Transforming Australia's Mental Health Service System, inc.

Re: Essential Components of Care for Australian Mental Health Services Version 4.2

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Based on & updated from version for National Mental Health Commission, June 2015

The Essential Components of Care [ECC] Framework

(An Australian National Framework for the Transformation & Ongoing Development of Mental Health Service Systems)

for

Australian Mental Health Service Jurisdictions

2020-2030

Reform Implementation Framework for Transformation of MHS [RIFT] Project

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Acronyms:

ACCHO = Aboriginal Community Controlled Healthcare Organisation

AHO = Affiliated Health Organisation

ANWIMH = Australian National Workforce Institute of Mental Health (Proposal)

CAMHS = Child & Adolescent Mental Health Services

SMHSOP = State Mental Health Services for Older People

CEO = Chief Executive Officer

CMO = Community Managed Organisation, an NGO.

CPC = Clinical Partnership Coordinators

CRRMH = Centre for Rural & Remote Research in Mental Health, University of Newcastle, Orange, NSW.

D-G = Director General

HSM = Health Service Manager

IHPA = Independent Hospital Pricing Authority

KPI = Key Performance Indicator

LAC = Local Action Coordinator

LHD = Local Health District

LIT= Local Implementation Team

MHC = Mental Health Commission

MHISG = Mental Health Implementation Steering Group,

MoH = Ministry of Health

MoU = Memorandum of Understanding

NACCHO = National Aboriginal Community Controlled Healthcare Organisation

NDIS/NDIA = National Disability Insurance Scheme/Authority

NMHSPF = National Mental Health Service Planning Framework

PHCO= Primary Health Care Organisation

PHN= Primary Health Network

VCCMHWB = Victorian Collaborating Centre of Mental Health & Wellbeing.

Essential Components of Care: A Reform Framework & Template

A Guide to this Framework

This framework is intended to be used as a guide to implementation of mental health service reform for Governments and their Mental Health Service Jurisdictions.

The Introduction suggests strategic directions for reform. It then provides definitions of the Essential Components of Care and the aims, scope, relevance and limits of this document, and an outline of a framework and workplan for implementation and further development.

The body of this framework is arranged as a series of brief narrative sections followed by relevant checklists of recommendations to the MoH for their Mental Health Action Plan in the form of tables.

PART A: Policy Development and Strategic Planning by Mental Health Commissions for Practical Reform Goals, Readiness, Workforce & Partnerships Strategies

PART B: focuses on Priorities for Implementation. These include priorities in terms of Essential Components of Care for mental health services in each age group and for all phases of life. It also summarizes some of the essential evidence-based components and the tools for implementation, evaluation and quality monitoring. It is completed with a recommended 7 Step Action Plan to implement the essential components of care.

APPENDIX 1 provides **in** tabular form a sample spectrum of Evidence-based Components in the Continuum of Care, with a community mental health service emphasis, divided into evidence based interventions and evidence based service delivery systems.

Introduction

This framework sets out the major components of a comprehensive, accessible and effective mental health service; it proposes a co-operative, integrated approach between all providers involved in the provision of mental health care; it outlines principles for mental health service delivery, and proposes a continuum (ie integration) across the public, private, NGO and primary health care sectors, and promotes "bottom-up" locality based service planning. It builds on the direction of the National Mental Health Strategy and the principles of the Mental Health Statement of Human Rights and Responsibilities.

For the mental health system to work well there will need to be jurisdiction-wide mechanisms for governance, resource management, performance evaluation and accountability monitoring within the mental health and wider health and support services systems. Most of these issues are covered within the MHC Mental Health Strategic Plan for NSW and the accompanying report.

Community based support and clinical care for people with mental ill health are essential services required across the age span from infancy through to old age. “The Essential Components of Care" outlines the nature of these essential components of community based care irrespective of provider organisations. It details the essential building blocks of community care and treatment needed for different age groups to better support the personal journey towards recovery.

The Essential Components of Care seeks a re-balancing of the mental health system towards a greater emphasis on a mental health service system which is shifting its centre of gravity and balance from hospital-centric with episodicl outreach, towards being more routinely community-based with in-reach to hospital as necessary.

Summary

Essential Components of Care: What are they?

They are the evidence-based**,** recovery-oriented, ethical and human rights enabling modules, teams or service delivery systems (the vehicles), and the menu of evidence-based interventions (the contents contained and carried in the service delivery vehicles to

consumers and families in need) which will be provided by them, which have been clearly demonstrated to produce the best outcomes as well as being the most cost-effective (see Appendix 1).

*The **service delivery systems*** include 24 hour mobile crisis response teams for all age-groups, low-key unlocked residential 24 hour staffed respite centres on suburban streets, mobile assertive community treatment for young people and adults with persistent turbulent conditions which would otherwise lead to many hospital admissions, Early Psychosis Teams for Psychosis and other disorders in young people and "Case Management"/Care Coordination Services (providing a much needed but less intensive continuity of care coordination approach).

*The **interventions*** include a range of Cognitive Behavioural therapies, Interpersonal therapy, Mindfulness Training, Family & multiple family interventions, Neuro-Cognitive Remediation for psychosis, and Dialectical Behaviour Therapy for Borderline states and self harming.

Strategies for a wide range of co-occurring conditions and complexity factors are included, as well as specific strategies for all age-groups, Aboriginal, transcultural, rural and remote populations. Wellness approaches and Social & Emotional Wellbeing [SEWB] strategies are also detailed.

Which Services are in scope for this Framework?

Those services **currently funded by State and Commonwealth government resources via the** Jurisdictional Ministries or Government Departments of Health, and other departments (including Human Services, Family & Community Services, Child Protection, Attorney-General, Police and Corrections, and Disability services) which fund or commission services relevant to individuals living with mental illnesses and their families, irrespective of provider. In particular, these recommendations assume that an optimal balance between public, NGO and other services funded via these jurisdictions will be negotiated, set and implemented.

Mental health service development in an interdisciplinary, multiple agency context is detailed in the Changing Workforce Programme (2005) by the Royal College of Psychiatrists (RCPsych) & National Institute of Mental Health England (NIMHE).

This plan does not attempt to comment on all aspects of mental health services and their delivery, but attempts to address key issues that have emerged from consultations as being priorities for investment, reform, planning and implementation of effective services, together with further investigation and evaluation.

Why is this Reform Implementation Framework needed?

1. Its implememtation will improve the lives of individuals with mental illness and their families, both in terms of engagement and interaction with mental health services, the palpable, practical and measurable effect of those services, and in instilling new hope and providing a platform for enhanced recovery

2. It will ensure that the juridictional MHS Strategies are updated to emerging standards and implemented in an orderly way, by

a) assuring adequate and stable resourcing for the implementation process

b) providing detailed guidance to assist the jurisdiction form an action plan which will be informed by evidence and the expressed needs of service users and their families and direct the development of

i) practical implementation guides and manuals for each essential component of care, as well as adapting fidelity criteria for quality monitoring and evaluation

ii) a coherent workforce strategy to provide adequate staffing and training for staff, with staff replacement during training, and review of existing work practices and duties, with skills-specific supervision, mentoring and communities of practice.

3. in 2015, TAMHSS in conjunction with the Australian National Mental Health Commission prepared an Implementation Guide and a checklist of recommendations for practical actions regarding the essential components of care which require consistent roll-out across a defined catchment , local health district, region or jurisdiction , consistent with the recommendations of the Report of the Mental Health Programmes and Services of the National Mental Health Commission. This was to be considered for use to inform the Mental Health Action Plan of particular jurisdictional departments or ministries of health corresponding to their jurisdictional Mental Health Strategic Plans.

4. Use of the ECC as a tool for setting service priorities is consistent with the Australian Productivity Commission Report into Mental Health Services,2019-2020, consideration of pooling of service funding sources to be possibly presided over, protected and dispersed at arm's length by Mental Health Regional Commissioning Authorities in conjunction with regional PHN's and LHD's.

5. ECC as a tool for setting priorities for widespread implementation of a repertoire of evidence based interventions and service delivery systems could be integral to the formation of a nationally consistent virtual institute of workforce training, supervision, communities of practice & pastoral mentorship systems and qualifications for teams of mental health professionals, support and peer workers. This proposal and framework for an Australian National Workforce

Institute of Mental Health [ANWIMH] has been under consideration by the Commonwealth Dept of Health Taskforce into Mental Health Workforce (2020-21) and the Victorian Collaborative Centre of Mental Health and Wellbeing [VCCMHWB] recommended by the Royal Commission into Mental Health in Victoria [RCVMH] (2020-21).

Work to be done within Jurisdictions

1. Jurisdictional Government and State MHC (if established) or independent stakeholders consultation group convening in partnership with MHS, to negotiate and agree a strategy for mental health service Corporate & Clinical Governance & Resource Management Strategies.
2. MHC or MHS in partnership with Stakeholders Consultation Group to propose a draft set of priorities from menu of candidate components of care in consultation with all stakeholders.
3. MHC or MHS to develop draft Implementation Guide for essential components of care to inform the jurisdictional Health Action Plan.
4. MHC or MHS to widely circulate 1st exposure draft leading to simultaneous
   a) consultation with relevant jurisdictional government departments and MHS executive and councils

   b) consultation with workforce re exposure draft Guide via Network Meetings to be arranged via Agency of Clinical Innovation, one of 4 pillars from Garling Report recommendations)

5. Implementation Guide revised
6. Wide circulation of 2nd exposure draft with opportunity for individuals and organizations to comment and advise again
7. Implementation Guide for Action Plan Mark II revised
8. Implementation Guide for Action Plan to MoH or Jurisdictional Dept Health MHS Executive.
9. Action Plan finalized by jurisdictional Health Department or Ministry in consultation with the jurisdictional MHC or equivalent arm's length monitoring body.
10. Action Plan implemented in phases
    a) developing implementation and training manuals and monitoring mechanisms
    b) piloting
    c) wide implementation & monitoring
    d) review and fine-tuning/ recalibration

Flexibility for Innovation

Where there is as yet insufficient evidence for an intuitively and/or empirically apparently highly promising idea for service development, particularly when it is supported by a growing social movement of individuals with lived experience of complex mental illnesses, families and providers, e.g.'s: Open Dialogue social systems intervention from Finland, neuroplasticity informed neuro-feedback with psychotherapy for trauma, psychoactive substance aided psychotherapies, replications of or participation in larger scale high quality international studies, or well researched pilot studies should be supported in Australia prior to deciding whether to implement widely. Rigorous research ensuring safety and effectiveness is needed not only for the more definable and commercially saleable high-tech aspects but also for the psychotheraputic components and treatment delivery settings of such combined packages, which are often more difficult to define and standardize.

Further Development

The Implementation Framework as preliminary to a Jurisdictional Guide and Action Plan will draw on the emerging National Mental Health Planning Framework, which combines existing data and both national and international reports to estimate the staffing levels, services and beds required to meet the mental health needs particularly of the 3% of our state population who will suffer a severe level of mental illness, across four age groups (children, youth, adults and older people), including co-occurring and complex disorders.

Building a more Community-based Mental Health System

The further development of jurisdictional mental health service systems must involve a shift of emphasis from inpatient care towards the development of more community-based services. At this stage, the evidence base does not lend itself to the precise specification of a singular model of community mental health care delivery. However, the emerging evidence clearly points towards the provision of local or regional networks of closely inter-linked evidence-based teams or modules of care in urban and suburban settings and regional centres. The overwhelming weight of evidence suggests that the centre of gravity of mental health services should be shifting from hospital-centric with occasional outreach when convenient for staff, to community-centred care with in-reach to hospital when needed (Keet et al, 2019, Rosen et al 2020). The more generalist model of fully integrated community health or mental health teams in rural and remote settings may need augmenting with workers from specialist regional teams with itinerant outreach workers, and/or availability of 24/7 tele-psychiatry crisis assessment and management, such as provided by the Mental Health Emergency Centre (MHEC) to all Western and Far West Local Health District Emergency Departments of NSW. They may be synergised by community mental health services working on the ground in combination with regular fly-in services and internet

fee-for-service providers.

The research and a growing clinical consensus, along with the expressed needs of both consumers and their families as to what is good practice, points very clearly towards a framework of effective community-based care, support and treatment. Such a framework of should be founded on holistic person-centred, needs-led and recovery-oriented principles, which create choice and take into account personal preferences.

While some excellent work is already being done by particular individuals, teams and services, overall the quality and quantity of service provision is patchy. The further development of the NSW mental health system must involve a significant shift of emphasis from inpatient care towards the development of more community based services. Such a framework, while sound in evidence based interventions and service delivery systems, should also be founded on holistic person-centred, needs-led, trauma informed and recovery-oriented principles, which take into account personal preferences of consumers, and will lead to the consistent inclusion of peer workers in teams.

Elements that improve Mental Health Service Quality

a. What conditions will it need for success?

We are assuming the parallel development of a framework for the adequate resourcing of services in Australia by leading to the setting of benchmarks and resource targets necessary to deliver quality mental health care on an equitable population basis. It will draw on and should be aligned with the emerging National Mental Health Planning Framework, when it is finally released, which combines existing data and both national and international reports to estimate the staffing levels, services and beds required to meet the mental health needs particularly of the 3% of our state population who will suffer a severe and often persistent level of mental illness, across four age groups (children, youth, adults and older people).

For our reformed mental health service system to develop, work well and to be sustained, it will need the backing of revamped Commonwealth and statewide mechanisms for governance, resource management, workforce re-orientation and training resources, performance evaluation and accountability within the mental health and wider health and support services systems. It will be directly linked to a recommended Strategy for Corporate & Clinical Governance and Resource Management which is to be developed in consultation between the relevant Jurisdictional Departments or Ministiries and the Jurisdictional MHC.

b. What does a good quality mental health service look and feel like?

There are many sound definitions (e.g. Boardman et al 2011). In essence, it is one which:

a) makes sense to individuals with mental illnesses, their families and to their providers, where all providers understand their own therapeutic and support roles in relation to the individual & their family, and to other providers and agencies.
b) is adequately and consistently resourced to carry out its essential functions
c) provides well-trained and supervised staff, welcoming facilities and interventions which work, are cost-effective, non-traumatising, recovery-oriented and human rights enabling,
d) enables individuals with mental illnesses and their families to feel they have been well supported, effectively treated and practically helped to restore and/or sustain their mental health.

c. Essentially, a quality integrated mental health care ecosystem service must:

a) enable easy access, early detection and intervention of mental illness;
b) ensure integrated provision of a wide range of evidence-based bio-medical and psychological treatments, social and cultural interventions, and a corresponding wide range of familiar & welcoming optimal settings for care.
c) provide community or home based acute and emergency interventions;
d) effectively ensure safety and do this collaboratively wherever possible;
e) include a range of psychosocial rehabilitation interventions, including home visits, which supports recovery, social inclusion, optimises resilience and creates opportunities for improving quality of life through maximizing personal choices, mentoring, education, skills training, employment, housing and relationships;
f) ensure coordination and continuity of care so that the person does not fall between service gaps
g) respect, encourage and support the informed and actively engaged consumer and carer role, by regular consultation, involvement in service improvement, and continuing education
h) develop and sustain an interdisciplinary workforce consistent with these aims, in teams including lived experience & family peer workers (van Os et al, 2019), dieticians, exercise physiologists, vocational and substance use, a community pharmacist, and physical care specialists (Rosen & Callaly 2006).
i) be wholistic, whole-of-life if needed, and person-centered in its care.
j) integrate into a unitary ecosystem, not just micro- and macro- components of mental health and general health services, but all of government, and all of community and social movement strategies to maximize mental health and wellbeing for a catchment or a

region (Rosen et al, 2020).

Whole of Mental Health Issues

National Mental Health Service Planning Framework

The Framework (NMHSPF) was commissioned by the Commonwealth with the support of the states and it:

- Is based on sound epidemiological data that quantifies the prevalence and distribution of the various mental illnesses, as well as evidence-based guidelines that identify the mental health care required for the range of conditions;
- Translates this knowledge about illness prevalence and required care into resources, measured in terms of the workforce and service components required to establish an adequate service system;
- Includes delineation of roles and responsibilities across the community, primary and specialist sectors, including the private sector and non-mental health specific services (e.g. aged care, general health services);
- Considers the workforce requirements to deliver the range of services;
- Includes acute, long stay, ‘step up/step down’ and supported accommodation services, as well as ambulatory and community based services;
- Considers the contribution of public, community managed sectors and private mental health service providers;
- Clearly differentiates between the needs of children and young people, adults and older people;
- Suggests role definitions and delineations to determine the recommended mix of services with comment on how to address scarcity or mal-distribution in some geographical locations; and
- Promotes flexible funding models that allow innovation and service substitution to meet specified targets in different delivery contexts.

