The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Australian Government Department of Health

Adult Mental Health Centres

July 2020

Improve the mental health of communities

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Royal Australian and New Zealand College of Psychiatrists submission

Adult Mental Health Centres

Purpose

The Department of Health is conducting a consultation on the proposed service model for the establishment of Adult Mental Health Centres. **Submissions close on WED 29 July 2020**

A number of Committees and Faculties were consulted to develop the RANZCP position (see Consultation report).

Background

The Australian Government is funding a trial of eight Adult Mental Health Centres across Australia, with one to be established in each state and territory. It has allocated $114.5 million over five years. The Centres will be located at: Corio (Geelong) – VIC, Penrith – NSW, Canberra – ACT, Launceston – TAS, Townsville – QLD, Greater Darwin – NT, North Perth – WA and Adelaide – SA.

The Centres are designed to provide a welcoming, low stigma, 'no wrong door' entry point for adults experiencing distress or crisis to access mental health information, services and supports. The Centres are intended to complement, not replace or duplicate, mental health services already provided in the community. For some people, attending a Centre may be their first experience engaging with a mental health service.

Primary Health Networks (PHNs) will be responsible for establishing the Centres in each State and Territory, except in South Australia where SA Health is responsible for the Centre. PHNs will undertake local consultation to co-design and shape services to meet the particular needs of the local area where the Centre is located, within a service model framework informed by this consultation.

Feedback to the survey questions has been requested via the Government's Consultation Hub

This submission provides a detailed response to the survey questions.

NOTE: The RANZCP response, once approved at EM, will be cut and pasted into the ONLINE SURVEY.

Principles (provided from the consultation document)

The Adult Mental Health Centres will be developed and operate at the local level under the following guiding principles. The Centres will:

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

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

Are the principles which underpin the service model appropriate?

~~Very appropriate~~, ~~Appropriate~~, Somewhat appropriate, ~~inappropriate~~

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

The RANZCP supports the goal to provide a welcoming, safe and supportive space for people in distress. However, the essential role of mental health experts, including psychiatrists, must remain central to any such service.

As the delivery of the Centres will be determined by local need, the details of the operation of the Centres are unclear, which makes the proposed model difficult to assess at this stage. Equally, the lack of transparency on the evidence base for the proposed model makes it difficult to endorse the approach.

The RANZCP has reservations about how the Centres will contribute to an integrated, universally accessible mental health system, without duplicating existing services, or without assuming that adequate services exist to provide the follow-up care that people will require.

The RANZCP urges the Government to consider whether the aims of the Adult Mental Health Centres could be better achieved by enhancing the capacity of existing community mental health services.

Consideration should be given to a hybrid model whereby the functions of the proposed Centres are co-located with existing community mental health services, sharing resources and key staff. Such a model would reduce the risk of duplication and fragmentation of services, would enable existing community mental health services to offer extended hours for crisis care, provide a direct conduit from crisis care to long term care, and support people to navigate other health and social service supports, beyond mental health. This approach would be further enhanced by including primary health care, such as General Practitioners, as well as other key social service providers. A useful example of such an approach is the Floresco service model, which has been established in some Queensland locations.

There are some key considerations that will impact the success of the model:

- The governance model of the Centres must be clinician-led and must recognise the critical role of psychiatrists as mental health experts and key risk managers. It is imperative that the Centres can offer comprehensive clinical assessments by psychiatrists. This will help to ensure that the focus of the Centres remains on mental health amidst the range of social services potentially provided by the Centres.
- Workforce shortages are a real concern in mental health and should be a key consideration before any new model of care is endorsed. The success of the proposed Centres will depend on having highly trained clinical staff to manage assessments and triaging. The proposed trial should be accompanied by a workforce strategy to assist Centres to engage appropriately skilled clinicians. Innovative workforce practices might need to be considered, such as virtual co-location of services or the contracting of services from private clinicians.
- Given the central role of the Primary Health Networks (PHNs) in this trial in most jurisdictions, the success of the Centres will be impacted by the quality of the working relationship between the PHN, the local public area health service, private psychiatrists and general practitioners.

People with lived experience report difficulty navigating the mental health system to find the help and support they need. While we support the principles to provide an immediately accessible source of support to people in distress and proactive guidance towards assessment and care from the first point of contact or help-seeking, the RANZCP has reservations about whether the proposed Centres are the best way to achieve these aims.

The proposed Centres assume that there are adequate community mental health services ‘behind’ the model to provide quality clinical assessment and care. RANZCP members note that this is not the case in all jurisdictions, particularly in rural and remote communities, and the proposed centres will risk fragmenting under-resourced services even further, and potentially confusing the community about where to seek help. The aims of the proposed Adult Centres may be best achieved by funding fit-for-purpose Community Mental Health Centres in which all adult services may be located and fully resourced to provide both crisis care and long term high level care to all who need it. This will enable provision of holistic mental health care and bring all services to a level commensurate with national standards.

