Response to Adult Mental Health Centres Consultation

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ONLINE SUBMISSION

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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).

Are the principles which underpin the service model appropriate?

○ *Very appropriate* ○ *Appropriate* ◉ *Somewhat appropriate* ○ *Inappropriate*

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.

Comments:

Community Mental Health Australia (CMHA) is a coalition of State and Territory peak mental health organisations. CMHA provides a voice for over 600 community-based, non-government organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

Suggested additions to some of the 10 Principles (additions in red) and additional comments

Principle 1: Offer a highly visible and accessible 'no wrong door' entry point for adults to access information and person-centred and directed services which are designed to empower, support and improve their psychological and physical health, and social and emotional wellbeing

Note: Need to operationally define 'no wrong door' (Principle 1) in some detail somewhere in this document, else it remains a fuzzy aspiration.

Principle 3: Provide a welcoming, compassionate, culturally appropriate and safe environment that is trauma informed and inclusive for all people accessing services or support.

Principle 4: Provide access to best practice on the spot advice, support and treatment for immediate, short term, and where appropriate, medium term needs delivered by a multidisciplinary team including a suitably trained peer support workforce, recovery coach and trauma specialist, nursing and allied health and specialist medical care, without prior appointments or a fee.

Note: The word "…professional health care.." is deleted, as the set of skills needed are broader than health and will need to include various social service supports to address social determinants. Similarly the word "care" is not favored (see more detailed discussion below on this matter)

Principle 8: Explore opportunities for the development and utilisation of innovation to complement defined core functions and ensure that people with lived experience are involved in co-design and co-production of these continuous improvement initiatives

Principle 10: Effective governance frameworks at both the national and local level, ensuring carers and consumers are represented at all levels of governance and conduct local evaluation activities, to ensure transparency and accountability and maximising service quality.

Suggested Additional Principles:

Principle 11: Services are provided within a holistic framework that includes Social Determinants of at least equal importance as the biological and psychological factors effecting of mental ill-health, mental health and wellbeing

Principle 12: Provide an integral role in ongoing local mental health service and workforce planning through the recording and reporting of all unmet bio-psycho-social service and support needs.

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.*

Are the assumptions appropriate?

○ *Very appropriate* ○ *Appropriate* ◉ *Somewhat appropriate* ○ *Inappropriate*

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

Comments:

There is significant evidence for the following: Though varying in distribution, there is a significant number of people with moderate to severe mental health issues, often with co-occurring issues, who are not eligible for the NDIS and for whom long term community based mental health support services are required.

Assumptions:

That being so then in relation to the AMHCs, one of these three assumptions must be true:

1. Local community based mental support services that can provide such long-term support exist to which warm referrals can be made.
2. If such local services do not exist, in-house "short to medium term targeted treatment and support" will resolve the issues for all (or at least the significant majority) of such clients…. *As implied in the proposed model description*
3. If 1 and 2 are not the case, some people will need to be either under-serviced, or repeatedly serviced (i.e. "revolving door").

NOTE: If under-serviced (or "discharged" from the service) the consequence may be increased morbidity, mortality or increased probability of an eventual mental health crisis occurring. This may significantly lower average "experience of service" and do reputational damage to the local Adult Mental Health Centres (AMHCs). If repeatedly serviced, the AMHC may eventually "fill up" with people in above cohort that would in time shape and define the culture of that AMHC.

Therefore, **in those locations where no community based mental health support services available to provide such long-term backup service support for the AMHCs, then those services should be created.** They will be necessary conditions for the successful operation of the AMHC. Without these service over time reputational damage may be done to the AMHC.

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.

Are these core services appropriate?

○ *Very appropriate* ○ *Appropriate* ◉ *Somewhat appropriate* ○ *Inappropriate*

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

Comments:

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

   Need to delineate this from services provided by ED and LHDs through promotion of this service as more a "safe place" or "safe haven" option. This should be coupled with a more proactive outreach (e.g. Open Dialog approach) to identify and support people and families in home to prevent emergency situations (i.e. police or ambulance involvement). Some AMHCs may also benefit from having nearby or co-located afterhours services that would be more informal. I.E. "Trieste style" 24/7 safe place services, that may prevent some 2am ED presentations.

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

   See comments made above about the need for a minimum background service context for AMHC success and the role that AMHCs could play in better identifying essential missing services

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

   It is essential that people undertaking the assessment have a thorough grounding and appreciation of the social determinant's domain (Domain 6 in the National Assessment Guidelines referred to in the consultation paper). This includes an appreciation of the relevant local services available for referral that can assist with issues in this domain. Without highly weighting this domain the danger of AMHC's devolving to just a psycho-medical mental health services is significant.

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

   Good to include both evidence-based and evidence-informed to allow a channel for risk managed innovation.