This complex and thorough population planning process is a tool to assist planning at any level and for any geographic area. It is not totally complete and it is a living process, to be improved over time, taking into account the evolution of mental health services. It is referred to in this document to simplify recommendations about resources, with the assumption that readers and NSW Ministry of Health developers of the Action Plan corresponding to the NSW Mental Health Strategic Plan will be able to have access to the spreadsheets and documentation of the NMHSPF for the details. It very important that there is separation of modelling between the age groupings, as needs are very different and strategic investments will be required to correct historical distortions in funding.

Resource Management & Governance Changes Required to Implement & Sustain Essential Components of Care for NSW Mental Health Services

A number of site visits and consultations were undertaken by the Mental Health Commission in NSW. These included Consumer and Carer groups, Executive and staff of the LHD's and representation from the Non-Government Sector. The site visits were undertaken to provide the Commission with first-hand knowledge of the current issues and practices in the provision of mental health care.

A similar pattern of themes and common strategies were evident across a number of locations. These themes consisted mainly of common concerns in relation to the operational and clinical provision of Mental Health Services. Broadly they related to the corporate and clinical governance within the state and at the LHD level for the provision of services. A planning framework that provided for evidence based interventions, a more consistent shift towards community care, and services delivery that would include the workforce and training needs of the LHD was seen as a major component required for mental health services to adapt and become reform ready.

As the provision of mental health services changes and a number of new services and funding streams emerge this provides an opportunity for a more holistic approach to mental health care, including an expanded, well trained and capable workforce with a full interdisciplinary range of clinicians, peer workers and other agencies providing components of care and service provision. The opportunity that this provides for holistic care and service provision underlines the importance of having a system and processes within mental health delivery that clearly articulate and monitor clinical and corporate governance structures. This provision of services has to be provided in an environment of budget transparency and certainty.

These are the recommended steps to be negotiated further with the NSW Ministry of Health if they are to effectively ensure more rational governance, resource stability and gradual growth to meet current & future demand for mental health services in NSW.

A briefing paper to government was prepared by the MHC of NSW from these consultations and site visits. It details the recommended strategic directions, and the actions that are required to provide a service system that is much more stable and community oriented, consistent with desired outcomes from the standpoints of consumers, their families, service providers, mental health directors and managers.

3. Practical Reform Readiness, Workforce Development & Sustaining strategies and the complementary role of the Mental Health Commission of NSW

Recommended actions pertaining to these are in Section A and Tables 1 & 2

Checklist for recommendations for Jurisdictional Mental Health Action Plans : PART A: Mental Health Commission complementary actions, Ministry of Health Further Policy Development for Reform Readiness and Workforce & Partnerships Strategies (Tables 1-3)

1. The Mental Health Commission Role

The National Mental Health Commission will need to take some complementary actions to facilitate the development of a Jurisdictional Mental Health Action Plan. Additionally, the Jurisdictional MHC or equivalent arm's length monitoring agency will require a partnership and consultative role as the Jurisdictional Government acts to implement many of the recommendations.

Table 1: Mental Health Commission						
Strategic goal	**Sub-Goals**	**Action**	**Who**	**Timeframe: Year 1 – 1.5**	**Timeframe: Year 5**	**Timeframe: Year 10**
Develop rational division of responsibilities between governments	To improve the distribution of resources by reducing confusion, duplication, gaps	Take the lead to develop a proposal	MHC + others	Complete to coincide with the recommendations of the National MHC Report		
Develop Guidelines for Models of Care to inform Provider implementation	LHD MH managers require guidance on models of care, service design and implementation, also important for contracting.	Commission a series of evidence based implementation guidelines	MHC	Main service delivery models of care published	Specialist models of care guidelines completed	Ongoing
Identify and agree promising emerging interventions for possible implementation	Speed up the translation of research by providing a mechanism to present the evidence for implementation to government.	Invite experts to provide reviews, business cases and training packages	MHC	Establish the mechanism to commission and make recommendations	Business cases completed for funding of services	Ongoing

2. Mental Health Service System Practical Reform Readiness

The Mental Health System is undergoing rapid change, for instance through the introduction of Activity Based Funding, additional Commonwealth funded services, the National Disability Incentive Scheme, the expansion of the Non-Government sector and the use of E-health. This change as well as the changes to components of care, therapeutic interventions and the changing face of the workforce, such as peer support workers, all leads to a changing service model for mental health services. Without comprehensive planning and understanding of the changes to clinical interventions, governance structures and the different components of care required to provide a

holistic service delivery model the Mental Health System will not meet the expectations and needs of the community. To be proactive and reform ready requires a planning framework and a change in the business practices of traditional mental health services delivery.

This reform readiness should be seen as an opportunity to grow and expand mental health service delivery into the future but must be underpinned by some common state-wide themes and levels of services provision. This can be achieved through a range of activities including Key Performance Indicators and a planning framework that takes into account the changing nature of mental health services.

TABLE 2: Mental Health Service Reform Readiness						
Strategic goal	**Sub-goals**	**Action**	**Who**	**Timeframe: Year 1 to 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Practical reform readiness						
Evidence based interventions agreed	The MHC develop a planning framework and specific input into Components of Care for Community Mental Health Services	The Mental Health Commission whole of Government plan completed KPI's or activity targets agreed Funding and resources required redistributed to achieve the new agreed interventions A framework developed to include the Essential Components of Care Essential Components of Care document completed.	MHC MHC & MoH agree on the funding and resources required	Whole of Government plan distributed and reported Essential Components of Care for Community Mental Health agreed to and implementation commenced	Implemented fully	Review & adjust

		A plan that shows new interventions or evidence of treatment in a holistic package of 'how services run or operate' Evidence based interventions agreed and additional growth expenditure required in subsequent NSW state budgets to take progressive steps to achieve targets set out in the National MHS Planning Framework.				
That each LHD + PHN governance structure agrees and promotes endorsed models of care	The MoH provide detailed planning and clinical interventions for Mental Health Services	Planning for new interventions or ways of working comes from MoH – what is the evidence, how should the services be structured and what are the resources required for the intervention	LHD's +PHN			
That each LHD governance structure has a planning framework for Mental Health Services	MH service in each LHD have some form of Board validated MH community advisory committee with a charter/Terms of Reference	LHD – New interventions need to begin with the promotion to and agreement of the MHS Board at LHD level MHS Board is involved and agrees with intervention, funding etc.	LHD's +PHN	Resolve, Prepare	Implement	Review
Develop Capital Requirements Plan	Including: a) one single unified mental health plan across all agencies and	**Regional Mental Health Services Plan** **I. A unified all - agencies Regional Mental Health Services**	PHN+LHD 's Board responsibil ity, with Director of	Completed by Year 2	Ongoing annual updates	Ongoing annual updates

	b) LHD Specific Mental Health Plan aligned with (a) Utilise population based planning for mental health services Use population based planning tools to enable community involvement in setting priorities for mental health services, irrespective of the funding source or provider.	**Plan:** All LHDs to produce a population based public plan as required under the Health Services Act, in collaboration with Primary Health Care Organisations, NGO providers, consumers & carers, & Human Services agencies, identifying specific local needs and using the NMHSPF to identify gaps, and report on the current funding mix. All stakeholders (e.g. Primary Health Care Organisations,, NGOs, Human Services organisations, LHD's) cooperate together to develop a Regional Mental Health Services Plan that covers all Mental Health Services and needs in the LHD. This Plan fosters cooperation and cohesion in the development and delivery of Mental Health Services in the LHD, Therefore each catchment would have **one unified mental health plan,** regardless of the agency or funding stream involved **II. Internal LHD MHS Plan to align with both all-agency unified single Regional MHS plan for whole catchment, and NSW Ministry Mental Health Action Plan.** Specific mental health strategic plan is based on the population needs of the LHD, consistent with	Mental Health supported by LHD + PHN health planners			+ Review

	That each LHD have a Mental Health specific Strategic Plan	the NMHSPF and KPI's. The plan is an internal document that would also inform a regional mental health plan				
Workforce **Readiness** A state-wide workforce plan be developed.	Provide a systematic and public planning process for identifying and prioritising the capital needs for mental health services.	All LHDs to prepare a capital needs report including an assessment of the current buildings for fitness for purpose and future capital needs, informed by the NMHSPF.	LHD + PHN Director of Mental Health supported by LHD health planners	Completed by Year 2.	Ongoing periodically	Ongoing periodically
A state-wide plan for distribution of training plans be developed.	A state-wide workforce plan be developed that involves the inclusion and employment of Peer support workers	Completion of the Planning and implementation of a Workforce plan for mental health services Workforce planning at a State level - working with agencies, colleges and University, TAFE etc about what types of workforce, curricula & qualifications are required	MoH	Workforce plan completed Training priorities agreed		
LHD's + PHN incorporate skills training and education into their workforce plan	There is a fair and equitable distribution and filling of training places	I. Agreement reached on the training of medical staff and the distribution, filling & supervision of places. II. Similarly, agreement on distribution, filling & supervision of	MoH + PHN's			

		Aboriginal Mental Health Worker trainee posts III. Similarly for longer practical placements of other student professionals				
		Retraining &/or upskilling of all mental health professionals in public sector, including preparation to work with evidence based modules of care, and in hybrid de-facto teams combining public and NGO sectors Utilising effective approaches to training & skill transfer including whole team approach, use of experts by experience & qualification, invivo work-based learning methodologies etc.				

This reform will entails the Jurisdictional MoH, LHD's and PHN's rapidly developing a framework or platform to create optimal conditions for reform readiness, and to demonstrate and consistently support their practical readiness to undertake serious reform of State & Territory mental health services.

Only paying lip-service to reform principles or providing gestural commitment to reform without taking these practical steps will result in a loss of reform momentum reminiscent of the many failed attempts that have been made to change the mental health service delivery system in Australia for the better.

Practical Workforce Readiness includes making a commitment to implementing the evidence based essential components of care, forming a unified mental health service plan with all provider organisations serving each catchment and a viable Workforce Readiness plan.

This reform readiness is essential to ensure that mental health services through its many providers and partner agencies provides a level of service that is consistent, contemporary and meets communities expectations.

3. Partnerships and Consortia

The current context of mental health service funding and the widening array of services suggests synergies which may only be properly integrated though formal partnerships, consortia, contractual arrangements or clear memoranda of understanding, combining the efforts of public, NGO and/or fee-for-service or corporate providers.

A real partnership entails respect, equality of standing, and a clear and mutually understood working relationship and division of labour between the partners. Consumer and family organisations sometimes complain that the dominant organisation in the field may only pay lip-service to the partnership when it is convenient to do so. It may gesturally talk up the partnership on official occasions, but often does not include them in crucial decision-making or treat them with the respect of a real and full partner.

This implementation guide of recommendations for a MoH mental health action plan sets out the major components of a comprehensive, accessible and effective mental health service; it proposes a co-operative, integrated approach between all providers involved in the provision of mental health care; it builds on principles for mental health service delivery, and proposes a continuum (ie integration) across the public, private, NGO and primary health care sectors, and promotes “bottom-up” locality based service planning.

Evidence-based cost-effective clinical services provided by clinicians, combining bio-medical expertise and psycho-therapeutic skills, are crucial to the *clinical* and *functional* recovery of individuals with severe mental illnesses and their families. However, we no longer rely on just the public system to resource and/or deliver a fully functional system alone, since it is now widely recognised that the support services needed may be also provided by NGO’s and other organisations, including much of the peer component of the workforce.
The new workforce must be *personalized service and* recovery oriented, and should include expertise in vocational, housing, leisure, skills coaching, financial and other support oriented arenas, crucially also involving trained and qualified peer workers.

Participation in a market environment which some governments and their departments seek to create, demands exploration of some innovative models, which may involve partnerships and consortia as an alternative to unbridled competition, capitation systems, wider interdisciplinary teams including peer workers and other new expertise, and hybrid funding streams merging to form de-facto teams. The

opening of the market may bring fresh innovation and leaner management, but if not regulated to serve catchments in a coherent, evidence based and integrated way, could lead to cherry-picking of profitable segments, while leaving the more severe and complex conditions to a more restricted and shrinking public sector.

Therefore evidence based modules of care for the future are much more likely to be delivered by a hybrid partnership consortia or de-facto teams funded on a multiple stream basis via the public, NGO/CMO and fee-for-service sectors. This may be preferable to a purely competitive market of duplicated, fragmentary and uncoordinated services.

The additional new context to be considered is the trajectory towards personalisation of support and clinical services, which may ensure more choices and an individualised say over which services are to be provided, furthering the negotiating empowerment of consumers and families, leading to a sense of real partnership in their own care.

The possible downsides of personal packaging of services include the additional expensive layering of access to services through service brokers and coordinators with limited knowledge, training and experience, further fragmentation of service delivery, blurring of catchment responsibility as commercial and NGO service providers contract across catchment boundaries, unstable funding and/or staffing and hence variable reliability of the provider agencies involved, and a further destabilisation and fragmentation of continuity of care services.

All these factors in the new organisational and funding environment for providers offer opportunities and risks which must be anticipated and well managed.

TABLE 3: Partnerships & Consortia					

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Strategic goal	Sub-goals	Action	Who	Timeframe: Year 1,5 to 2	Timeframe: Year 5	Timeframe: Year 10
Micro Level: **Personalised Services Partnerships**	Individual Care /Recovery/Wellness Plans Brokerage of Personal Package Plan	Individual Care Plans to be co-constructed with & signed off by consumer, family or confidante carer & service provider. Proportion of ICP's completed to be trended and compared a cross LHD's as a KPI. Active engagement of all MoH funded services in assisting to construct personalised package plans	Team Leaders & Care Co-ordinators	Plan & Develop	Implement & Monitor	Review & Sustain
Meso-Level: **LHD + PHN catchment partnerships**	LHD's to initiate negotiations to form one unitary mental health plan for whole catchment (see Table 2) Partnerships contracted via LHD to provide specific services Development of Hybrid De-facto evidence based teams with multiple parallel funding streams	LHD + PHN to initiate & coordinate consultations towards a joint MHS plan with all other health & mental health service delivery organisations serving catchment (see Table 2) Respected partnership relationship, not contractor dominant relationship just "calling the shots" Consortia formed to co-manage such teams including as required, Public, NGO, Aboriginal Community Controlled Health Services, PHCO's, Fee for service providers	LHD CEO, PHN & Director of MHS	Plan & Develop	Implement & Monitor	Review & Sustain

	Involvement & Consulting of Consumers and Families in Service Design, .Policies & Procedures	Ensure Standing Advisory Committees And Management Committees including local Consumer & Family movement representatives				
Macro-Level: **MoH partnerships with other government departments & agencies & services**	Partnerships as required with Housing, Employment Services, NDIS (NDIA), NGO's Private Services etc All of Government & All of Community approach to key population mental health issues eg Completed & Attempted Suicide Prevention Respect in & receptiveness of all agencies to working with people living with mental illness and their families	Development and Regular Monitoring of MoU's & contracts between MoH & other government depts. & agencies & other services Multifacetted Multidisciplinary approach with joint all of community, all of government commitment and combined effort, as in approaches to Motor Vehicle Accident mortality & morbidity Training all agencies re how to relate to individuals living with a mental illness and their families	MoH in consultation with MHC	Plan & Develop	Implement & Monitor	Review & sustain

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Checklist for recommendations for the Mental Health Action Plan of the Jurisdictional Ministry of Health:
PART B: Priorities for Implementation (Tables 4-21)

With the dissatisfaction of both consumers and their families with hospital based mental health services, pressure on our hospitals and the need to create capacity in the emergency departments and acute mental health units, more welcoming and easily accessible solutions need to be found. We need to do this both to cope with demand, and to make our services and facilities less forbidding and more humane. While some areas may have bed deficiencies (e.g. SMHSOP beds), or units that need to be replaced (as they are not fit for purpose by today's standards), in general, adding more acute beds will not be as effective as reforming and upgrading our community based mental health services.

The envisaged reforms are compatible and conform with the principles, objectives and indicators enunciated in the National Mental Health Strategy (2009-2014), the revised National Mental Health Service Standards (2010), and particularly the new recovery standard, the National Practice Standards for the Mental Health Workforce (2002), the CoAG National Mental Health Roadmap (Rosen, 2012) the Report Cards of the National Mental Health Commission (2012-2013), as well as the draft national targets determined by its Expert Reference Group, and the Australian National Framework for Recovery Oriented Mental Health-Policy and Theory (AHMAC, 2013) .

The practical reform of NSW Mental Health Services should be aligned with the as yet still developing National Mental Health Services Planning Framework (NMHSPF) to determine adequate and equitable staffing, and resourcing implications for each category of mental health service per catchment population, and will be subject to an Activity Based Funding system designed by the Independent Hospital Pricing Authority (IHPA), which has been taking advice from the mental health community to provide a wider range of community-based proxies for hospital-related care to determine the Commonwealth contributions to government payments for episodes of care to LHD's.