The RANZCP recognises that there are a number of peer support-led drop-in support services emerging in Australia, such as Safe Haven and Safe Spaces, which appear to have some overlap with the goals of the Adult Mental Health Centres. These services aim to provide an open, friendly environment, that fosters a sense of belonging and reduce feelings of being burdensome, which are related to risk of suicide and relapse. The proposed Adult Mental Health Centres appear to be aiming to provide a similar

environment, but with the addition of a mental health clinic. The RANZCP is concerned that this could lead to confusion amongst the community and mental health professionals, and ambiguity and fragmentation on accountability and governance. Centres should partner with any existing local walk-in peer support services to reduce duplication in this area.

It is unclear how a walk-in service can provide short to medium term multidisciplinary care and ensure continuity of care (case-management by one clinician), particularly in the case of fluctuating illness and distress. There are also questions around safety, quality and governance in a model of 'on the spot' care. For example, liaison with families is important but takes significant time. The RANZCP has concerns that the complexities of supporting people in crisis has been under-estimated in the proposed model.

Clinical interventions remain a crucial component of suicide prevention. Psychosocial treatments and coordinated, proactive, aftercare have been shown to be the most effective treatments for supporting patients in suicidal distress. Psychiatrists play an important role in supporting individuals in psychological distress and providing clinical assessment and treatment.

There is limited information about the evaluation, such as how it will be conducted and who will conduct it. The evaluation also appears to focus on short-term measures however it would be useful to understand long term goals and outcomes before the Government commits to widespread implementation of such a model.

The RANZCP suggests the following amendments to Principles:

- Principle 1 should be expanded to include adults "and their immediate family members, including dependent children".
- Principle 4 should include explicit reference to clinical assessment (in addition to providing advice, support and treatment) and psychiatric care and support. A core function of any mental health service must be to offer comprehensive clinical assessment.
- Principle 5 –While digital mental health services can supplement face-to-face services they should never fully replace them in these circumstances.
- Principle 7 could be expanded to specify the provision of psychosocial treatments and the coordinated, proactive, aftercare.
- Principle 10 should clarify that the governance frameworks must be clinician-led.

The RANZCP suggests the addition of the following Principles:

- Provide continuity of care and case management.
- Operate under the principles of trauma-informed care and practice
- Consumers, carers and practitioners work in partnership to guide and develop services, including a supported decision-making approach to service delivery
- Local evaluations to consider existing services and identify any duplications and the potential impacts of the local service environment on outcomes of the trial.
- Mental health clinicians (including public and private psychiatrists), general practitioners and people with lived experience should be involved in co-designing the Centres.

Assumptions (provided from the consultation document)

Assumptions underpinning the service model:

1. Centres will welcome adults experiencing emotional distress, crises, mental ill health, and/or addiction, and their families and carers through a 'no wrong door' approach.
2. Young people aged 12-25 years old should be encouraged to seek access and ongoing care and support from more appropriate and youth friendly services such as headspace services and other services targeting the needs of young people.
3. Centres should offer a holistic approach to care, addressing a broad range of social, physical and emotional needs, supported by best practice in evidence-based and evidence-informed care. This should include integrated care for people concerned about AOD use which coexist with mental ill health and culturally appropriate best practice.
4. Centres should be required to provide or facilitate core functions within an agreed framework, in a way which complements and does not duplicate existing services, including acute or long term services.
5. Centres must adhere to the principles of the Gayaa Dhuwi (Proud Spirit) Declaration in the development and delivery of services to ensure culturally safe services for Aboriginal and Torres Strait Islander people are included as part of the broader model.
6. Centres should have some flexibility for regional variation, over time, to address other cultural or local population needs and to make optimal use of already available services. This includes opportunity for the development of innovative approaches to complement core services provided through Centres.
7. Centres should be promoted as supporting people at times of crisis and distress, and not in terms of language of mental illness.
8. Centres will connect people to pathways to less urgent longer-term care. The Centres are not expected to provide services of an ongoing nature, but will have capacity to provide short to medium term targeted treatment and support.
9. Centres should promote optimal use of digital mental health and AOD services, including integrating digital forms of support into treatment plans and supporting their use.
10. A quality framework should support the model of service, including by ensuring the risks of supporting individuals who may be experiencing high distress are managed, and attending to appropriate ongoing support, supervision and training for all staff, including peer support workers.

Are the assumptions appropriate?

~~Very appropriate, Appropriate~~, Somewhat appropriate, ~~inappropriate~~

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

People experiencing a mental health or suicidal crisis need immediate care, assessment and referral. The proposed model aspires to provide timely intervention for an episode of care, as well as support to navigate more long-term health care and support services. Crisis mental health care has a crucial role in preventing suicides.