Language is important and while the word "care" expresses an emotional attitude (kindness) that most would accept, in this context it also implies a relationship that is potentially patronizing. The word "treatment" is no better. There is no perfect term, but at this stage with word "support" is better as it least implies that the person being supported is also contributing to their recovery. The term episode also has an additional meaning (i.e. having a "mental health episode") that may have subtle unwanted connotations, so the suggestion is "occasions of support".

A suggested additional Core Service is *Research and Evaluation that would mandate partnerships with suitable research and evaluation partners*.

Additional Comments: On page 7 a core service listed (to be done in-house or through referral) is "Assistance managing stressors associated with high levels of distress, including financial problems, civil and criminal legal issues, family support, accommodation instability and social isolation". This is one of the few explicit mentions of services focused on the social determinants and its scope of "assisting with managing stressors associated with..." is ill conceived and incomplete.

Individuals in such situations are also and indeed mainly looking for practical assistance in the matters that significantly concern them, not just assistance in dealing with or coping with the stress associated with those issues. For example someone who is homeless, or dealing with DV does not need just psychological stress coping tools, or even worse anxiety assisting medication, they want and need some practical assistance. Psychological coping tools are adjunct supports. So this core service should be both advanced higher up the list of services and restated as "Assisting with finding solutions and managing stress associated with a range of problems such as unemployment, financial problems, civil and criminal legal issues, family support, accommodation instability and social isolation ..."

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).

Is the list of out of scope services clearly explained? ○ *Yes* ◉ *No*

Please provide comments on the services that are out of scope, including any suggested amendments.

Comments:

Page 8 states... "Centres will provide immediate support and clinical interventions to help individuals become stabilized before referring them to other longer-term services, if required and where these are available. It is recognised that for some people there will not be readily available services to which they can be referred, and in these circumstances targeted medium term treatment will be appropriate as an episode of care. "

On page 9 it also states " The provision of continuing assistance with care navigation to individuals who are experiencing moderate to severe levels of psychological distress, to ensure they are not left without services"...

The problem with this arrangement is the dilemma described above in the section on the model's Assumption. Where services are not available and "targeted medium term treatment" in insufficient, AMHCs face a choice of having to either discharge and breach a possible duty of care, or to continue to provide long term services that are out of scope (and maybe eventually "fill up" with people in this

cohort).

The remedy for this dilemma is to ensure that all AMHCs have the support and backup of suitably funded and resourced community based mental health services that can provide necessary long-term support and to which they can make suitable referrals.

AMHC will only thrive if they have a healthy surrounding service ecology which most importantly this includes a health soil of community support services and networks.

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.

As described, will the service model meet these establishment aims?

○ *Yes* ◉ *No*

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

Comment:

As Principle 3 States Centre will... "Provide a welcoming, compassionate, culturally appropriate and safe environment that is inclusive for all people accessing services or support."

Unfortunately the strong impression from reading the details of the model is that while aspirations for inclusion are stated in the model, unless there is a strong and explicit counter-strategy there is a high likelihood that many AMHCs will feel and appear to various groups as "medical model services"... this is for example borne out by the stated intention to locate them near major hospitals (page 5), and is also the favor and culture of a number of PHN services (with some significant and outstanding exceptions).

Underlying this is that there is a significant "cultural barrier issue" that many people who have working in traditional clinical mental health services are largely oblivious to. There is a "culture blindness to the fact that many traditional medical services have a strong implicit hierarchy and power structure which is exactly the opposite of what is needed in establishing rapport, inclusion and empowerment of many people who have, for much of their lives, experienced social status discrimination (perceived or real) and which is in itself a significant contributor to their unwellness.

Thus, as a minimum a strong focus on:

a) co-design of AMHC location, appearance, welcoming and inclusion processes that involve local people and particularly those with lived experience and from relevant diversity groups is essential.

b) ensuring that the service offering is in word and practice holistic and based upon a broadly based and locally tailored social and emotional wellbeing framework is essential.

c) the AMHCs have and are seen to have high levels of lived experience and diversity inclusion

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.

Comments:

Please see comments in the previous section.

Branding includes name, centre appearance, symbolism and welcoming practices. It also includes service style and culture and its also its reputation which grows out of what is actually done and what is seen to have been done (or not done).

Thus, crafting an identifiable national brand is a complex issue. It is strongly suggested that the word "mental" or "mental health" is not used as it carries too much stigma for some groups. The options are between "indirect" brand names like "headspace" and those that state more explicitly what they are, such as name options that might include the word "wellbeing".

Brands like "Black Dog" and "Beyond Blue" while well-known have too much of an implied focus on depression in their title. Some other options are already taken up by existing organisations which also shrinks the options pool.

A suggestion is that the naming exercise becomes a promoted public co-design process, involving various diversity groups and people with lived experience. This may serve a double purpose of promoting the centres immanent establishment and then being able to attribute the selection of the name to that broad process (as you can never please all of the people all of the time). Of course democracy is no guarantee of quality (cf USA) so maybe this process could at least be used to develop a short list of options.

We look forward to any further consultations as the AMHCs proceed.