It helps to understand the needs if we take a phase of care approach, to address early detection, early intervention, maximise acute home care, comprehensive early family interventions, specific therapies and an appropriate level of follow-up by clinical and support services. The Independent Hospitals Pricing Authority (IHPA) is developing an activity based funding model for mental health services, and this model will need to be based on the development of meaningful phase of care and specific intervention categories

to ensure appropriate funding of these distinct elements. e.g. studies indicate that mobile intensive services involving numerous home visits or services for involuntary service-users, or those with greater functional disabilities should attract greater cost weightings. In service terms this requires clinicians and support staff organised to provide:

- Intake (Telephone or Walk In, 24/7)
- Triage (Telephone or Walk In, 24/7)
- Assessment (Community or Hospital, 24/7)
- Acute Care (Home, Supported Accommodation or Hospital, 24/7)
- Specific Therapies and Mental Health Education
- Specific Strategies for Co-Occurring Disorders
- Care Coordination (related to evidence-base on Case Management)
- Functional Rehabilitation & Personal Recovery Programs (the latter include more unique, personalized, socially inclusive and empowering goals compared with the more limited previous scope of Rehabilitation)
- Personalised, Family and Group Disability Support Programs
- Telehealth and Visiting services providing rural/remote proxies for evidence based care

The NMHSPF recognises most of these distinctions and provides for separate dedicated allocations of resources for assessment and care in an emergency department, in the hospital inpatient wards and the community. Where separation of staff resources and clear separation of purpose is lost, acute home care is sacrificed, yet it is the key to reducing demand for acute beds. It is of no real benefit if you get an excellent assessment in a hospital, but there is no-one to care for you at home. A properly staffed acute home care team cannot only avoid admissions but shorten the length of stay by enabling earlier discharges. The demand for these entry services varies dramatically from day to day and most presentations are in the afternoons and evenings, so staff have to be rostered to match demand with flexible capacity and full responsibility in managing risk, with embedded psychiatrists.

While all areas of service need improvement, it must be a high priority that the Ministry of Health and LHDs provide sufficient funding based on the NMHSPF to enable a population based equity of access and functional teams operating with fidelity to the evidence base. Whether activity based funding can be effectively applied to Australian mental health services is still in serious doubt. We are still in need of comparative financial mapping of mental health services, especially as a baseline. Implementation needs to get started as early as possible in coming financial years so that the true costs of providing these services can be accurately established before activity based funding is applied.

Access to Mental Health Services

Improving access to effective and efficient treatment and support is a major international issue and must be a key national and state priority. It is estimated that unmet need for mental health care in developed economies range from 35.5% up to 50.5%, with higher rates in undeveloped countries (WHO, 2004). The existing Australian National Standard on Access is weak and fails to capture the significance and importance of the range of issues on which access to good quality care depends. For example, access must be more than a simple open door and should address issues relating to the "**who, what, how, where and when**" of individual need. In terms of "**who**", everyone should have access to quality care linked to their identified needs. "**What** "services are provided should be both effective, based on interventions that work, and efficient, that is delivered through systems that optimise positive outcomes and are resource efficient. "**Where**" services are delivered should be determined by where need is most, namely the community, at home or close to home, shops and transport and not in hospital. "**How**" people access services will be optimised where an easy and straightforward single point of contact provides for information giving, signposting and triage to needed care. In the complex world of multi-agency service provision, effective models of care coordination emerge as even more significant and essential components of enabling access to more integrated packages of treatment and support. Eg Community based "one stop shops" and comfortably appointed, welcoming, low-key fully staffed respite facilities. Finally, access must be available "**when**" people need it, in a timely fashion on a 24/7 basis. Longitudinally, this translates to the need for access to early detection and intervention in the early stages of the illness (Marshall et al, 2005) , rapid access when in crisis or an emergency to a range of acute community based alternatives to inpatient care (Joy et al, 2007), and access to continuing care coordination based on a collaborative and therapeutic alliance, and assertive or mobile active-response care as the platform for enabling access to a range of treatments and supports based on need (Rosen & Teesson, 2001; Rosen et al, 2013a).

4. Intake, Triage, Assessment and Acute Care

Some of these services can be shared across age groups (e.g. intake, triage, initial assessment) and others are better organised by age (different sets of knowledge, skills and care partners) or special circumstances (e.g. forensic, co-occurring disorders). However, the staff doing the initial assessment and acute care work often have to cover all ages due to the variability in demand.
These intake/triage services actually need to directly connect people up with needed care, and not just "pass the parcel' down-stream into community mental health teams for further assessment & re-triaging.

Table 4: Access, Intake, Triage, Assessment & Acute Care Priorities						
Strategic goal	**Sub-Goals**	**Action**	**Who**	**Timeframe: Year 1 – 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Access: Ease, Appropriate Portals & Rapidity of Access	1. Ease 2. Timeliness: Readiness, Rapidity of Response on 24hr basis 3. Appropriate Range of Portals 4. Emergency Department role 5. No exclusions or diversions	1. Convenient sites of entry, in community, near shopping and transport hubs 2. 24 hour crisis community/mobile access 3. Home visits 7 days & nights 4. Emergency Department access as back up or in life threatening emergency circumstances 5. No wrong door, No waiting lists, No diversions	MoH & LHD's & PHN's	Expand access to meet new standard	Implement statewide with effective proxies as necessary in rural catchments	Review, adjust and sustain
Access: Partnerships	Combined Mental Health Service/Police/Ambulance response for acute presentations otherwise via police alone	Form and train combined assessment teams on 24hr basis like Pacer teams in Victoria , Car 87 teams in British Columbia. Agression Response & De-escalation Training for Police Ambulance & MHS	MoH LHD's & Police & Ambulance	Training protocol , courses & manuals developed . Teams established in every LHD	Implement statewide	Review, adjust & sustain

Effective Intake/Triage/ED assessments	Reduce the considerable variability in resources and service delivery between LHDs and within LHDs	Dedicated resource according to the NMHSPF	MoH & LHD's	First phase enhancement target by....?	Ongoing with population growth	Ongoing with population growth
Effective Hospital Mental Health Consultation & Liaison: assessments and acute care	Reduce the considerable variability in resources and service delivery between LHDs and within LHDs	Dedicated resource according to the NMHSPF	MoH & LHD's	First phase enhancement target by,,,,?	Ongoing with population growth	Ongoing with population growth
Effective Community assessment and acute home and community based treatment & care	Reduce the considerable variability in a) resources and b) levels of fidelity to evidence based models of service delivery between LHDs and within LHDs	Dedicated resource, including staffing levels according to the NMHSPF Ensure "upskilling" of staff working in these teams in order to achieve acceptable levels of fidelity in practice.	MoH & LHD's & PHN's	First phase enhancement target by....?	Ongoing with population growth	Ongoing with population growth

5. Infant, Child & Youth Mental Health Services

With the mounting evidence of the economic benefits of investing in childhood, adolescent and youth (0-24) interventions, every year that we fail to properly implement the evidence based interventions, the more personal, family and societal distress and costs are imposed in future years. These interventions fall into the categories of prevention, early detection, early intervention therapies and family system solutions.

The NMHSPF process has highlighted the proportional underfunding of interventions for this age range and there are considerable variations in the level of state funded positions across the state. A priority is to ensure equity of access across NSW by topping up integrated teams and the specialist targeted programs that are necessary to ensure that high risk groups receive skilled care.

Table 5: CAMHS and Youth						
Strategic goal	**Sub-Goals**	**Action**	**Who**	**Timeframe: Year 1 – 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Funding effective programs for the 0-4 Age Group	Reduce the high variability in funding for peri natal and early childhood services, now X% of NMHSPF to a consistent level of Y% (yet to be negotiated)	Increase equitable basic funding to achieve Y% of NMHSPF	MoH & LHDs	2 years	Increase progressively to newly defined percentage of NMHSPF or revised NMHSPF	Increase progressively to achieve revised NMHSPF
Funding effective programs for the 5-11 Age Group	Reduce the high variability in funding for childhood services, now A% of NMHSPF to a consistent level of B% (yet to be negotiated).	Increase equitable basic funding to achieve B% of NMHSPF	MoH & LHDs	2 years	Increase progressively to newly defined percentage of NMHSPF or revised NMHSPF	Increase progressively to achieve revised NMHSPF
Funding effective programs for the 12-17 Age Group	Reduce the high variability in funding for adolescent services, now D% of NMHSPF to a consistent level of E% (yet to be negotiated).	Increase equitable basic funding to achieve E% of NMHSPF	MoH & LHDs	2 years	Increase progressively to F% of NMHSPF or revised NMHSPF	Increase progressively to achieve revised NMHSPF
Funding effective programs for the 18-24 Age Group	Reduce the high variability in funding for youth services, now G% of NMHSPF to a	Increase equitable basic funding to achieve H% of NMHSPF	MoH & LHDs	2 years	Increase progressively to J% of NMHSPF	Increase progressively to achieve

	consistent level of H% (yet to be negotiated).				or revised NMHSPF	revised NMHSPF

6. Perinatal Period

The National Perinatal Depression Initiative provided Commonwealth funding for these programs and that funding will cease in June 2014, unless renewed or an alternative source of funding is provided.

Table 6: Perinatal Period						
Strategic goal	**Sub-Goals**	**Action**	**Who**	**Timeframe: Year 1 -2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Effective Perinatal Intake, Assessment and Care	Improve considerably from current baseline: 3 Perinatal & Infant Mental Health (PIMH) teams cover 5 LHDs, with only 1 PIMH worker in 10 LHDs, who is unable to provide adequate cover for all maternity units. No longer allow several positions to remain vacant	Negotiate a stable source of funding to enable equity of access to this important early detection, early intervention and prevention program	MoH & LHDs	2 years	Implement statewide	Review
Effective State-wide Perinatal Advice Service (SwOPS) for mental health	Implement & regularize temporary or pilot only funding for SwOPS	Negotiate a stable source of funding to maintain this support to all areas of the state	MoH & LHD's & Perinatal NGO's	2 years	Implement Statewide	Review

7. Children

Immediate priorities need to target investments in early detection, early intervention, acute and longer term family care, which results in major reductions in distress, education failure and future cost savings.

There is increasing evidence that children who will struggle with completing education, likely to abuse drugs, to become involved in crime and generally require a lot of services later in life, can be detected through disruptive behaviours in early schooling. Public costs incurred per individual with conduct disorder in the USA were estimated to be around US$2 million across the life span. Effective actions to improve outcomes are being implemented and evaluated (e.g. Getting On Track In Time "GOT IT!" program at Mt Druitt, Newcastle and Dubbo). This service model includes a whole school approach, child focussed interventions, family/parenting interventions (Triple P, Incredible Years), school-based interventions, and referrals to CAMHS where further intervention is required.

23% of all Australian children live in a family with a parent with mental illness (ABS data) and they have a 41-77% risk of developing a mental illness or a serious socio-emotional disorder. Others are removed into alternate residential care due to the severity of parental disorder. Support for these children needs to be targeted and proactive with specific staff having the responsibility to intervene and effective partnerships with other agencies.

Table 7: Children						
Strategic goal	**Sub-Goals**	**Action**	**Who**	**Timeframe: Year 1 – 1.5**	**Timeframe: Year 5**	**Timeframe: Year 10**
Children of Parents with Mental Illness (COPMI) program, integrated with the adult mental health services for teamwork	Improve the employment of dedicated staffing with a clear model of care for an effective program to match evidence.	Review paper with proposed model of care	MoH & MHC	2 years	Implement consistently	Evaluate Review
Completion of GOT-IT! Pilots and evaluation	An important "Keeping Them Safe" response needs stable funding for completion	Ensure funding to June 2015 until the evaluation is published and considered	MoH & LHDs	Ongoing funding to be decided by 2 years	ditto	ditto

8. Adolescents & Youth

There has been an increased demand for early intervention in mental illness services in the 12-24 age groups, due to the interaction with illicit drugs and the value of providing assessment and acute care in the community, if at all possible. Developmentally appropriate clinical services are best provided by staff trained in family work and connected to education and specialist adolescent and youth support services. While adult intake, triage, assessment and acute care staff have a role, when it comes to providing acute care, it is important to ensure that there is an extended hours assertive and rapid response capacity in the adolescent and youth service. The usual volume of work does not require a stand-alone team, but the capacity to provide urgent intensive care in the family home.

Following the offer of Commonwealth funds under a under a National Partnership Agreement, in January 2012 the Ministry submitted a request to establish 6 EPPIC Hubs to enable coverage of the NSW population. The offer of funding was withdrawn and one renamed “Enhanced Headspace” has been funded for Western Sydney/Blue Mountains, linked to the Headspace offices at Penrith, Mt Druitt and Parramatta. The NMHSPF recommends sufficient funding to provide similar services at a further 5 hubs, to ensure full coverage of this important program for the whole of NSW. Access Economics (June 2009) calculated that investing in best practice youth mental health care gave a benefit to cost ration of 5.6:1 “thus, preventively oriented interventions targeted to young people aged 12-25 have the capacity to generate greater personal, social and economic benefits than intervention at any other time in the lifespan”.

As communication and information delivery becomes fully electronic, there is rapid progress in providing on-line, social media and telephone health information, prevention and treatment programs, with Australian developers in the forefront. The use of smart phones enables the use of apps to prompt behaviours (e.g. take pill reminder, store personal safety plans), set up appointments, and provide time efficient personal messaging. What is needed now is a process to collect innovative ideas, distribute them and assist staff, consumers and carers to implement them. The Commission could sponsor a competition, in partnership with TheMHS Mental Health Service Achievement Awards program to reward the best innovation each year, which would draw out otherwise hidden innovations.

Table 8: Adolescents and Youth						
Strategic goal	**Sub-Goals**	**Action**	**Who**	**Timeframe: Year 1 - 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
School-Link to engage and support schools with prevention, detection and care	The growth in diverse school programs has the potential for duplication and the development of gaps	Review paper with revised model of engagement and support	MoH & MHC	by 2 years	Implement consistently statewide	Evaluate Review
Assertive CAMHS to enable acute home care	To be implemented widely if pilots are successful (Two pilot sites are being evaluated currently)	Evaluation to be completed and published. Wide implementation to follow if outcomes are very good	MoH	In time for budget decision on rolling out to all CAMHS in 2 years	ditto	ditto
Early Detection, requiring active education for the community, education facilities and primary care clinicians plus a clear pathway to assessment and care	Create a coordinated system to provide all the elements to achieve early detection, which requires a whole of state and federal governments plan for efficient and effective actions	A paper proposing solutions needs to be developed in cooperation with other governments.	MoH & MHC	For COAG/National Cabinet agenda	ditto	ditto
Implementation of EPPIC inspired model of services across NSW	While there are some staff currently allocated to early intervention, more investment is required to provide all the essential elements identified	Produce a plan to provide equity of access to best practice adolescent and youth care, including headspace and EPPIC	MoH & MHC	By 2 years	ditto	ditto

	in recognised best practice models in every LHD					
Effective use of electronic media	A mechanism to find and publicise innovations would lead to high acceptability by and engagement of young people, improved efficiency, effectiveness and service delivery savings.	Commission a report on the current situation. Sponsor a competition to find innovative applications. Comparatively test these innovations for effectiveness	MoH & MHC MHC	By 2 years By 2 years	Ongoing	Ongoing

9. Specialist Mental Health Services for Older People (SMHSOP)

A comprehensive plan was developed for the 2005-2015 decade to address the ageing of the population and the expected increase in mental disorders and dementia with behaviour disturbance. This plan had a mid-term evaluation in 2011 by the consultants Health Policy Analysis and the report concluded that the plan provides clear strategies towards achieving the aims of improved access to specialist services for older people with mental illness. However, at the time of the report, access to SMHSOP was “well below the level indicated by estimated need” and compared to other Australian states and territories. “Access is particularly poor for priority groups, which include Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, rural residents and older people in custody”.

Consultations with the sector have also revealed the need for a consistent range of models of care guidelines to be developed to clarify provider roles and responsibilities to ensure effective and efficient service delivery. The NMHSPF needs to be applied to identify service and resource gaps. Special plans will be required to address the needs of the above priority groups. Phase two of the current state plan should be implemented, informed by the model of care guidelines.

Table 9: Specialist Mental Health Services for Older People						
Strategic goal	**Sub-goals**	**Action**	**Who**	**Timeframe: Year 1 – 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Continued implementation of phase 2 of the NSW Service Plan for SMHSOP and to match aged population growth	Reduce high variability in funding and improve quality of care and prevention, currently averaging M% of NMHSPF to a consistent level of N%	Increase equitable basic funding to achieve N% of NMHSPF	MoH & LHDs	By 2 years	Increase progressively to Z% of NMHSPF or revised NMHSPF	Increase progressively to achieve revised NMHSPF
Effective special needs groups plans	Create specific plans and resource allocation	Needs reviewed and plans developed	MoH & MHC	By 2 years		
Effective model of care guidelines to achieve comprehensive, but focussed, care and teamwork in a multi-provider environment	In the light of changing responsibilities between governments and multiple funding sources, create a unified model of care guideline for service delivery within and across provider boundaries	A consistent range of models of care be developed in consultation with the stakeholders	MoH & LHD	By 2 years		

10. Adult Mental Health Services

Evidence-based components needed to establish and maintain high quality care

Evidence-Based, Recovery-Oriented, Human-Rights Upholding, High Quality Mental Health Care
Just like any other area of health care quality services are essential for the mental health and emotional wellbeing of people who experience mental illness. There is now strong consensus about the elements required to promote and implement high quality mental health services.