Many people in psychological distress report that their only option to receive care in a time of crisis is through hospital emergency departments. The RANZCP welcomes the Government's focus on improving crisis support, however, we question whether introducing a new layer of service is the best way to achieve this goal. The provision of immediate care in a safe environment with appropriate assessment and referral should be features of existing community mental health services.

The RANZCP makes the following comments and suggestions on the Assumptions:

- Assumption 1: while the assumption that Centres will operate a 'no wrong door' approach is a worthwhile goal, it is somewhat misleading given the short-term nature of the services and the exclusions, particularly the 18-25 year old cohort.
- Assumption 3 should include access to specialist psychiatric, medical and psychological care.
- Assumption 4: while there is an 'assumption' that the Centres will not duplicate existing services, there is a lack of information about how it integrates with public and private psychiatry. The RANZCP is concerned that the addition of Adult Mental Health Centres could fragment, rather than complement, existing mental health services.
- Assumption 5 should include safety for people from Culturally and Linguistically Diverse backgrounds.
- Assumption 7 appears to exclude the diagnostic model and therefore not supported by the RANZCP.
- The RANZCP acknowledges that the assumptions indicate the Centres will support people at times of crisis and distress, however there is no assumption that the Centres should have extended opening hours. The extended opening hours, or hours of operation outside standard business hours, should be an essential feature of the Centres, and the RANZCP would question the value of the Centres if this cannot be achieved at a local level. If workforce shortages limit the opening hours, we suggest that priority be given to opening 7 days per week, and during the evening period, for example, 2pm-10pm. The RANZCP expects that there should be an assumption that Centres will operate outside of normal business hours. 24 hour crisis care is of great importance for preventing suicide deaths.
- The assumptions should include a commitment to partner with mental health clinicians and people with lived experience of suicide or mental health crisis in designing and delivering supports.
- The Centres should include a suicide prevention focus, including a commitment to provide proactive aftercare.

Core services (from the consultation document)

Core services to be provided **'in-house'**, **using funds available to the Centres** must include the following:

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

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

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

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

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

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

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

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

Centres will also ensure that the following core services are available to people who present to the Centre, either on an **'in-house', 'in-reach' or referral basis**:

- Medical assessment, including initiation or continuation of medication management where appropriate; and assistance with physical health needs from GPs, or psychiatrists;
- Structured psychological therapies such as cognitive behaviour therapies, including services provided through Medicare Benefits Schedule (MBS) arrangements;
- Specialised suicide prevention follow-up services, such as the Way Back Support Service;
- Assistance identifying and managing comorbid substance misuse from addiction specialists;
- Integrated vocational support services such as Individual Placement and Support (IPS);
- Assistance managing stressors associated with high levels of distress, including financial problems, civil and criminal legal issues, family support, accommodation instability and social isolation;
- Culturally safe services for Aboriginal and Torres Strait Islander people;
- Connection to peer-led services such as peer networks, support groups, or phone lines; and
- Other services which are essential to the integrity of the model, depending on the particular geographic, cultural and service needs of the region (see flexibilities below).

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

Are these core services appropriate?

~~Very appropriate, Appropriate~~, Somewhat appropriate, ~~inappropriate~~

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

The RANZCP recognises that in many settings, there are inadequate services to appropriately support people experiencing a mental health crisis, with many people in distress reporting that their only option to receive care is through hospital emergency departments. Similarly, there are limited care options for people who are not acutely unwell enough to be admitted to an inpatient unit, or who do not meet the criteria for episodic or ongoing care through the community mental health care model. Unless they have the means to access the private system, there is often no service available for them.

The RANZCP understands the motivation to relieve pressure on emergency departments and improve crisis care in Australia, however we urge the Australian Government to consider crisis mental health care in the context of the whole mental health system. The proposed model relies on referring people onto other services for longer term care and appears to assume that adequate services exist. However, community mental health services remain significantly under-resourced and under pressure. Adding a

new point of crisis care risks feeding a crisis-centric approach to mental health care unless the gap in treatment services is addressed and the new centres are integrated into the existing system.

Furthermore, the RANZCP believe it is important to understand that the lack of capacity in treatment services contributes to the demands and delays in emergency departments in the first place. Recovery requires longer term clinical interventions and support from continued therapeutic relationships with mental health professionals. Improving the capacity of existing mental health services to provide services might more effectively achieve the aims of reducing emergency department presentations and providing better support and outcomes to people from the point of crisis through to recovery.

The RANZCP supports the primary goals of the Centres to reduce distress and assess needs (mental, physical and practical), provide information and assist people to access and navigate appropriate support services. However, our psychiatrist members report that existing community mental health services already aim to fulfil the core functions of the proposed Adult Mental Health Services, as much as is possible within tight budgetary constraints. The introduction of the Adult Mental Health Centres risks further fragmenting service delivery and duplicating existing services.

