing profile increases • Staffing Budget variances • Staffing Vacancy rates • LOS – AMHU • 28-day readmission rates to inpatient units • % clinically managed ED presentations • Discipline specific OOS • Number of recovery plans, Advance Agreements, Advance Consent Directions. • Clinical documentation audit • Consumer feedback • Benchmarking
Improved workplace culture that reflects clarity of vision and role expectations and improved staff wellbeing	• Reduced staff absenteeism and increased staff satisfaction • Improved Culture Survey results and other audits of staff satisfaction and workplace harmonisation. • Embedded Quality Improvement activities • Reward and recognition processes • Reduced number of Staff Accident and Incident Reports (SAIRs) • Occupational Health and Safety (OH&S) audits • Staff retention and reduced workforce vacancy • Recruitment successes	• Culture survey • Number of quality improvements • Number of SAIRs • Staff vacancy rates

7. Abbreviations

AA	Advance Agreement
AMH	Access Mental Health
ACD	Advance Consent Direction
ACMHS	Adult Community Mental Health Service
ACOS	Assertive Community Outreach Service
ACT	Australian Capital Territory
ACTAS	ACT Ambulance Service
ACTPAS	ACT Patient Administration System
ADS	Alcohol and Drug Services
AHPRA	Australian Health Practitioner Regulation Agency
AMHDS	Adult Mental Health Day Service
AMHRU	Adult Mental Health Rehabilitation Unit
AMHU	Adult Mental Health Unit
AOD	Alcohol and Other Drug
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Unit
CHHS	Canberra Hospital and Health Services
CHN	Capital Health Network
COPMI	Children of Parents with Mental Illness
CRS	Community Recovery Service
DMHU	Dhulwa Mental Health Unit
ECR	Electronic Clinical Record
ED	Emergency Department
FMHS	Forensic Mental Health Service
GP	General Practitioner
HAART	Home Assessment and Acute Response Team
IMPACT	Integrated Multi-agencies for Parents and Children Together
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex

LOS	Length of Stay
MDT	Multi Disciplinary Team
MH	Mental Health
MHC	Mental Health Clinician
MHCCACT	Mental Health Community Coalition ACT
MHJHADS	Mental Health, Justice Health and Alcohol & Drug Services
MH Link	Mental Health Link
MHSSU	Mental Health Short Stay Unit
MoC	Model of Care
NDIS	National Disability Insurance Scheme
NEAT	National Emergency Access Targets
NOCC	National Outcomes and Casemix Collection
NSMHS	National Standards for Mental Health Services
NSQHSS	National Safety and Quality Health Service Standards
OOS	Occasions of Service
OPMH	Older Persons Mental Health
PACER	Police, Ambulance, Clinician Early Response
SAIR	Staff Accident Incident Report
SUSD	Step Up Step Down

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9. Model of Care Development Participants

Position	Name
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Canberra Health Services acknowledges the Traditional Custodians of the land, the Ngunnawal people. Canberra Health Services respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. Canberra Health Services also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

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