The following sections outline evidence based a) intervention components (e.g. CBT, DBT etc) and b) potential service delivery systems (e.g. respite facilities, crisis & ACT teams) for these components (AHHA TheMHS & PWC, 2008. See Appendix 1).

- **GP and liaison shared care is at the core.**

  It should be delivered by primary mental health liaison team or coordinator and incorporated supported transfer of care co-ordination systems (e.g. Victorian CLIPP studies, Meadows et al, 2007).

- **Public health proactive approach** to prevention, early detection and intervention

  Encouraging help seeking is also critical. It should be delivered through mental health literacy programs, web-based and telephone based education and brief intervention services, 'youth friendly' early intervention services such as 'headspace', early intervention teams (McGorry & Jackson, 1999) which can now demonstrate much more positive outcomes for 8-10 years (Mihalopoulos C et al 2009) and include prodromal assessment and support. (see Helen Christiansen section).

- **Crisis and family interventions, home visits, acute respite care and emergency psychiatric services**

  These should be based, respectively, in community settings and [the latter] in general hospitals, involving triage and effective interventions are needed. The most recent Cochrane Intervention Reviews (Murphy et al, 2012, Joy et al 2007) reinforce the conclusions of Stein & Test,1978, Hoult et al 1984, Rosen 1997 etc that Crisis Intervention for individuals with severe mental illnesses appears to reduce repeat admissions to hospital while lessening family burden and increasing consumer and carer satisfaction. Crisis intervention needs to be based in the community (Rosen et al, 2010a, Rosen et al 2012) offered 24/7 or through extended mobile community services.

Acute and Subacute Respite can be delivered via 24 hour supervised local community-based residential respite facilities, as alternative to hospital admission, including step-up step-down and “instead-of” care, with equal safety and greater satisfaction for most, resulting in less involuntary care (Johnson et al, 2009).

There is some descriptive evaluation (MH-Inform, 2008, Frank et al, 2005) but no rigorous evidence for Psychiatric Emergency Care Centres (PECC’s) despite their recent proliferation, There may be more promising and cost-effective strategies which require comparative study, such as a 24 hour roster of emergency psychiatric triage nurses, or an emergency department follow-up brief intervention “green card” clinic (Wilhelm et al. 2007).

- **Active-response intake and mobile care coordination** (refer to evidence base on case management) system, is needed.

  It should be delivered through local community-based mental health centre, ideally at a one-stop-shop with primary health care available near shopping and transport hubs (Rosen et al 2010a).

- **Assertive Community Treatment**,

  This is a specific highly evidence-based delivery system (Killaspy & Rosen 2011, Harvey et al, 2011,), or Intensive community care management, a European variant with less fidelity, (Rosen et al 2001, 2007.2013a) for individuals with persistently severe disabilities is an essential element, delivered by an assertive community treatment team. These teams now usually include vocational housing and drug & alcohol specialists. Evidence based standards for these ACT teams have been developed by the Ontario Provincial Dept of Health (2000) , policy implementation guidelines have been deployed systematically by the Dept of Health (2000-2002) in the UK, and 2 generations of fidelity criteria & standardised measures of adherence to them (DACT, TMACT) have been developed by Teague G et al, 1998, and Monroe-DeVita M et al 2011. Contemporary versions of ACT involve peer workers, strengths based care coordination and recovery orientation and these are now encompassed by the fidelity measures.

- **Biological interventions**

  These may be designed to enhance medication adherence and safety (eg National Mental Health Development Unit, 2009) **and regular attention to physical health needs are also required.** These can be administered by delivery systems that monitor and adverse effects/interactions/polypharmacy minimizing risk management system, community pharmacist consultation and liaison service (Bell et al, 2007, Gisev et al, 2009). Interventions for physical health needs include: Protocols, monitoring and intervention systems to minimize physical illness and risk factors in individuals with mental illness such as CVS and diabetes regular risk factor monitoring system, and aerobic exercise and weight monitoring programs.

- **Psychological interventions**

  Including CBT for many disorders, DBT (Klein & Miller, 2011, Kienast & Foerster, 2008, Paris, 2010) for personality disorders, including those with suicidality or addictions, IPT (Campanini et al,2010), ISSRT (Frank et al 2007, Germain et al, 2008), neurocognitive remediation (Delahunty 1993, Wykes et al, 2007, 2011), supportive psychotherapy, counselling, medication adherence (Kemp et al, 1996, Haynes et al, 2008) delivered by systems that involve systematic training, supervision, plus monitoring for fidelity (Beidas et al, 2010, Brooker,2001) .

- **Social interventions include leisure, education, work and financial domains.**

  Examples include clubhouse or equivalent, leisure/recreation/aerobic physical activity programs, expert vocational rehabilitation counsellors operating individual placement and support (IPS) programme and financial counselling services. Residential interventions are also indicated. These include living in your own home wherever possible but also supervised residential care where appropriate. Residential inpatient interventions are also needed.

- **Supportive interventions**

  These also have an emerging evidence base. These include: recovery support services provided largely by NGOs, psycho-education and adaptive communication, problem solving skills and supportive psychotherapies on an individual, group and family basis.

Inpatient Care

Maj (2010) states that we have learnt from *experience* that public hospital beds are necessary in psychiatry and correctly says that it is not true, as sometimes asserted, that 'psychiatry does not need any beds'. However, justification for inpatient services can no longer rely merely on our "experience" or "consensus" of the psychiatric establishment, as there is a dearth of research about psychiatric inpatient care, which creates frustration for those designing inpatient implementation guidelines (Department of Health, UK 2002). It has never been shown in any rigorous studies to be superior to comprehensive community based alternatives to inpatient care (Rosen et al, 2010a, 2012b).

As there is little evidence to support acute inpatient admissions generally and considerable evidence to support community-based care less restrictive alternatives should be sought as soon as possible, whether for acute short term or supervised extended stay residential care. Long-term inpatient care achieves better outcomes in small-scale non-institutional community settings, without involuntary orders or restraints, and with a full range of psychosocial interventions (Taylor et al, 2009, Johnson S et al, 2009).

Architecture and environment of mental health facilities:

Clinical technologies should be supported by ease of access, location convenient to local communities, welcoming, comfortable and healing environments and social interventions. There should be maximizing of human rights and dignity, minimizing of involuntary care, sedation, restraint or locked doors. Inpatient facilities should be designed for optimal support, giving consideration to general atmosphere, natural light and outlooks, with airy, attractive welcoming spaces indoors and outdoors, modularized to allow separate safe places for different genders and age groups (Coombes, P, et al, 2008)

Human Rights & Medico-Legal issues :

Implement existing effective strategies for upholding human rights and minimising involuntary care (Rosen A et al, in Dudley, M, et al, 2012), and for seclusion and restraint (Foxlewin, B et al,2012) should be implemented.

- **Cultural interventions** are also indicated.

  These have both micro (family, intimates, confidantes, and proxies) and macro (addressing universal cultural tools such as rites of passage, extended kinship support networks, communal and societal (including media) components of stigma and discrimination (Rosen A 2006a & b) .

- **Integrated Mental Health Care:**

  Finally, there is also recognized need for **service integration** so that providers will collaborate in systems that work together to develop individual care plans and personalized recovery programmes. This requires interdisciplinary mental health teams, hybrid de-facto teamwork between public, NGO and fee for service sectors, regardless of funding stream, with well integrated care coordination of delegated roles.

Recovery oriented interventions

These are also key to quality services.

We should aspire to all of our interventions being recovery oriented. We should not categorise some interventions as recovery oriented and others not – if they're subject to individual choice, evidence based, humane, potentially healing and empowering they should be under the recovery umbrella.

The prospects of recovery can be enhanced specifically by a combination of the following elements: Recovery-oriented staff & facilities; Consumer peer support specialists certified training and placement in clinical teams; Recovery oriented experiential workshop training for service users, providers and families; Working with communal organizations and workplaces towards social inclusion and full citizenship; Recovery orientation of service monitoring (Burgess et al 2011); Practices which boost coping, resilience, buoyancy, work/life balance and hope; Skills training for service users, providers and families; Consumer & Carer participation in service management, quality improvement activities, recruitment etc; Consumer choices take precedence, where possible, in drawing up own individual plan.

There is also growing evidence of the effectiveness of specific elements of the recovery agenda (e.g. Warner R, 2010), particularly in terms of the contribution of the following as elements of empowerment, to measurable improvement.: of paid work, interpersonal support, and internal locus of control (or mastery through personal choice and decision making), and low internal stigma .

All Age Groups' Mental Health Services

10.1 Dealing with Co-Occurring Disorders and Complexity issues

These **need** to be addressed simultaneously, with dual interventions for mental illness in conjunction with those for other concurrent disorders such as:

- substance abuse (see Dept of Health, 2002) , and gambling addiction disorders
- concurrent personality factors, dysfunctional or unsociable habits, or recurrent patterns of self harming or suicidal behaviours and intent

- intellectual disability, learning disability,
- eating disorders,
- brain injury,
- physical illnesses & disability, including HIV+ status

10.2 ....**while also dealing with complexity issues such as:**

- homelessness or unstable housing,
- poverty, unemployment, lack of purposeful role
- loss, bereavement and aggravated grief
- isolation & social exclusion, including lack of family, intimates, confidantes, friends & community
- trauma including sexual physical & verbal abuse, intimidation, violence and exploitation
- Disasters of nature, war, genocide, dispossession and displacement
- LGTI orientations,
- justice/forensic issues.
- Stigma & Discrimination due to a combination of these factors.

See specific position papers commissioned by the MHC of NSW, in MHC of NSW Report, 2014.

Table 10.1+.2: Dealing with Complexity, including Co-Occurring Disorders						
Strategic goal	**Sub-Goals**	**Action**	**Who**	**Timeframe: Year 1 – 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Integrated Care approach	Bridging fragmentation between simultaneously needed services into one team	Establish team portfolios & then functional teams combining Mental Health + Drug & Alcohol (or other co-occurring disorder) Expertise + Support	LHD's & NGO's + PHCO's/	Every LHD to establish demand for dual disorder sub-teams in	Implement actual or de-facto hybrid team in each	Sustain, review & modify if needed

	Taking a "No wrong door " approach, then providing information,education & stepped care at the consumer's own pace	Implement as service policy and practice	PHN's + Relevant Private Clinics & health & lifestyle practitioners	partnership with other sectors	catchment, then fine-tune	
Fostering All of Health, All-of –Government, All-of-Community approach	Coordinated one-stop-shop approach	One-stop-shops in local shopping & transport hubs combining services for co-occurring disorders & complexity factors for each major age-group	As above	As above	As above	As above
Attend to Physical Health of individuals with Mental illnesses	Work to eliminate the morbidity & mortality gaps of people with severe mental illnesses due to physical illnesses, lifestyle factors and medication side effects	Teamwork with Health educators, Dieticians, Sports Physiologists, Physiotherapists, Life Coaches, Community Pharmacists, & PHN's.	As above	As above	As above	As above
Accessing Specialty Co-Occurring Disorder Services	Staff in local/regional services for co-occurring disorders should have sufficient training to provide confidence and Competance to assess and treat Capability of local service to access expert advice, supervision assessment & treatment if required by specialty service	Consistent practical training for local teams in each significant co-occurring disorder Implement Central or Regional Specialty Co-Occurring consultation & treatment services, available to local services on 7 day/night basis	As above	As above	As above	As above

11. Transcultural Mental Health Services

There are two organisations providing state-wide services for migrants and refugees that receive funding from the NSW government – The Transcultural Mental Health Centre (TCMHC) hosted by Western Sydney LHD and the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), an incorporated affiliated health organisation. While STARTTS has a board with members nominated by organisations with an interest in refugee welfare or relevant special skills, TCMHC has lost its advisory board and so diminished its connections to relevant organisations, communities served and expertise. Both organisations have been shown to provide effective services, relevant to the evolving demographics of their target groups, across the whole state. However, because the demographics evolve with new waves of arrivals, resources, both human and materials, need to be updated. The TCMHC Brokerage Program casually employs contracted skilled clinicians with the consumer's language and cultural background, to enable efficient and effective assessments and culturally relevant care plans to be developed, for main stream services to implement.

Table 11: Transcultural Mental Health Services						
Strategic goal	**Sub-Goals**	**Action**	**Who**	**Timeframe: Year 1 - 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Culturally effective and efficient assessments and care planning	Improve the Brokerage Program to provide clinician consultants for the 130+ language groups	Funding to restore an equitable, basic, market demand driven service	MoH	By 2 years	Adjust for changes in demand	Adjust for changes in demand
Effective governance and refreshed model of care for TCMHC	Improve the connections to relevant organisations, communities served and expertise for effective service governance	An independent review of the governance, models of care and services provided be commissioned with stakeholder involvement	MHC reviews with recommendat-ions to MoH	By 2 years		

12. Aboriginal & Torres Strait Islander Peoples

Australian Mental Health Services need both more Aboriginal Mental Health Worker (AMHW) professionals, traineeships and qualified AMHW positions in every mental health team with a significant proportion of Aboriginal people in the catchment population. At the same time eligible Aboriginal individuals should be encouraged to apply for scholarships and support to pursue mental health professional qualifications in all the health disciplines. It is a matter of this and that, not this versus that. AMHW's often start their university course without having completed high school. They may need preparatory and continuing assistance with literacy and study skills. Continuing Mentorship and pastoral support can help with retention for all trainees and graduates. AMHW's are essential professionals in their own right, in their contribution to the work of mental health teams in allregions where there is a substantial Aboriginal TSI population, to both engage indigenous potential service users and their families, to a) assist them to learn to trust mental health services and b) to be able to both recommend to clinical service providers, service-users and their families, and assist in the delivery of a blend of up-to-date Western evidence based treatments and traditional healing practices. Aboriginal service users are often more likely to trust and heed advice from both well-trained Indigenous expert clinicians as well as AMHW's and peer support workers.

Future developments should include providing more Aboriginal Official Visitors and AMHW professionals to assess all Aboriginal individuals with acute conditions for which involuntary orders are sought, to ascertain whether there are culturally appropriate alternatives to such involuntary care, as provided for in the new Western Australian Mental Health Act.

