



# **Adult Mental Health Centres**

**Mental Health Victoria's responses to the  
Australian Government Department of Health's  
online survey questions**

**July 2020**

# 1. Principles

*The Adult Mental Health Centres trial aims to balance local needs with national consistency. To achieve this aim, the proposed service model includes a set of ten operating principles (p 18 of the consultation paper, and reproduced below). Please provide comments on the principles including if there are principles that are missing or any suggested amendments, providing your rationale for the suggested change.*

Mental Health Victoria (MHV) welcomes the opportunity to provide feedback on the Department of Health's *Consultation Paper – Potential Service Model for Adult Mental Health Centres* of July 2020.

MHV held three Victoria-wide consultation forums in July 2020 which attracted more than 150 representatives from across the mental health sector and related sectors. In total, 115 organisations were represented including Area Mental Health Services, community health and mental health service providers, consumer advocacy organisations, peak bodies, local and state governments, medical colleges and associations, unions and emergency services.

Our consultations found very broad support for the principles proposed in the paper.

Stakeholders raised few objections but made a number of suggestions to complement the principles as proposed.

Of note, many participants recommended that the core purpose of the Centres should be drawn-out and clearly articulated under its own heading.

## Governance

A recurring theme across the consultations was the issue of governance and the need to balance national consistency, accountability and transparency with local/regional tailoring and interface with relevant state or territory systems. Strong national governance and direction were deemed essential to ensure model fidelity.

Participants wanted assurance that the trial would from the start be governed by a new body responsible for national governance, direction (with powers to make this happen), brand management, model integrity, oversight, monitoring and reporting functions, with each trial centre co-commissioned with the PHNs.

Many participants pointed towards a recent Victorian Auditor General Office report (<https://www.audit.vic.gov.au/report/managing-support-and-safety-hubs>) on the roll-out of Orange Door family violence hubs across Victoria which have not lived up to their potential due to ineffective centralised governance and a lack of guidance, oversight and performance management.

## Lived Experience

Of note, many participants recommended that more work could be done to ensure that recognition of Lived Experience and a commitment to co-design and co-production was explicitly reflected in the principles, along with consumer and carer involvement in care and service delivery.

Participants further noted that the documents as a whole would benefit from a review of the language used to ensure that recognition of Lived Experience and commitment to co-design and co-production is reflected throughout.

### Multidisciplinary care

Similar to the feedback above regarding Lived Experience, participants would like to see multidisciplinary or transdisciplinary care emphasised throughout the document and reinforced at each stage of the consumer journey.

### Other feedback

Many participants suggested that the principles be presented under core themes, for example:

- Lived Experience
- Inclusion (expand Principle 3 to include women, Aboriginal & Torres Strait Islander, CALD and LGBTIQ+ communities)
- Care models (trauma-informed, recovery-oriented, person-centred, family-inclusive, community-based and stepped care)
- Access (and include a definition of 'No wrong door')
- Services (including digital)
- Safety
- Confidentiality
- Quality and continuous improvement
- Governance & National Oversight
- Research and Innovation
- Workforce

## 2. Assumptions

There are a number of assumptions underpinning the service model (p 4 of the consultation paper) that help to set the scope for the Adult Mental Health Centres trial. These assumptions are based around:

- the population cohort of local communities who would use the services offered by the Centres;
- the expected physical environment of all Centres, such that they provide a highly visible and accessible entry point for individuals, their families and carers;
- ensuring the services provided are culturally appropriate, welcoming and safe; and
- service provision which involves short to medium term targeted treatment and support.

Please provide comments on the assumptions, including any assumptions that are missing or any suggested amendments, providing your rationale for the suggested change.

The assumptions identified were supported by the majority of participants.

### Duration of care

Many participants were concerned about the limitation imposed on the duration of care. Participants agreed that there was a need for medium- to longer-term coordinated care as required by the individual.

### Risks and issues

A large number of potential risks were raised that, if realised, could impede the centres from achieving their full potential.

It was generally agreed that in addition to the assumptions, the paper should also identify high-level risks and how these could be mitigated.