Table 12: Aboriginal & Torres Strait Islander Mental Health Services						
Strategic goal	**Sub-Goals**	**Action**	**Who**	**Timeframe: Year 1 - 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Self-determination of mental health services by Aboriginal Communities wherever possible	Joint governance and provision of services between public and NGO mental health services with Aboriginal Community	Formal partnerships between public & NGO mental health services and ACC health organisations (e.g. AMS's)	AMS + LHD in partnership	Develop	Implement year 2 Review year 5	Review

	Controlled Health Services (ACCHO's)	A single mental health plan for catchment inclusive of all relevant agencies, including public mhs, AMS, PHN's, PHCO's (AMS's) and NGO's				
Close the Gap of decreased life expectancy associated with a combination of mental Illness, drug & alcohol use, social determinants and Aboriginal heritage interface with the colonising culture	Tackle simultaneous risk factors: a) transgenerational dispossession, dislocation and demoralization b) individual, communal & clinician neglect of concurrent risk factors contributing to physical disease including substance abuse a) preoccupying mental illness	Adapt iPhys programme & teach empowering cultural healing factors for social & emotional wellbeing programmes in Aboriginal communities, of all age groups Culturally appropriate & empowering quit smoking, substance (including alcohol) reduction, and appropriate nutrition programs e.g. Pitstop, Kicking Goals.	AMS, PHCO & LHD + PHN + DoH in partnership with community elders, community working party & Land Council, and all levels of Government	develop	Implement year 2-3	Review
Develop the Aboriginal Workforce	Further dissemination of Aboriginal Mental Health Worker professional program Develop Aboriginal Consumer & Family peer worker program	Provide resources & training positions to recruit & retain more trainees to AMHW degree program. Provide incentives including regular training supervision, pastoral mentorship & support and permanent positions for AMHW's and peer workforce	MoH + LHD's + PHN's with Charles Sturt University(NSW) & Edith Cowan University (WA) plus AMS's & Health Education & Training Institutes or	Further develop Set up Supervision & Mentorship networks	Implement widely Achieve at least 1 AMHW for each 1000 Aboriginal people	Review

			National Institute (VCCMHWB+ ANWIMH initiative) .			
	Encourage eligible Aboriginal individuals to pursue training as mental health professionals in all clinical professions, but not at expense of supporting AMHW professional courses, traineeships and positions	Provide scholarships and trainee positions for both and for post qualification internship & AMHW professional positions				
Official Visitor & Medico-Legal provisions	Future developments should include: a) providing more Aboriginal Official Visitors and b) providing AMHW professionals to assess all Aboriginal individuals with acute conditions for which involuntary orders are sought	a) Make specific provision for Aboriginal Official Visitors b) Amend NSW Mental Health Act to ascertain via AMHW assessment whether there are culturally appropriate alternatives to such involuntary care, as provided for in the new Western Australian Mental Health Act.	Minister of Mental Health plus MoH plus Official Visitors plus AMHW curriculum designers at CSU	Amend legislation and Develop provision	Implement	Review & Sustain

13. Rural & Remote MH Services

Components of or proxies for all evidence based modules of care must be made available and easily accessible in all parts of this state. This includes regional functional teams with in-person outreach capacity to more remote centres, and use of tele-health interactive assessments and reviews, and e-strategies, but not to the exclusion of intermittent and as-required live contact with mental health professionals. **Recovery oriented and trauma informed and evidence based intervention training and continuing supervision for public mental health professionals, NGO's and peer workers in rural settings must also be ensured.**

Table 13: Rural and Remote MH Services						
Strategic goal	**Sub-Goals**	**Action**	**Who will do what**	**Timeframe: Year 1- 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Planning, development and delivery of effective and sustainable mental health services in rural/remote parts of state or territory, requires special consideration and planning approaches.	Distinct though related strategies for regional, rural and remote parts of state or territory	Development of a rural MH plan for NSW as a sub component of the overall state MH plan. Utilize a planning methodology as proposed by Fanning, Buss, Hoskin (2013)	MoH in liaison with MHC	Develop	Implement year 2	Review
Workforce to develop wider understanding of the precipitating factors to development of mental illness in rural remote parts of state or territory - changing socio- demographics,	Specific strategies for special needs groups such as farmers, Aboriginal people, itinerant workers and those from a CALD background	Ensure that adequate weight is given to the above factors to allow the development and implementation of a proper range of public health/mental health from prevention and early intervention through to	MoH in liaison with CRRMH's (eg Qld,NSW) + MHC + ANWIMH + VCC MHWB initiatives	Develop	Update	Review

the impact of environmental change and economic variables (commodities prices etc) and the special needs of high risk groups		treatment and rehabilitation Consult adequately with local communities, including key organizations such as National Farmers Associations, the Mining Council, local government, rural doctors, the Rural Health Alliance, PHCO's, police, ambulance, judiciary, churches, charities, Aboriginal Controlled Health Services, Rural Psychiatrists Association and community groups	CRRMH's & MoH to ensure that the feedback given at CRRMH forums in recent years is accessed and updated where applicable so it is not lost in the planning process			
Correct inequities in resourcing of Rural MHS	Protect both MH budgets and governance at PHN +LHD level to ensure fairness, equity and proper accountability	Oversight of setting of MH budgets for rural LHD's, ensuring Directors of MH have full budget delegation and costs levied against the MH program reflect the actual cost of service(s) and are agreed by MoH, MHC and the local Director of MH	MoH in liaison with MHC			

Rural MH services within LHDs need special attention to ensure appropriate policy, planning and service development.	Monitor dedicated funding that the CRRMH receives from the Jusrisdictional Ministry of Health to facilitate statewide work in these key areas as opposed to research alone.	Key Performance Indicators for dedicated projects need to be established and regularly monitored to ensure high priority work is undertaken in consultation with all LHDs	MoH in liaison with CRRMH + MHC			
Adequate consultation with expert service users and providers	a) to capture the specialist knowledge of rural MH providers with enormous experience at a clinical, policy, planning and administrative level. This increases the risk that high value rural service models will not be identified and replicated, particularly after 20 years of reform of health administration b) to properly understand the impact of mental illness on consumers and carers living in regional parts of state or territory, and the difficulty in obtaining access to services let alone early intervention	a) consult existing and former long serving rural MH specialists to document their knowledge and experience of developing and implementing rural service models b) consult consumer and carer groups about their lived experience, including drawing on feedback given in the development of rural projects in the past and what has worked and what hasn't and why	LHD's + PHN's in liaison with MHC	Develop	Implement widely	review
Mapping for range of facilities and personnel required, including IT connectivity & e-mental health services	To ensure that rural people have the same access to services as people living in metropolitan areas, albeit through different service models and funding arrangements. E health	Ensure that all funders and providers are brought together at a Commonwealth, state and LHD level to ensure the full mapping of existing services and to identify	MoH in liaison with CRRMH + MHC	Develop	Implement findings	review

	should not be seen as a substitute for locally based services, but supplementary	gaps				
Establish and stabilize specific Peer Support and bicultural professional positions in workforce for rural communities	Establish and develop peer support workers and bicultural professional positions with programs to support their training, supervision and placement in rural services Address the specific needs of Aboriginal, specific nationality refugee, asylum seeker and traumatized populations	Develop a workforce plan for rural peer support workers, and bicultural MH professionals including the requirements for support and supervision	LHD + PHN+ MoH	Establish	Implement	Review
Retention of rural MH workers, including resident psychiatrists and the higher demands placed on GP's as a consequence		Undertake proper workforce planning, including the adequacy of preparation for rural work plus ongoing professional development needs and clinical supervision. Identify specialist rurally based education providers and budgets to support this function	LHD's & PHN's + MoH in liaison with CRRMH's			

14. A Wellness & Wellbeing Approach

Wellness & Wellbeing is organised below in 4 modules. Wellness of the general population (addressing social determinants of mental health), Wellbeing in the Workplace, the potential contribution of Indigenous and other traditional cultures to mental health in the wider community alongside empirical evidence based Western methods, and a wellness approach to managing mental illnesses. There is increasing evidence and understanding of the importance of good mental health and well-being, and much more is now known about what can be done to sustain resilience, mental health and well-being for organisations, communities, families and individuals of all ages (Henderson G, Wellbeing and Public Mental Health National Lead 2009-11, UK National Mental Health Development Unit). Toolkits such as that developed by the Maudsley NHS Foundation and the UK National Mental Health Wellbeing Impact Assessment (MWIA) Collective for wellbeing assessments and interventions for individuals, workplace and community groups, are now emerging, being promoted and adopted widely (Cooke et al, 2011) .

Table 14: Wellness, Wellbeing, Social & Emotional Wellbeing						
Strategic goal	**Sub-Goals**	**Action**	**Who**	**Timeframe: Year 1 – 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Wellbeing in Everyday Life in Population	Maximize Social Determinants of mental health & minimize the social determinants of mental illness This also entails optimising social determinants of general health & wellbeing	MoH to plan for, coordinate & contribute to all-of-government efforts to mitigate the mental illness predisposing impacts of these factors at population & community levels Ensure or restore Mental Health Promotion & Prevention Expertise to initiate & coordinate	MHC + MoH coordinating all of government plan LHD Public Health Unit + MHS + PHN/ PHCO coordinate at LHD level	Plan	Implement on population scale	Sustain, review & modify if needed
Wellbeing at Work	Amplify Employers & Employees awareness of wellness, stress reduction and mental health counselling and / or mental illness / drug & alcohol assessment & care access & care pathways.	Mental Health & Wellbeing Awareness & Education programmes in Workplace Confidential Pastoral, Mentoring & Counselling services provided	MoH with Australian & Canadian National MHCommissions + Workforce	Plan	Implement widely in workplaces	Sustain, Review & Modify if needed

		by employer, but at arm's length from & not reporting to employer	Australia + beyond-blue			
Social & Emotional Wellbeing	Integrate Scientific Evidence Based & Traditional wellness, healing & illness mitigating factors into one holistic Health & Wellbeing Facilitating System (Rosen 2006a+b) Operationalise & Implement Therapeutic Optimism plus mental and physical activity	Government & Wider Community demonstrate valuing of traditional healing factors of indigenous and traditional cultures, by providing education about these factors to general public Implement Positive Psychology & Learned Optimism & Mental & Physical approaches to wellness.eg disseminate Act-Belong-Commit principles	MoH in consultation with MHC plus Aboriginal & Transcultural expertise	Plan & publically commit Jurisdictional Government & MoH.	Implement	Sustain, Review & Modify if needed
Wellness approach to Mental Illness	Recovery approach entails taking a wellness approach to dealing with mental illness, by optimizing wellbeing practices and wellbeing enhancing factors, in complementarity to clinical treatment & care as needed	Wide dissemination of wellness oriented programmes among individuals with mental illnesses & their families. eg "WRAP", to be undertaken in synergy & coordination with empirically evidence based mental illness clinical programmes	ANWIMH +VCCMHWB Initiatives MoH + LHD to fund. To be taught by Consumer & Family Peer Workers in partnership with mh professionals	Plan & Train facilitators	Implement	Sustain, Review & Modify if needed

13. Useful Tools for Implementation (all age groups)

The emerging disciplines of Implementation Science and Practice of Delivery entail developing a multi-level continuous process from a Policy Implementation Unit at the highest level of government (eg Tony Blair's very effective prime ministerial example, Barber, 2013) to Implementation Science, with input from academic and advisory units (eg Whiteford et al, 2013, Salvador-Carulla

et al, 2011) to practical applications of implementation and sustainability methodologies on the ground. Implementation science "creates generalizable knowledge that can be applied across settings and contexts to answer central questions": eg. Why do established programs lose effectiveness over time and how can this be overcome? Why do well-tested programs sometimes lose some of their effectiveness or exhibit unintended effects when transferred to a new setting or when disseminated widely, and how can this be prevented? How can multiple interventions be effectively packaged to capture cost efficiencies and to reduce the splintering of health systems into disease-specific programs? (Madon et al, 2007; National Institutes of Health, 2013). Implementation science recognizes and address the multitude of gaps that impede evidence-based interventions from producing optimal health outcomes. These knowledge and practice gaps include:

- "Research-to-policy" gaps which exist when research evidence is not adequately or appropriately considered and integrated in the development of health outcomes.
- "Research-to-program" gaps which exist when research evidence is not adequately or appropriately considered and integrated in the development of health policy.

Our challenge is to bridge these gaps and shorten the lag-phase from strong evidence of positive outcome to policy to widespread practices and programs.

To be effective, service implementations require fine leadership, wide consultation of all stakeholders, availability of coherent current service data for preliminary analysis, baselining and monitoring, dissemination of knowledge of and training in evidence based best practices. They should invoke collaborative models of change management, which will encompass complexities and apparent contradictions, seeking consensus from all those with relevant professioinal and lived-experience expertise, and invite broad co-ownership. For sustainability, newly adopted evidence based interventions and service delivery systems will require knowledge & skills updates, systematic supervision and mentoring networks and knowledge exchange and reciprocal support through communities of practice, as well as assured resource stability and transparent and comparative quality monitoring and accountability. These approaches should mobilize, operationalise, manualize and disseminate translational research, and also be ethically sound as described by Values Based Practice (Fulford et al, 2012): which holds that " All decisions stand on two feet, on values as well as on facts, including decisions about diagnosis & intervention". In values-based practice, conflicts of values are resolved primarily by processes designed to support a balance of legitimately different perspectives (Personal Autonomy Vs Involuntary Care, Rosen et al, 2012c).

Such implementation also relies on accessing a focussed array of useful tools as exemplified below:

Standards and Quality

Despite the National Standards for Mental Health Services (National Mental Health Strategy [NMHS], 1996) being endorsed and celebrated by the consumer and carer movements, they were watered down in the revised version (NHMS, 2010, Miller et al 2010), and both the access to and quality of mental health care vary wildly depending on where you live, being particularly patchy in regional, rural, remote and indigenous communities (Buss et al, 2012, Rosen et al 2010a). Other highly relevant standards include the Area Integrated MHS Standards which preceded them (Rosen et al, 1989, 1991), National Service Framework Standards (Dept Health, England 1999), Recovery Competencies (O'Hagan, 2001), and National Standards for Workforce (NMHS,2002) and Workplaces (MHC Canada, 2012). The USA Quality Chasm series (Institute of Medicine, 2006, Pincus,2009) state that quality in mental health care depends on setting practical goals, applying continuous measurement and a reliably-tested methodology for reform.

Fidelity, Outcome Measures, CPG's and PIG's

Fidelity monitoring ensures that teams or services are applying the core ingredients of evidence based service delivery systems (e.g. Assertive Community Treatment (ACT), Rosen & Teesson, 2001) or of an Intervention (e.g. Cognitive Behavioural Treatment (CBT), Brooker, 2001)

Outcome measurement: Australia has been a pioneer in the routine application of a mandated standard set of outcome measures to all mental health service users of all age groups, including symptomatic, functional and subjective measures, with recent explorations regarding the adding a recovery oriented measure (Burgess et al, 2011).

There is also strong agreement that validated collection of the consumer experience of care is critical, but underdeveloped. MH-COPES in NSW and MH-ECHO in Victoria are both promising models which deserve further exploration as vehicles by which to assess the consumer perspective on the quality of care for the purpose of service improvement. Neither these nor a social inclusion survey measure being developed based on generic ABS questions could adequately replace the addition of a comprehensive recovery measure to the national suite.

Policy Implementation Guidelines (PIG's) were introduced to mental health services in the UK in 2002 to support the consistent delivery of national mental health policy for all local service providers. Whilst certain service models are specified there is also emphasis placed on tailoring services to meet local needs (Department of Health, 2002).

Clinical Practice Guidelines have been developed by professional bodies, often with government support, on the basis of expert committees and consensus, to encourage standardization and consistency of practice of qualified members in line with scientific knowledge (e.g. RANZCP, 2003). They have been critiqued because they may interfere with clinical autonomy and innovation, or st they are often not implemented continuously and allowed to go out of date.

Rebalancing Services

There is broad agreement that Australia's mental health service system is currently heavily skewed towards hospital-based care. There is little evidence to justify this bias, and a better balance is required (Thornicroft and Tansella ,2002, 2004) together with integration at both health service and all-of-government levels (Rosen, 2002). The World Psychiatric Association International Guidance (Thornicroft et al 2010) now proposes models" with most services… provided in community settings close to the populations served, (and) with hospital stays being reduced as far as possible, and usually located in acute wards in general hospitals."

This brief review describes the key elements need to improve service quality, and summarizes the major components needed for high quality care.

Elements that improve service quality

The following elements have been found to improve service quality.

- **Skills training** and regular in-service skills updating Service **development and transformation strategies:** Sainsbury Centre, NIMHE (UK), MH-POD (AUS), Recovery Innovations (USA), Te Pou (NZ) and Pincus, 2009.
- **Supervision pyramids**, with supervisors of evidence based practices (EBP's) at each level receiving supervision themselves by supervisors at a higher level, as introduced for IAPT in the UK, with skills transfer from supervision (Milne et al 2003). This entails that every worker has a supervisor either individually or in group supervision, and a more senior supervisor supervises the supervisors and so on, for every evidence based suite of interventions and /or service delivery systems.
- **Communities of practice**, allowing teams with common evidence based clinical or support functions to exchange local adaptations of best practices (MHCCanada, 2012).
- **Individual and group mentoring** to assist service-providers to reflect on resolving any difficulties with their place in their organization, their career pathway opportunities and their work/life balance, conducted confidentially with a mentor who does not report up to the organisation's management (Brideson T et al 2013).
- **A Knowledge Exchange Centre** to provide free public access to the latest reviews or "units of knowledge" in plain language to service-providers, service-users, their families and the whole community about
  (a) critical well-validated knowledge (EBP's) and

(b) specific feasible practices and service delivery systems which follow from that knowledge (Mental Health Commission of Canada 2007, Rosen et al 2010, Rosen 2012).

There is also reason to support a more systematic approach to system-wide service planning. An effective method of increasing the specificity, uniformity and fidelity of nationwide implementation is to define individual service components and staffing levels required to deliver a comprehensive, locality-based continuum of community care (Henderson et al, 2000, Andrews et al, 2006). These authors specified the intervention costs fairly accurately, but vastly underestimated the costs of the service delivery systems, essential key management and physical infrastructure.

The Role of Evidence-based Services

Evidence based mental health service interventions provide a 3:1 advantage on investment in terms of improved outcomes and health gain (Whiteford H et al, 2013) and specific community based service delivery systems or modular evidence based teams also significantly improve outcomes (Rosen A, et al, 2013a).

The Australian based Tolkien II project (Andrews and Tolkien II Team, 2007) used data on the prevalence and disability associated with 15 mental and substance use disorders to estimate the burden reduced by a mental health service, using a stepped care model to provide optimal care to the people currently in contact with the system by reorganising the system and using the current budgets. Tolkien II estimated that a 30% increase in budget could treat 60% more people and produce a 90% increase in health gain (Disability Adjusted Life Years or DALY's averted). (Whiteford H, et al, 2013). Whereas, there is no evidence that non-specific counselling (in public, NGO or fee-for-service sectors) and low level case management without use of evidence based skills and interventions or generic, relatively sedentary community mental health teams improve outcomes at all (Lambert G, Gournay K, Training for the mental health workforce: a review of developments in the UK, ANZJP 1999, 33:694-700; Rosen et al 2013 ibid).

As Whiteford et al (2013 ibid) suggest as the trajectory for their NHMRC National Centre for Research Excellence on service system translational evidence: Changing the delivery of health services requires not only workforce changes but changes in the way the services are organised and funded (Brooks et al., 2011). To design a service system that delivers optimal interventions matched to population need and distribution requires a service taxonomy, a description of the work of each service component or platform and the burden it averts, and specification of how each platform in the system could be changed to avert more burden at the same or lower cost. Once the service system is developed, empirically derived planning targets can be obtained to quantify the required changes in service delivery and to monitor progress towards agreed goals.

7 Step Action Plan to implement essential components of care

The following is a 7 Step Action Plan to support the further development of recovery oriented and evidence based community mental health services in Australia through the implementation of the Essential Components of Care. These are the key actions for developing the "how" to deliver, sustain and monitor the implementation of the Essential Components of Care, ECC, including who does what and within what timeframes. Essential key components of both interventions and service delivery systems which have evidence of cost-effectiveness, of being recovery-oriented and human rights compatible are described in Appendix I & II below. The key actions in the suggested 7 step action plan include:

Step 1: Essential Components of Care (Table15)

As a starting point and to ensure ongoing consistency & focus, there is a need to finalise and publish the Essential Components of mental health service delivery. In addition, it will be important to identify and/or develop supportive service development tools and policy implementation guidance to assist effective and consistent statewide implementation.

Table 15: Essential Components of Care						
Strategic goal	**Sub-goals**	**Action**	**Who**	**Timeframe: Year 1 - 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Finalise status of the ECC	1. Develop supportive guidance for implementation on how to roll out.	a. Agree the final Essential Components for service delivery. b. Identify and/or develop supportive service development tools, fidelity rating materials & policy implementation guidance to assist effective and consistent statewide implementation.	MHC	Develop (a), (b), (c),	Implement	Review, Improve & Further sustain

		c. Develop self-assessment benchmarking tool-kits to assist local providers determine service gaps relating to the ECC.				

Step 2: Service Principles and Culture (Table 16)

In a world of potentially many providers, there is a need to develop an inclusive service culture, framed by a common language of understanding, integrating the ethos of human rights and recovery oriented values with person centred psychosocial disability support and evidence based clinical excellence. The foundation of an integrative framework of principles and culture, is most effectively supported through several key elements including explicit commitment to:

- a recovery approach which recognises the domains of both “personal” and “clinical” recovery, and the need for psychosocial disability support and clinical treatment to assist where needed, the individual effort towards recovery;
- the combined value of expertise derived through both the lived experience and the expertise derived through qualification;
- evidence based practice, (interventions that are proven to work and assist consumers in recovery), including emerging, innovative and promising approaches based on practice based evidence;
- person-centred care, acknowledging individual needs and preferences and supporting greater choice and control

Table 16: Service Principles And Culture						
Strategic goal	**Sub-goals**	**Action**	**Who**	**Timeframe: Year 1 - 2**	**Timeframe: Year 5**	**Timeframe: Year 10**

Promote widespread knowledge and understanding of the ECC to enhance development of a commonality in language, principles & culture that will be applicable across multiple provider organisations.	Develop integrative framework of principles based on the ECC which includes: 1. a recovery approach which recognises the domains of both “personal” and “clinical” recovery, and the need for psychosocial disability support and clinical treatment to assist where needed, the individual effort towards recovery;(AHMAC 2013, Davidson et al, 2006,2007). 2. the combined value of expertise derived through both the lived experience and the expertise derived through qualification; 3. evidence based practice, (interventions that are proven to work and assist consumers in recovery), including emerging, innovative and promising approaches based on practice based evidence (Mueser et al,2013); 4. person-centred care (Disability Care Australia, 2013), acknowledging individual needs and preferences and supporting greater choice and control.	Develop dissemination strategy including: a. Publish manuals & implementation guides b. Evidence Based and Practical Presentations c. Training Modules d. Supervision pyramids e. Mentoring networks f. Communities of Practice.	MHC & others as needed	(a), (b), (c)	(d), (e), (f),	Review, improve , sustain

Step 3: Local Implementation Plan (Table 17):

At the catchment area or LGA level, a plan of implementation is also needed, in order to translate the ECC into the specific context of the local community and to ensure the development of a coordinated and consistent system of treatment and care. A mechanism to take this forward is the development of Local Implementation Teams, LITs[1] [2], within each designated patch e.g., LHD or LGA. LITs would enable multi-stakeholder and provider engagement, strategic planning and adaptation of the ECC to local circumstances within the parameters of state guidance and the coherent development of integrated systems of treatment and care. The LIT would have delegated responsibility for implementing all ECC, using the recommended tools and guidance and developing one local, integrated delivery plan, which meets performance expectation & KPIs within agreed monitoring and performance frameworks. The LIT (possibly chaired by the largest local provider) would meet regularly as needed to develop the local plan, and monitor progress in its delivery. It should be responsible to the NSW Statewide implementation steering panel, which will monitor the progress of such LIT's continuously and comparatively.

Table 17: Local Implementation Plan						
Strategic goal	**Sub-goal**	**Action**	**Who**	**Timeframe: Year 1- 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Establish mechanism for local implementation of consistent & integrated approach within context of multiple providers	1. Establish necessary local structures & processes, at catchment area level, in order to translate the ECCs into the specific context of the local community and to ensure the development of a coordinated and consistent system of treatment and care (DoH,2000).	a. Develop Local Implementation Teams, LITs, within each designated catchment e.g. LHD or LGA. LITs would enable multi-stakeholder and provider engagement, strategic planning and adaptation of the ECC to local circumstances within the parameters of state guidance and the coherent development of integrated systems (DoH, 2001).	Local provider organisations including NGOs & LHDs	Develop, pilot & implement Year 2 onwards	Implement widely	Review

Step 4: Monitoring, Performance and Quality Improvement (Table 18):

- A performance and quality monitoring framework will ensure a consistent approach is taken to the implementation of the ECC. Apart from the usual monitoring of service outputs and consumer outcomes, this additionally involves monitoring actual inputs in terms of the development and implementation of the ECC. This should be based on specific KPI's relating to model fidelity and other relevant quality indicators, providing evidence of the implementation and the sustaining and adequate resourcing of the ECC.
- Establish a statewide Mental Health Implementation Steering Group MHISG.

Table 18: Monitoring, Performance and Quality Improvement						
Strategic goal	**Sub-goal (s)**	**Action**	**Who**	**Timeframe: Year 1 - 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Develop a state-wide performance and **fidelity monitoring framework** (separate to existing frameworks such as Australian Conmmision on HealthCare Standards ACHS-EQUIP), specific to performance within an ECC environment to ensure a consistent approach is taken to the implementation	1. Establish a practical & efficient process of **monitoring performance and model fidelity** (where relevant)	a. Establish relevant benchmarks for determining baseline and charting development & implementation of the ECC b. Develop relevant KPIs to determine performance, quality & efficiency c. Develop fidelity rating & monitoring tools for relevant / appropriate models of care, to determine concordance with evidence base; d. Conduct base line and tri-annual fidelity ratings e. Establish a statewide Mental Health Implementation Steering	MoH & MHC	Develop (a), (b), (c), (d), (e),	Implement & consolidate	Sustain Review & Modify if needed

		Group, MHISG, representing all appropriate stakeholders at a senior level, including consumer and carer representation and meeting every 8 weeks for first 18 months in implementation phase, then 4 times annually in longer term. This should relate to the Mental Health Service Development Support Unit (see 5. below).				

Step 5: Service Development and Support (Table 19):

Local providers and stakeholders will benefit from access to expertise in service development and redesign in order to effectively implement integrated systems of care and demonstrate fidelity and concordance with evidence based and recovery oriented practice and the principles of the ECC. The availability of expertise through a Mental Health Service Development Support Unit, such as was available in the UK through two organisations at arm's length from the funding, implementation and regulatory bodies: the Sainsbury Centre for Mental Health (a non-government organization) & the National Institute for Mental Health–England, NIMHE, would be of great benefit in developing models of care. They could accelerate implementation and improving the quality and consistency of the ECC roll out, across the complexity of local systems regardless of provider organisation. The MHC should be holding these "knowledge management" functions to balance and differentiate them from the MoH-LHD practical implementation roles, and to provide support apart from the regulatory functions of the MoH.

The facilitation of the change management process needed to implement the ECC would be assisted through the existence of a combination of a set of "must do's", along with availability of the needed expertise, guidance and support to take the process forward.

Engagement will be optimized if it is voluntary, supportive, facilitatory and well organized with attractive and inexpensive orientation and training materials and courses. Managers and senior clinicians of both public & NGO services will seek out and welcome this input.

Access to centrally developed and affordable Practical Training Modules, suites of support packages around up-skilling staff and implementation of best practice, including manualised content and/or in-person coursework for whole of team and/or whole of service training, would benefit the quality implementation of the ECC.

Recognising and showcasing early adoption of the ECC, through awarding of "Beacon" or "Pathfinder" Status to local services and organizations would also act as an accelerant to implementation. Reinforcing progress through the awarding of extra funding and kudos to support site visits from other teams with role modelling demonstrations, would also encourage greater consistency of implementation. Once a critical mass of ECC early adopters is reached, a cascade effect will support a more comprehensive implementation statewide.

Organisational stepwise development of the recovery approach is manualised in Shepherd et al 2008, 2010.

Table 19: Service Development And Support						
Strategic goal	**Sub-goal**	**Action**	**Who**	**Timeframe: Year 1 - 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Develop access to expert support & guidance on redeveloping services and local systems of care & treatment to enable consistent implementation of the ECC	1. Prepare concept and options paper for discussion and agreement regarding how to provide affordable access to expertise in service development and redesign & development, including the change management processes needed for implementation of ECC	a. Subject to agreement with options Paper, establish a compact Mental Health Service Development Support Unit, [MH-SDU] eg. within the MHC of NSW, working in close consultation with the MoH, in order to support training and quality monitoring services to	MoH in consultation with MHC	(a), (b), (c), (d), (e),	Consolidate (e),	Sustain Review & Modify if needed

		implement and sustain integrated systems of care and demonstrate fidelity and concordance with evidence based and recovery oriented practice and the principles of the ECC. It would also draw on the expertise of and support the Mental Health Implementation Steering Group (MHISG) or an Implementation Delivery Unit to provide development & implementation expertise and support. b. Assist with /advise on local self assessment, benchmarking & gap analysis. c. Provide expertise on model of care & implementation; d. Develop & provide selected key training modules strategically vital to ECC implementation; e. Recognising and showcasing early adoption of the ECC, through awarding of “Beacon” or “Pathfinder” Status.				

Step 6: Workforce Development (Table 20):

A Workforce Development Strategy is essential to ensuring the quality delivery of the ECC. Elements of an effective Workforce strategy would need to address and include the following:

- **Leadership development**: This is important at multiple levels from Team Leader, Clinical Leadership (Psychiatrists), Operational (sector managers) and Strategic levels (service or organisational directors).

- **Skills and training**: It is essential to support the development of recovery oriented, evidence based and person-centred practice with training for the multi-disciplinary workforce.

- **New Roles**: The core workforce is changing and expanding. Valuing & integrating new roles into services, such as consumer and family peer workers, Aboriginal mental health professionals, bi-cultural mental health counsellors, trauma specialists, community pharmacists, dieticians and sports physiologists will require support and guidance.

- **Team development**: Teams are the "bricks and mortar" of contemporary community mental health systems. Generic community multidisciplinary teams will be challenged to deliver the ECC, and to operate within extended community systems of multiple providers, facilitating hybrid teamwork between public & NGO, state and federally funded service providers including the NDIA, PIR, PHAMS and HASI. Access to team development and support (e.g. "Developing Capable Teams" methodology, NIMHE:DoH, 2007)

- **New ways of working**: Role flexibility will be key to working within a system of care focused on the needs of consumers and families. This will involve reengineering more flexible work roles, to be more community based, mobile, accessible and integrated into a more team working approach. A Recovery-Oriented approach can be adopted by an entire service, if this service development has strong & unambiguous support from management (eg Shepherd G et al 2008, 2010).

- **Recruitment and retention**: Attracting and maintaining a capable workforce is crucial to the effective delivery and operation of the ECC. Workforce retention is facilitated by positive staff morale and being part of a learning organisational culture, supported through provision of opportunities for lifelong learning, knowledge updates, skills escalators and internal career advancement possibilities to keep the values and culture alive and thriving.

- **Supervision:** Supervision is an essential ingredient to support the transfer of up-skilling acquired through training and to maintain a high level of workforce capability. - Methodology includes supervision pyramids, mentorship and communities of

practice. Supervision also supports staff to maintain their resilience and manage effectively the impact of life events, organizational turbulence, vicarious and secondary trauma encountered in treatment and care provision.

- For Supervision Pyramids, Pastoral Mentorship, Communities of Practice & Knowledge Exchange Centres, see **Elements that improve service quality p13**

Table 20: Workforce Development						
Strategic goal	**Sub-goal**	**Action**	**Who**	**Timeframe: Year 1 – 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Prepare Workforce Development Strategy	Ensure strategy includes plans for: 1. building capacity and 2. capability with the new systems of care 3. across providers within a recovery paradigm	Develop workforce action plan which addresses: a. Leadership development b. Skills & Values training curricula + modules c. New roles d. New ways of working e. Recruitment & retention f. Supervision pyramids g. Mentorship network h. Communities of Practice i. Knowledge Exchange Centre j. Team development	MoH with in consultation with MHC's +VCCMHWB +ANWIMH initiatives + DoH, Deputy Chief Medical Officer (Mental Health) Cwealth Dept Health	Develop (a), (b), (c), (d), (e), (f), (g), (h). (i), (j)	Implement , network widely & consolidate	Sustain Review & modify if needed

Step 7: E-Health, Telehealth and Technological Support

Modern services require contemporary technology to provide easier and more congenial access to mental health services by particular sub-populations of potential service users and families (eg. younger, more computer literate, homebound, clinic-averse,

socially anxious and isolated, rural-remote, including indigenous) and to support efficient and effective working, to enable staff in "working smarter". This includes:

a. iPads for portability of recordkeeping on home visits and to prevent duplication and to aid legibility of clinical recording & communication; shift to secure and confidential electronic clinical records with enhanced service user access to and holding of their own records.

b. e-health strategies to complement clinical services plus e-support "apps" and warm-lines, blogs and websites, social media;

c. tele-health supplementing of in-person services for rural, remote & ATSI communities;

d. developing innovative & effective proxies for evidence based ECC's via tele-health and e-mental health strategies complementing rather than replacing face-to-face mental health services.

Table 21: Technological Support						
Strategic goal	**Sub-goal**	**Action**	**Who**	**Timeframe: Year 1 – 2**	**Timeframe: Year 5**	**Timeframe: Year 10**
Promote better use of currently available technology to increase both staff efficiency and enable greater consumer and family access to evidence based e-mental health technology	Review current situation and develop feasibility proposal for way forward Training and familiarisation	Develop and resource a statewide plan for consistent and equitable provision of technological aids to effective mental health care. Training Program for all Mental Healthcare leaders, professionals and staffing in emerging e-strategies to aid decision	MoH & LHDs & PHN's & NGOs in consultation with MHC ANWIMH + VCCMHWB initiatives	Consult widely and complete statewide plan	Roll out and monitor use	Review & modify if needed

		making and everyday practice				
Statewide & National consistent Strategies for continual improvement and re-equipping services with the most practical technologies	Technology for a) record keeping and confidential clinical communication b) assessments & reviews & theraputic purposes service quality monitoring & evaluation	Provide current technology to facilitate digital augmentation & optimal operation of & balance between on-line & telehealth & face-to-face & home outreach mental health services.	MoH & LHD's & PHN's			

e-Health Mental Health Interventions.

Automated digital services can provide a much larger scale of reach at the population level, and can be most effective as primary screening & secondary prevention strategies, and can be very effective as interventions alone, particularly for milder to moderate disorders. This may lower demand for in-person services for milder disorders by GP's, community mental health teams, and private psychiatric and psychology services. But it could also uncover latent population demand for in-person services for moderate to severe disorders, which cannot be met with existing workforces.

When individuals accessing e-health mental health hubs need escalation for higher severity and acuity, and/or perceived danger of harm, automated escalation is not sufficient nor always reliable or safe. Explicit protocols need to be systematically applied to ensure formal confirmation of acceptance of hand-over of duty of care, at an appropriate level of urgency. This needs to be assured and communicated both ways, verbally and with documentation, between identifiable service provider persons. Monitoring and management of this and of peak flows of demand for escalation are issues for integration mechanisms between services, including formal service agreements. Public mental health services, and particularly Community mental health staffing levels and mobility,

should be reviewed to ensure that sustained increases in demands via these portals can be met.