Participants identified the following high-level risks for inclusion:

- **Model fidelity:** Regional variability should not compromise service quality, consistency and brand integrity – strong national governance, direction, monitoring and oversight from a dedicated body with the powers and responsibilities outlined above was deemed essential.
- **Governance:** Centres will individually develop suitably integrated models appropriate to their State/Territory. National direction and comprehensive oversight must be provided before individual centres are scoped and tender documents are finalised. National direction on the following areas must be provided before centres are commissioned:
  - consumer involvement
  - community involvement
  - performance
  - clinical governance
  - centre governance
  - organisational processes
  - functional capacities

- multi-disciplinary team-based approach to service delivery
  - quality
  - safety
  - integration with local models, services, sectors, private actors and government agencies, including mutual responsibility arrangements.
- **Specialist expertise:** Access to specialist expertise e.g. psychiatry must be mandated. Each centre must provide a comprehensive suite of services co-funded by trial program funds and the MBS, as well as relevant Commonwealth/State program funding to expand the scope and capacity of each centre. Without access to specialists, the impact of each centre will be constrained and the potential benefits of multidisciplinary care will not be realised.
  - **Consumer support:** Centres need the full support of consumers – to achieve this, co-design and embedding of consumer choice in the model are essential. Facilities must also be able to provide a safe, therapeutic and family-inclusive environment for all – this may be supported through co-designed trauma-informed guidance to inform facility design, and guidance around how to manage presentations associated with acute distress/symptoms/behaviours of concern.
  - **Target population:** Clear articulation of the model's target audience is required, and consideration that an episode-of-care model will not address long-term fluctuating needs leading to repeat presentations.
  - **Workforce:** Centres must be able to identify workforce needs and recruit a sufficient number of suitably trained professionals. National and state/territory efforts to develop segments of the workforce (e.g. peer workers, mental health nurses and psychiatrists) are required along with a plan to address workforce shortages in the short- to medium-term, noting that there is likely to be fierce competition for staff as the Victorian Royal Commission reforms get underway from 2021 onwards.
  - **Demand management:** Centres must not be overwhelmed with unmet need, thereby compromising community trust – sufficient and flexible funding is required, along with a long implementation phase. Trial centres will need to carefully assess likely demand and work in partnership with other relevant parts of the mental health system e.g. area health services, local hospital EDs, police and emergency services.
  - **Emergency care:** A clear definition of what constitutes the need for urgent ED care versus the care provided by these Centres is required. These roles must be clearly defined to ensure referrals are targeted and specific, and that Centres do not unnecessarily direct consumers to EDs due to narrow definitions of appropriate cases. Furthermore, the scope needs to consider the potential of the Centres to reduce ED presentations and that greater gains could be achieved by expanding this to include direct referral pathways to mental health inpatient services without needing to go via ED,

and options for ambulance services and the ED to direct patients to the Centre.

Participants noted that the broader mental health and related systems in Victoria should complement the model – particular considerations relevant here include:

- the availability of external services, especially long-term mental health supports and AOD detox services
- delineated roles of centre crisis supports vs emergency departments
- existing services which already provide part of what the model intends to provide (especially area mental health services).

Participants also noted that while high visibility was desirable and would help with efforts to reduce stigma, unbranded services to support access for groups such as people from CALD backgrounds and people in small rural/regional communities may be required.

### 3. Core services

The proposed service model provides for operational flexibility which will allow each Centre to meet the specific needs of the local community. However, there are a number of services that all Centres will provide 'in-house' using available funding.

The proposed service model does not intend to limit the services that can be provided by the Centres. Other important and essential services and supports will be available, but the method by which these services or supports are received may vary based on local arrangements.

Additional service could be provided either:

- in-house (provided by staff of the Centre);
- in-reach (whereby another health professional or agency who has a partnership with the Centre would attend the Centre to provide a service); or
- on referral (where an individual would be seamlessly connected to the service that they need outside of the Centre).

The proposed service model (p 7 of the consultation paper) outlines four core services to be provided in-house by all Centres.

Please provide comments on the core service elements, including any suggested amendments, providing your rationale for the suggested change.

The core services proposed in the paper were broadly supported.

Significant concerns were voiced regarding the appropriateness of devolving further decision-making to PHNs in the absence of a very strong national governance and oversight model.

#### National consistency and limitations on PHN flexibility

In relation to core services, participants were firmly of the view that national consistency should be mandated and that the operating model must require that each centre provide a comprehensive suite of services co-funded by trial program funds and the MBS, as well as relevant Commonwealth/State program funding to expand the scope and capacity of each centre.

In relation to the additional core services outlined on page 7, participants noted that medical assessment from GPs or psychiatrists, MBS-funded services, and Commonwealth-funded suicide prevention services must be provided as part of the service suite in each centre. While this is implied in the text, participants would like to see the following amendment:

Centres ~~will also~~ **must** ensure that the following core services, which are essential to the integrity of the model, are available to people who present to the Centre ...

#### Consumer journey

To improve understanding of the model, and support national consistency in its implementation, participants agreed that the paper should describe how different elements of the model fit together, e.g. by structuring the paper to take you on a 'journey' through a centre (from external visibility through entry, concierge/greeting, assessment, crisis support, information provision, treatment and referral) with flowcharts and other diagrams to aid understanding.