Telepsychiatry and other Telehealth mental health services

Psychiatrists and other clinicians offering telehealth consultations and advice are best provided in combination and balance with intermittent in-person (face-to-face) psychiatric consultations and reviews in balance with home outreach as required, optimally by the same psychiatrist or by the same rostered and collegiate group of psychiatrists, providing local team and GP consultation, and clinically hand over to each other. Such a combination should provide better engagement, greater accuracy of assessment and review, better appraisal of physical health needs, better communication and clinical supervision with local GPs and community mental health teams, and better peer review. While telepsychiatry and telehealth counselling are now becoming highly valued components of mental health services for rural and remote communities, it should be part of a mixed and balanced economy or well integrated spectrum of mental health services. It should not be offered as a stand-alone service, particularly in rural settings, without firm Commonwealth, Medicare and RANZCP requirements to act in close and regular clinical communication with GPs, community mental health teams, and families, especially if agreed by the initial service-user. It is often community mental health teams who have to deal with ensuing crises and acute admissions, sometimes by complete surprise, as telehealth practitioners are not required to do nor are they separately reimbursed for such regular communications.

APPENDIX 1

Evidence-based Components in the Continuum of Care, with a community mental health service emphasis

Derived in part from Rosen A., Mental Health Services: Evidence-based Components in the Continuum of Care, in Mendoza J et al, eds, Obsessive Hope Disorder, 2013, and Rosen A. 2008, Evidence Based and Promising Components of Mental Health Services: Interventions and Delivery Systems, AHHA/THeMHS/PWC National Roundtable (AHHA: Australian Hospitals & Healthcare Association, 2008)

Please note: while it is important to identify & provide accurate costings for evidence based interventions which should be provided by all comprehensive mental health services, (column 1), it is equally important to identify & cost the essential infrastructure & evidence based vehicles or sub-systems which allow them to be appropriately accessed & delivered to the appropriate people in a timely manner at the most effective site (column 2).

Evidence-based (or promising) Interventions i.e. contexts of care	Delivery systems for the Interventions supported by evidence
1. Primary Care GP liaison & shared care	1. Primary care mental health liaison team or coordinator & supported transfer of care coordination systems (e.g. CLIPP)
2. Promotion, Prevention and Early Intervention Public health proactive approach to prevention, early detection & intervention seeking	2 a) Mental Health First Aid Course 2 b) Telephone help lines, web-based mental health information & brief intervention services 2 c) "headspace" centres for youth & young adult self & family referral, professional referral, assessment & engagement. 2.c) Prodromal assessment, monitoring and support service 2.d) Early intervention team in youth centre context (the Early Psychosis Prevention and Intervention Centre – EPPIC Model) Short term results are positive. Long term results increasingly promising.
3. Acute and Crisis Care 3.a) Crisis and family intervention 3.b) Home visit assessments interventions and reviews 3.c) Acute respite care	3.a) & b) 24 hours or extended hours 7 days & nights mobile community-based crisis intervention services. Strong evidence of effectiveness. 3.c) 24 hour supervised community-based residential respite facility, as alternative to hospital admission, plus step up and

Evidence-based (or promising) Interventions i.e. contexts of care	Delivery systems for the Interventions supported by evidence
3.d) Emergency psychiatric services in general hospital emergency departments, including effective triage & brief, targeted, behavioural interventions as required 3. e) Open Dialogue (Finland). Combines prompt and regular home visits in crisis, early intervention, involving extended family, confidantes and practically useful agencies, minimising use of medication, amplifying and respecting dialogue of individual and family at face value. Only 1 RCT by authors, no international replication as yet.	down care. Growing evidence of acceptability and effectiveness, and avoiding involuntary admissions. 3.d) Examples include: 24 hour roster of psychiatric triage nurse consultants in busy emergency departments – emerging evidence of effectiveness. However, this component should not replace crisis services, though staff can be usefully rotated through ED from crisis team; 2) brief intervention clinic or role of crisis team in delivering repertoire of behavioural interventions following ED presentation—emerging evidence. **NOTE** – PECCs or psychiatric emergency centres approximated to or in emergency departments – very costly, yet no high quality evidence to support any advantage over less restrictive alternatives, such as 3.c above. May well be justified only where there is a high prevalence of highly complex presentations, including co-morbidities with drugs & alcohol, HIV positive status, organ failure, homelessness and forensic issues. 3.e) Original version requires high level staffing, high level of mobility, and 4 year psycho-therapeutic training, though cut down model including specifically trained peer specialists now being trialled in USA, though without randomised research. Requires further pilot studies with rigorous replications.
4. Assertive Community Treatment 4.a) Active-response intake & mobile care coordination (case management) sub system 4.b) Assertive/Intensive community care management for individuals with persistently severe disabilities	4.a) Local community-based mental health centre near shopping & transport hubs 4.b) Assertive community treatment (ACT) team, meeting international fidelity criteria. 40+ years of rigorous replications with positive results. UK has been disinvesting however on the basis of flawed low fidelity studies.
5. Biological Interventions. 5.a) Medications & other technologies 5.b) Attending properly to physical care of individuals with mental illness	5.a) Monitoring & adverse effects/interactions/polypharmacy minimizing risk management system, community pharmacist consultation & liaison service 5.b) Protocols, monitoring and intervention systems to minimize physical illness & risk factors in individuals with mental illness. Examples include: CVS & diabetes regular risk factor monitoring system; aerobic exercise & weight monitoring programs, individual & group

Evidence-based (or promising) Interventions i.e. contexts of care	Delivery systems for the Interventions supported by evidence
6. Psychological & Neuropsychological Interventions – CBT (Cognitive Behaviour Therapy) – DBT & CAT (Dialectical Behaviour & Cognitive Analytic Therapies for Borderline and Self Harm behaviour patterns) – IPT (Inter-Personal Therapy – IPSRT (Inter-Personal Social Rhythm Therapy for Bipolar conditions) – NCRT (Neurocognitive Remediation Therapy) – MBCT (Mindfulness Based Cognitive Therapy) – MACT (Medication Adherence Cognitive Therapy) Plus less formally evidence based or promising (as yet) therapies, such as: – Supportive psychotherapy – Trauma Informed Care (see below) – Primary health care counselling – Acceptance & Commitment Therapy – Eye Movement Desensitisation & Reprocessing (EMDR) Therapy	Policy Implementation Guidelines, Service delivery & supervision network, plus monitoring for fidelity. E-therapy delivery: e.g. c-CBT (computerized CBT). Beyond Blue new graduate life coaches & mentors, brief training in CBT ,for mild disorders (High acceptability, promising service evaluation only, but research under way) Graduate Primary Care mental health workers (IAPT, UK)
7. Social Interventions 7.a) Types of intervention: – social – leisure – education – work – financial 7.b) Residential Living in your own home wherever possible A range of different levels of supervision in residential settings 7.c) Residential: Inpatient Interventions Rigorous evidence - sparse for optimal characteristics & effectiveness. Supportive Interventions	7.a) Type of facilities or personnel. Examples include: clubhouse or equivalent; leisure/recreation/aerobic physical activity program; expert vocational rehabilitation counsellors operating individual placement and support (IPS) programme; financial counselling service 7.b) Residential A range of supervised residential facility options. Examples include: support in your own home; 24 hour supervised community residential care plus medium to long term residential cluster home scheme; Medium to long term community residentials with partial supervision; 24 hour supervised care residential units on general hospital sites 7.c) Residential: Inpatient Team and facilities Rigorous evidence - sparse for optimal characteristics & effectiveness. Setting:

Evidence-based (or promising) Interventions i.e. contexts of care	Delivery systems for the Interventions supported by evidence
– Psycho-education and adaptive communication and problem solving skills on an individual, group and family – Supportive psychotherapies on an individual group and family basis – As there is little evidence to support inpatient admissions generally, seek less restrictive alternatives ASAP, whether for acute short term or supervised extended stay residential care Clinical technologies & associated interventions: Medication, ECT, TMR etc require up to date: – Equipment, regular staff training and refreshers, daily pharmacist input – Minimise / eliminate restraint & seclusion – Minimise involuntary care – Minimise locking of doors – Minimise holding down – Adherence to & encourage exercise of human rights	– On general hospital site (in UK and USA sometimes in suburban setting away from general hospital) – Small scale, semi-domestic atmosphere. – Attractive, welcoming spaces, softly furnished, calming colours. – Modularized unit, allowing separate – safe spaces for vulnerable or dangerous inpatients – Separate acute observational locked sub-unit & unlocked sub-acute sub-unit – Maximise staff: inpatient ratio and interaction – Minimise lockable doors, restraints, seclusion & restriction of leave. – Maximise indoor & outdoor spaces – Separate bedrooms with good sightlines for staff with acute observation inpatients – Minimise hanging points & other dangerous environmental features – Unobtrusive but effective duress alarm system for service providers, inpatients & visitors
8. Cultural Interventions 8.a) Micro-cultural: – family education support and communication and problem solving skills intervention, including surrogates, confidantes and support persons. 8.b) Macro-cultural: – community awareness – community education – challenging stigma and discrimination	8.a) Micro-cultural: – Individual family intervention at home – Multiple family group intervention conducted by team which can systematically provide staff to work with families out of office hours 8.b) Macro-cultural: - Community awareness local meetings/local action committees - Mental Health First Aid courses - Community awareness public/media campaigns - Challenging stigma local public media campaigns - Challenging stigma workplace programs

Evidence-based (or promising) Interventions i.e. contexts of care	Delivery systems for the Interventions supported by evidence
9. Comorbidities Dual interventions for: a) Substance abuse & mental illness b) Intellectual disability & mental illness c) Specific learning disability & mental illness d) Brain injury & mental illness e) Severe physical disability & mental illness f) Eating/dieting disorders, physical & psychiatric components g) Forensic problems and mental illness h) Consultation-liaison psychiatric services to medical & surgical wards	For 9 a) to g). Service delivery system with professional expertise and facilities which will address both problems simultaneously, ideally by one team, not making the treatment of one problem conditional and secondary to treatment of the other. h) Consultation-Liaison psychiatric team for each general hospital facility and for shared care with Primary Health Care – evidence that these significantly decrease lengths of hospital stay and increase community tenure
10. Integrated & Comprehensive Service Systems 10.a) Integrative holistic comprehensive interventions i – continuity over time ii – integrated coordinated efforts at any one time	10.a) Integrated at several levels: i. care coordinator (developing from international evidence base on case management) working closely together with service-users & family, to develop & review care plan. Some models have greater evidence of effectiveness (ACT, clinical and strengths based recovery oriented case management models) while office based brokerage models are least effective. ii. inter-disciplinary mental health team with coordinated delegation of tasks around service-user needs, encapsulated in an individual care plan, which is regularly reviewed. Teamwork is cost-effective in studies. Team includes peer support workers, and where possible dietician, exercise physiologist, community pharmacist, housing and vocational worker & leisure worker. iii. collaborative planning between: primary care, acute mental healthcare and longer term rehabilitation recovery work and specialist health services iv. coordinated planning and service delivery between public private & NGO mental health services v. coordinated planning & service delivery between mental health & all other relevant agencies e.g. housing, work, education, welfare, financial/ benefits, recreation & leisure – i.e. integrating efforts of State & Federal funded agencies vi. Person-centred and personalised care
10.b) Recovery oriented interventions towards: i – growth throughout life ii – empowering service users	10.b) Recovery-Oriented staff & facilities: i. Consumer peer support specialists certified training & placement in clinical teams ii. Recovery oriented experiential workshop training for service

Evidence-based (or promising) Interventions i.e. contexts of care	Delivery systems for the Interventions supported by evidence
iii – setting your own goals and priorities iv – control over your own life v - social inclusion and citizenship vi - resilience	users, providers & families iii. Working with communal organizations & workplaces towards social inclusion & full citizenship iv. Skills training for service users, providers & families – e.g. coping, resilience, buoyancy, work/life balance, etc. v. Consumer & Carer participation in training, supervision and service management vi. Consumer choices take precedence, where possible, in drawing up own individual plan
10.c) Age-appropriate interventions	10.c) Age-appropriate, phase of life specific delivery systems provided specifically for each age-group wherever possible. Eg. Mental Health One-Stop-Shop for each phase of life.
10.d) Trauma Informed Care (Promising as yet, though Guidelines and Standards developed). Trauma Specific Care emerging based on Neuroplasticity evidence leading to Neuro-Feedback assisted Psychotherapies for developmental and secondary complex PTSD.	10.d) Training programs available in some centres. Often taught in conjunction with recovery oriented care. Promising empirical evidence emerging, Systematized services available so far via Transcultural torture & trauma & Veterans mental health programs.

References

Andrews G et al, (2006) Tolkien II: A needs-based, costed stepped care model for mental health services. Sydney: WHO Collaborating Centre for Classification in Mental Health

AHHA: Australian Hospitals & Healthcare Association, The Mental Health Services (TheMHS) Conference of Australia & New Zealand, Inc. PriceWaterhouseCoopers (PwC) , 2008. Mental Health Funding Methodologies and Governance, National Roundtable discussion paper. Sydney: Available at http://www.aushealthcare.com.au/publications/publication_details.

AHMAC (2013.). Australian National Framework for Recovery Oriented Mental Health-Policy and Theory National Mental Health Strategy.

Barber M, (2013) The Origins and Practice of Delivery. Stanford Social Innovations Review

http://www. ssireview,org.blog/entry/the-origins-and-practice-of-delivery

Bell J.S, Rosen A, Aslani P, Whitehead P, Chen TG. Developing the role of pharmacists as members of community mental health teams: Perspectives of pharmacists and mental health professionals. Research in social and administrative pharmacy: RASP 2007: Vol 3, 4 pps. 392-409

Beidas, R., & , Kendall, P. (2010). Training Therapists in Evidence based practice: A critical Review of studies from a systems-contextual perspective. Clinical Psychology : Science & Practice, Vol: 17: 1-30.

Brideson T, Rosen A, Crawford V, Stanley D, Mentorship Programme for Aboriginal Mental Health Professionals & Trainees, 5 year evaluation, Themhs Conference symposium, Melbourne, August 2013.

Brooker, C. (2001). A decade of evidence-based training for work with people with serious mental health problems: Progress in the development of psychosocial interventions. Journal of Mental Health, Vol. 10, No. 1 : Pages 17-31.

Boardman J,Parsonage M, (2005) Defining a good mental health service: A Discussion Paper, © The Sainsbury Centre for Mental Health, 2005

Burgess, P, Pirkis J, Coombs T, Rosen A, Assessing the value of existing recovery measures for routine use in Australian mental health services, Australian and New Zealand Journal of Psychiatry 2011, 45:267-280.

Buss R , Rosen A , Unicomb A, Hiskins D (forthcoming, 2012) Rural & Remote Mental Health Emergency & Critical Care (RRMHECC) Care Evaluation Framework, Centre for Rural & Remote Mental Health, MHDAO:NSW Ministry of Health.

Campanini, R. F. B., Schoedl, A. F., Pupo, M. C., Costa, A. C. H., Krupnick, J. L. & Mello, M. F. (2010). **Efficacy of interpersonal therapy-group format adapted to post-traumatic stress disorder: An open-label add-on trial**. *Depression & Anxiety,* 27(*1*): 72-7.

Cooke, A., Friedli, L., Coggins, T., Edmonds, N., Michaelson, J., O'Hara, K., Snowden, L., Stansfield, J., Steuer, N., Scott-Samuel, A. (2011) 3rd ed., London: National MWIA Collaborative

Coombes P et al (2008) . Literature Review: Evidence Based Design: Acute Inpatient Mental Health Units, Queensland Health, Queensland Government.

Davidson L & Roe D, (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. Journal of Mental Health, August 2007 (Pg. 463); 16(4): 459 – 470

Davidson L, O'Connell M, Tondora J, Styron T, Kangas K. (2006). The Top Ten Concerns About Recovery Encountered in Mental Health System Transformation. Psychiatric Services. PS.Psychiatryonline.Org May 2006 Vol. 57 No. 5. pg. 643.

Delahunty, A. & Morice, R. (1993) A Training Programme for the Remediation of Cognitive Deficits in Schizophrenia. Department of Health of Australia.

Department of Health (1999) *National Service Framework for Mental Health. Modern Standards and Service Models.* London: Department of Health.

Department of Health (2000) Implementing the MH National Service Framework-NHS plan implementation programme. London: DoH.

Department of Health (2001) The Mental Health Policy Implementation Guide. London DoH.

Dept. Health UK. (2000). Policy Implementation Guidance(s). (CMHTs, Crisis Resolution & Home Treatment Teams, Assertive Outreach Teams, Early Intervention Teams).

Dept. Health. (2002). Policy Implementation Guidance: Community Mental Health Teams. Dept. Health U.K

Dept. Health UK. (2002). Policy Implementation Guidance-Dual Diagnosis - Mental Illness & substance misuse.

Department of Health, (2002) The Mental Health Policy Implementation Guides, National Health Service: Department of Health, London UK, including Crisis resolution & Home Treatment teams, Acute Adult Inpatient Care Provision, Community Mental Health Teams, Personality & Dual Disorders, Dual Disorders. Dept. Health UK. (2002).

Department of Health (2007) NIMHE: Creating Capable Teams Approach. Best Practice Guidance to support New Ways of Working and New Roles. DH. London

Disability Care Australia, (2013) Good Practice Guidelines for Person-Centred Planning and Goal Setting for People with Psychosocial Disability. A Project Report for Disability Care Australia. May, 2013

Foxlewin B, 2012, What is happening at the Seclusion Review that makes a difference? – a consumer led research study. Australian Capital Territory Mental Health Services Seclusion & Restraint Reduction Project.

Frank R, Fawcett L, Emmerson B, (2005) Development of Australia's First Psychiatric Emergency Centre, *Australas Psychiatry September 2005 13: 266-272,*

Frank, E., Swartz, H. A. & Boland, E. (2007). **Interpersonal and social rhythm therapy: An intervention addressing rhythm dysregulation in bipolar disorder**. *Dialogues in Clinical Neuroscience,* 9(*3*): 325-32.

Fulford KWM, Peile E, Carroll H, (2012) Essential Values-Based Practice: Clinical Stories Linking Science with People Cambridge UP: Cambridge.

Germain, A. & Kupfer, D. J. (2008). Circadian rhythm disturbances in depression. *Human Psychopharmacology,* 23(*7*): 571-85.

Gisev N, Bell JS, O'Reilly CL, Rosen A, Chen TF, (2009) An expert panel assessment of comprehensive medication reviews for clients of community mental health teams, Social Psychiatry and Psychiatric Epidemiology, October 2009, 45:11: 1071-1079.

Harvey C, Killaspy H, Martino S, White S, Priebe S, Wright C, Johnson S (2011) A comparison of the implementation of assertive community treatment in Melbourne, Australia and London, England. *Epidemiology and Psychiatric Sciences;20(2):151–61.</jrn>*

Haynes RB, Ackloo E, Sahota N, McDonald HP, Yao X (2008)
Interventions for enhancing medication adherence (Review) The Cochrane Collaboration, Wiley & Sons

Henderson S, Andrews G, & Hall W. (2000). Australia's mental health: an overview of the general population survey. Australian and New Zealand Journal of Psychiatry,2000.

Hoult J, Rosen A, Reynolds I. Community orientated treatment compared to psychiatric hospital orientated treatment. *Soc Sci Med* 1984; 18: 1005–10. doi:10.1016/0277-9536(84)90272-7</jrn>

Institute of Medicine. (2006) Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, DC: National Academies Press.

Johnson S, Gilburt H, Lloyd-Evans B, Osborn DPJ, Boardman J, Reese M. *et al.* In-patient and residential alternatives to standard acute psychiatric wards in England. *Br J Psychiatry* 2009; 194: 456–63.

Joy C B, Adams C E, Rice K, (2007) Crisis intervention for people with severe mental illnesses (Evidence Systemic Review) Joy CB, Adams CE, Rice K. Issue 4, The Cochrane Collaboration.

Kemp, R., Hayward, P., Applewhaite, G., Everitt, B., David, A. (1996). Compliance Therapy in psychotic patients: Randomised Controlled Trial. BMJ, 312: 345.

Kienast, T. & Foerster, J. (2008). **Psychotherapy of personality disorders and concomitant substance dependence**. *Current Opinion in Psychiatry,* 21(*6*): 619-24.

Killaspy H , Rosen A, Case management and assertive community treatment in Thorniocroft g et al, (2011) , Textbook of Community Psychiatry, Oxford: Oxford University Press.

Keet R, de Vetten-Mc Mahon M, Shields-Zeeman L, et al. Recovery for all in && the community: position paper on principles and key elements of community-based mental healthcare. BMC Psychiatry 2019; 19:174.

Klein, D. A. & Miller, A. L. (2011). **Dialectical behavior therapy for suicidal adolescents with borderline personality disorder**. *Child & Adolescent Psychiatric Clinics of North America,* 20(*2*): 205-16.

Lambert G, Gournay K, Training for the mental health workforce: a review of developments in the UK, ANZJP 1999, 33:694-700;

Madon T, Hofman KJ, Kupfer L, Glass RI. Public health. Implementation science. *Science*. 2007 Dec 14;318(5857):1728-9.

Maj M, (2010) Mistakes to avoid in the implementation of community mental health care World Psychiatry 9:2 :65-66.

Marshall, M., Lewis, S., Lockwood, A., Drake, R., et al (2005). Association between duration of untreated psychosis and outcome in cohorts of 1st episode patients. A systematic review. Archives of General Psychiatry; 62(9): 975-83.

Miller V, Rosen A**,** Gianfransesco P, Hanlon P, Australian *National Standards for Mental Health Services*: a blueprint for improvement, International Journal of Leadership in the Public Service, October 2009, 5, 3, 25-42.

Miller V, Rosen A, Parker GB, AIMHS Guide: A guide to standards of care and quality assurance for Area integrated Mental Health Services, (AiMHS), AiMHS Standards & Quality Assurance Project , St Leonards, Sydney.

Milne D L, Pilkington, J, Gracie, J, James E, (2003) Transferring skills from supervision to therapy: a qualitative and quantitative n=1 analysis Behavioural and Cognitive Psychotherapy, 2003, 31, 193–202

McGorry PD, Jackson HJ, eds. The recognition and management of early intervention: A preventive approach. Cambridge: Cambridge University Press. 1999

Meadows, **G N;** Harvey, C., A; Joubert, L., Barton, D. & **Bedi, G.** (2007) The Consultation-Liaison in Primary-Care Psychiatry (CLIPP) Program: A structured approach to long-term collaboration in mental health care. *Psychiatric Services, 58,* 1036-1038.

Mental Health Commission of Canada (2007, 2012) Initiatives & Projects: Knowledge Exchange Centre. **http://www.mentalhealthcommission.ca/English/Pages/KnowledgeExchangeCentre.aspxNat**

Medibank Health Solutions/Nous Group Consultancy (2013) The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design.
http://www.medibank.com.au/Client/Documents/Pdfs/The_Case_for_Mental_Health_Reform_in_Australia.pdf

MH-Inform (2008) Psychiatric Emergency Care Centres (PECCs): The first twelve months, NSW Mental Health (Sara et al) MHDAO: NSW Health.

Mihalopoulos C, Harris M, Henry L, Harrigan S, McGorry P. Is early intervention for psychosis cost- effective over the long term?]Schizophr *Bull* 2009

Meuser KT, Deavers F, et al (2013) Psychosocial Treatments for Schizophrenia. Annual Reviews of Clinical Psychology, 9, 465-497

Monroe-DeVita M, Teague G B, Moser L L, (2011) The TMACT: A New Tool for Measuring Fidelity to Assertive Community Treatment Journal of the American Psychiatric Nurses Association 17: 17

Murphy S, Irving C B, Adams C E, Driver R (2012) Crisis intervention for people with severe mental illnesses, The Cochrane Collaboration, J Wiley & Sons

National Institute for Clinical Excellence, NICE (2009, 2013). Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care. London

National Institutes of Health (2013), Implementation Science, Fogarty International Center for Advancing Science for Global Health, May. http://www.fic.nih.gov/News/Events/implementation-science/Pages/faqs.aspx

National Mental Health Commission, 2012, 2013, A Contributing Life: the National Report Card on Mental Health & Suicide Prevention 2012, 2013. Sydney: NMHC: Australian Government

National Mental Health Commission, 30 November 2014, "Contributing lives, thriving communities": Report of the National Review of Mental Health Programmes and Services, Volumes 1-4, Australian Government

National Mental Health Development Unit, (2009) Getting the medicines right, Medicine management in mental Health crisis resolution and home treatment teams, College of Mental Health Pharmacy, London.

National Mental Health Strategy (2010a), National Standards for Mental Health Services, Safety & Quality Partnership Subcommittee, Mental health Standing Committee, Australian Health Ministers' Advisory Council, Commonwealth of Australia

National Mental Health Strategy (2010), National Standards for Mental Health Services, & Implementation Guidelines, Safety & Quality Partnership Subcommittee, Mental Health Standing Committee, Australian Health Ministers' Advisory Council

National Mental Health Strategy (2002) National Practice Standards for the Mental Health Workforce, National Mental Health Education and Training Advisory Group National Education and Training Initiative

Naylor C, Bell A (2010) Mental Health And The Productivity Challenge: Improving quality and value for money. SCMH, Kings Fund. London

O'Hagan M, (2001) Recovery Competencies for New Zealand Mental Health Workers, Mental Health Commission New Zealand.

Ontario Provincial Dept Health. (2000). Intensive Case Management Service Standards for Mental Health Services and Supports.

Paris, J. (2010). Effectiveness of different psychotherapy approaches in the treatment of borderline personality disorder. *Current Psychiatry Reports,* 12(*1*): 56-60.

Pincus, H A (2009) From PORT to Policy to Patient Outcomes: Crossing the Quality Chasm Schizophrenia Bulletin vol. 36 no. 1 pp. 109–111, 2010

Rosen A, Miller V, and Parker G, (1989) Standards of Care for Area Mental Health Services, Australian and New Zealand Journal of Psychiatry, 23: 379 - 395.

Rosen A, Miller V, and Parker G B, (1991) Area-Integrated Mental Health Services (AIMHS) Manual of Standards, AIMHS Project, Royal North Shore Hospital and Community Mental Health Services, Sydney.

Rosen, a., Teeson, M. (2001). Does case management work? The evidence and the abuse of evidence based medicine. Australian & New Zealand Journal of Psychiatry; 35(6): 731-46.

Rosen, A, (2002) Integration is as essential as balance: invited leading commentary on Thornicroft, G. and Tansella, M., Balancing Community-based and Hospital-based Mental Health Care, World Psychiatry; 1:2: 91-93.

Rosen A, Callaly T. Interdisciplinary teamwork and leadership: issues for psychiatrists. Australasian Psychiatry 2005. Vol 13, 3 pps. 234-40

Rosen A. (2006a) Destigmatizing day-to-day practices: what developed countries can learn from developing countries. World Psychiatry 5:1 21-24.

Rosen A. (2006b),The community psychiatrist of the future. Current Opinion in Psychiatry: Vol 19, No 4: 380-8.

Rosen A**,** Clenaghan P, Emerton F, Richards S. Integration of the Crisis Resolution function within community mental health teams in Johnson S, Needle J, Bindeman JP, Thornicroft G (eds). Crisis Resolution and Home Treatment in Mental Health. Cambridge: Cambridge University Press, 2008.

Rosen A**,** Gurr R, Fanning P. (2010a) The Future of Community-centred Health Services in Australia: Lessons from the mental health sector. Australian Health Review, 34, 106–115

Rosen A, Goldbloom D, McGeorge P (2010b). Mental health commissions: Making the critical difference to the development and reform of mental health services, clinical therapeutics. Naber D,Pincus, H (Eds.). Current Opinion in Psychiatry, 6, 593-603.

Rosen A, McGorry P, Hill H, Rosenberg S, (2012a) The Independent Hospital Pricing Authority and Mental Health Services : it is *not* a case of "one size fits all" Medical Journal of Australia 18th June, 196 11) 675-677,

Rosen A Gurr R, Fanning P, Owen A, (2012b) The future of community-centred health services in Australia: 'When too many beds are not enough", Australian Health Review, 36, 239–243.

Rosen A**,** Rosen T, McGorry P, (2012c) The Human Rights of People with Severe and Persistent Mental Illness: Can Conflicts between Dominant and Non-Dominant Paradigms be reconciled? in Dudley M, Silove D, Gale F, eds. Mental Health and Human Rights, Oxford: Oxford University Press.

Rosen A, (2012d) the Mental Health [10 year] Roadmap Needs Work, Croakey: Crikey.com.au, January 19. http://blogs.crikey.com.au/croakey/2012/01/19/mental-health-roadmap-needs-work..

Rosen A, Killaspy H, Harvey C, Specialisation and marginalisation: how the assertive community treatment debate affects individuals with complex mental health needs The Psychiatrist (2013a), 37, 345-348, doi: 10.1192/pb.bp

Rosen A., Mental Health Services: Evidence-based Components in the Continuum of Care, in Mendoza J et al, , eds, Obsessive Hope Disorder, 2013b, Brisbane: Connetica Consultancy.

Rosen A, Gill N S, Salvador-Carulla L, The future of community psychiatry and community mental health services, Current Opinion in Psychiatry, 33: 4: 375-390, July 2020.

RANZCP (2003) Clinical Practice Guidelines, Royal Australian & New Zealand College of Psychiatrists, Melbourne http://www.ranzcp.org/Publications/Clinical-Practice-Guidelines-2.aspx

Royal College of Psychiatrists (2010) Looking ahead
Future development of UK mental health services: recommendations from a Royal College of Psychiatrists' enquiry
Occasional Paper OP75 June, Royal College of Psychiatrists London

Royal College of Psychiatry & the National Institute for Mental Health England NIMHE. (2005). New Ways of Working for Psychiatry- Enhancing effective, person-centred services through new ways of working in multidisciplinary and multiagency contexts. Changing Workforce Programme, Leeds.

Salvador-Carulla L, Garcia-Alonso C, Gibert K, Vazquez-Bourgon J, (2011) Incorporating local information and prior expert knowledge to evidence-informed mental health system research, Ch 14 in Thornicroft G, Ruggeri M, Goldberg D, eds, : The Global Challenge of Improving Mental Health Care, Wiley: Oxford

Shepherd, G., Boardman, J., Slade, M. (2008). Implementing Recovery: A new framework for organisational change. SCMH London.

Shepherd G, Boardman J, Burns M, Implementing Recovery: A methodology for organisational change (2010) Sainsbury (Trust) Centre for Mental Health, London.

Stein LI, Test MA. Alternatives to mental hospital treatment. New York: Plenum Press. 1978</bok>

Taylor T, Killaspy H, Wright C, Turton P, White S, Kallert T W, et al (2009) A systematic review of the international published literature relating to quality of institutional care for people with longer term mental health problems, BMC Psychiatry, 9:55

Teague GB, Bond GR, Drake RE. Program fidelity in assertive community treatment: Development and use of a measure. Am J Orthopsychiatry. 1998;68(2):216–32.

Thornicroft, G., Tansella, M., (2002) Balancing Community-based and Hospital-based Mental Health Care, World Psychiatry; 1:2: 84-90.

Thornicroft G, Alem A, Antunes R, Dos Santos A R, Barley E,
Drake RE, Gregorio G, Hanlon C, Ito H, Latimer E, Law A, Mari J, McGeorge P, Padmavati R , Razzouk D, Semrau M, Setoya Y, Thara R, Wondimagegn D, (2010) WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care, World Psychiatry, 9:67-77

van Os J, Guloksuz S, Vijn TW, et al. The evidence-based group-level && symptom-reduction model as the organizing principle for mental healthcare: time for change? World Psychiatry 2019; 18:88–96.

Warner R, Does the scientific evidence fit the recovery model, The Psychiatrist , 2010, 34,3-5.

WHO World Mental Health Consortium (2004). Prevalence, severity and unmet need for treatment of mental disorders in the WHO World Mental Health Surveys. *Journal of the American Medical Association*; 292(21): 2581-90.

Wilhelm K, Finch A, Kotze B, Arnold K, McDonald G, Sternhell P, Hudson B (2007). The Green Card Clinic: Overview of a brief patient-centred intervention following deliberate self-harm, Australasian Psychiatry, 15 (1), 35-41.

Wilson, K., Mottram Patricia, G. & Vassilas, C. (2008) Psychotherapeutic treatments for older depressed people. *Cochrane Database of Systematic Reviews*.

Whiteford H , Harris M, Diminic S 2013, Mental health service system improvement: Translating evidence into policy, *Aust N Z J Psychiatry* published online 28 June 2013).

Wykes,T, Reeder, C, Landau, S, Everitt, B, Knapp M, Patel A, Romeo R,
(2007) Cognitive remediation therapy in schizophrenia
Randomised controlled trial, British Journal of Psychiatry (2007), 190, 421-427

Wykes T, Huddy V, Cellard,C, McGurk S R, Czobor P, (2011) A Meta-Analysis of Cognitive Remediation for Schizophrenia: Methodology and Effect Sizes *American Journal of Psychiatry 168:5, May, 472-485*

Zygmunt A, Olfson M, Boyer C A, Mechanic D, (2002) Interventions to Improve Medication Adherence in Schizophrenia, American Journal of Psychiatry,*159:1653–166*

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