The model should also clearly articulate the individual's role in their care at all stages, including identifying goals, understanding interventions, exercising choices, participating in a living plan (reviewed throughout each treatment episode and continuing beyond an individual's involvement with the centre) and having input into evaluation processes.

#### Include research and evaluation as a 5<sup>th</sup> core service

Due to the importance of research and evaluation (R&E) for facilitating innovation, informing service planning and reducing repeat presentations, participants agreed that R&E should be included as a fifth core service. It should explicitly encompass data collection (including access/service use and outcomes), evaluation (including service delivery and pathways), use of evidence (including emerging evidence where appropriate) and quality improvement.

#### National direction and oversight

To reduce duplication in the implementation phase and support consistent quality in ongoing centre operations, the national model requires explicit national guidance on:

- delineation of crisis supports from emergency department supports, including after-hours
- standardised assessment tools, protocols and classification scales, including requirements for integrated assessments to identify relevant needs (ie mental health, physical health, AOD, family violence, cultural, whole-of-family etc)
- comprehensive suite of optional service considerations (e.g. Centrelink, employment services, legal services, family violence services)
- commissioning services and developing partnerships
- processes for warm and internal referrals
- data-sharing framework between centres
- data collection to inform an evaluation of the trial
- performance, monitoring and reporting frameworks
- workforce matters including:
  - training and development needs
  - minimum staffing requirements including:
    - peer-led guide/navigator role (to support people throughout their engagement with a centre, including follow-ups)
    - care coordination (to connect service sectors, support people to identify needs, and avoid other workers performing this role by necessity)
    - psychiatrists
    - GPs (to provide Mental Health Care Plans, physical assessments, etc)
    - targeted allied health service needs.

## 4. Services out of scope

*The Centres are not designed to duplicate or replace state or territory funded services, including longer term specialist care or inpatient care. To ensure that demand for services is managed, some services will be out of scope for the Centres (p 8 of the consultation paper). Please provide comments on the services that are out of scope, including any suggested amendments.*

Out-of-scope services are generally supported and well-articulated, with some alterations suggested below.

Participants recommended the following changes:

- Pharmacy services should be in-scope to facilitate access to compassionate/after-hours supply of medications.
- Referral from emergency departments should be in-scope, presuming suitable transportation with appropriate professionals.
- Forensic services should be acknowledged as out-of-scope.

It was also suggested that the model clarify that 18–25-year-olds may access centre services when local youth services cannot meet their needs. Concerns were raised regarding what appears to be a blanket exclusion of 18–25-year-olds from the model.

## 5. Inclusive support and treatment

*The Centres will be established to provide inclusive, non-stigmatising and culturally appropriate mental health support and/or treatment for individuals, and their family and carers who seek advice or assistance.*

*Please comment on the establishment aims, including any suggested amendments, providing your rationale for the suggested change.*

The broad approach to inclusivity was supported by participants.

While the model includes welcome elements that promote inclusivity and counters stigma, it is recommended that consultation with diverse population groups be undertaken before the model is devolved to PHNs to ensure all centres have sufficient guidance on considerations for best-practice inclusivity.

To ensure all centres operate with shared understandings of inclusive approaches for all groups, national guidance is required on:

- best-practice strategies for engaging different communities (e.g. physical design of centres to be accessible and trauma-informed)
- how centres will be accountable to local communities
- workforce guidance to support inclusivity including:
  - training needs for centre workers
  - strategies to ensure the workforce reflects local diversity
  - role requirements to address community needs, e.g. bicultural workers for CALD communities, specialised translators for people with low English proficiency, outreach workers for at-risk groups, and childcare workers (including by in-reach services or external partnership) for parents.

In addition to being inclusive, non-stigmatising and culturally appropriate, centres should also be 'locally attuned', 'timely', 'person-centred', 'family-inclusive', 'community-based', 'recovery-oriented' and 'accessible'.

## 6. National branding

*The Centres will adopt a nationally consistent brand that will assist people to identify where help is available.*

*What factors could make a national brand easily identifiable? Please provide comments on the factors that will assist in creating an easily identifiable national brand.*

Participants were supportive of the development of a consistent national brand.

Participants recommended that branding should be developed through co-design with marketing professionals and communities with lived experience, Aboriginal and Torres Strait Islander peoples, CALD and LGBTIQ+ communities, people with cognitive impairments, and people with low English, health and/or digital literacy.

Specific branding suggestions which arose during consultation include:

- avoid acronyms, jargon, government language, medicalised language and deficit-focused language
- ensure the name is easy to remember and easy to find online
- consider options for co-branding with local services
- commit funding to ensure a strong advertising campaign across a range of mediums, supported by a range of spokespeople (lived experience, clinical, non-clinical etc.) to ensure people know where to go, when, for what, what to expect, and when to go elsewhere.