The RANZCP also has significant concerns about the potential for the Centres to identify more cases without the commensurate resourcing to provide treatment, therefore placing more strain on the public mental health system. It is also unclear how the Centres will integrate with public and private psychiatry.

The aims of the Adult Mental Health Centres may be best achieved by funding existing community mental health services to co-locate and fully resource both the point of entry service (crisis care) and the services that lie behind and provide the long-term care. This would be further enhanced with the integration of the additional core services proposed in the model, ideally in-house. The co-location of services to achieve a ‘one stop shop’ would facilitate holistic, person-centred care, and reduce duplication and fragmentation of services An example of such a model exists in Queensland as Floresco Centres, which house public mental health staff alongside a range of other health professionals including GPs, NGOS and AOD services. Such a model depends on a solid recurrent budget for both infrastructure and salaries. While the Medicare Benefits Schedule (MBS) could subsidise some clinicians, it should not be the sole source of reimbursement for clinical services. Headspace, which relies on the MBS to fund clinicians, is reported to be experiencing major challenges in meeting the demand for services, primarily due to workforce shortages.

A core function of any mental health service must be to offer comprehensive clinical assessment and specialist psychiatric care. If a serious mental illness is missed, it can have devastating and long term impacts. The RANZCP would urge that this should be made explicit under this model.

The commitment to actively communicate with services to which the person is being referred, as well as the provision of continued support whilst waiting for an appointment from the new service, is a strong and positive feature of the proposed service model, and is supported by the RANZCP. However, ‘warm transfers’ should explicitly entail careful treatment planning to services that are actually available and affordable. A major complaint of people who use services is that too much time is spent on assessing and then referring without offering any effective treatment so that the crisis is prolonged whilst awaiting a useful intervention. The proposed strong links with emergency departments are also essential, however it is unclear how these links will be governed. The more integrated services are, the lower the risk of human error and subsequent adverse events.

Collaborative, individualised care is the basis of high-quality mental health care. The proposed multidisciplinary team approach, with a combinations of clinicians, including psychiatrists and AOD support, and peer support workers appears to include key support staff and services. The ability to supplement supports with MBS funded practitioners, as needed, will be beneficial, however should not be the basis for employing core staff.

The phased implementation recognises that while the provision of after-hours services, by a multidisciplinary team, are key features of the Centres, workforce shortages may present challenges,

especially in rural and remote areas. Furthermore, ongoing resourcing of the Centres must factor in the particular needs and challenges facing rural and remote communities, and may need to consider innovative workforce practices to utilise private psychiatry, for example. For more information on the challenges facing rural psychiatry, see the RANZCP Position Statement 65: Rural Psychiatry.

Given the links between trauma and mental illness and suicide, the RANZCP is heartened that the proposed assessment process intends to identify complexities such as comorbidities, and the impacts of family violence, homelessness and trauma. These vulnerable groups would particularly benefit from integrated and tailored support. The RANZCP also welcomes the intention for the services to be recovery focussed, trauma informed and person-centred.

The RANZCP recommends that services be delivered with a case-management approach, with continuous and coordinated care, wherever possible.

Services out of scope (copied from the consultation document):

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

Centres are not funded to provide:

- Services for people in need of urgent emergency department care;
- Acute reception of police or ambulance referrals;
- Pathology, radiology or pharmacy services;
- Ongoing, long term psychosocial support or recreational services;
- Direct financial support;
- Residential or bed-based services;
- Services targeting children and youth under 25 years old (which could be provided more appropriately by headspace or other specialised children or youth mental health services;
- Disability support services provided through the NDIS (although the Centre will assist with referral to the NDIS and related information);
- Other services which are provided by other agencies in the area (see referrals below).

Is the list of out of scope services clearly explained?

Yes ~~No~~

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

The proposed list of services deemed out of scope is reasonably clear in theory, but will become more complicated to implement in practice. Firstly, the 'out of scope' services are not entirely consistent with the 'no wrong door' assumption, which creates an expectation that any person can seek support for any

issue at any time. Therefore, these expectations need to be clarified and carefully conveyed to the community. Similarly, expectations will need to be conveyed to, or agreement reached with, the alternative services that are filling these 'out of scope' gaps. For example, it is unclear what arrangements would be made for NDIS clients requiring crisis support, and whether they are to be excluded from accessing the Centres. Furthermore, determining which individuals are suitable for urgent emergency care from those who can be treated at the Centre, requires both a good working relationship and a governance framework. An important feature of the governance framework is the ability for both services to review cases with poor outcomes. This could assist to reduce fragmentation.

It is unclear how Centres will respond to people who present in distress on multiple occasions. Given the episodic nature of some mental illness, the RANZCP considers that it is important for Centres to remain a welcoming space for people to seek support in times of crisis or distress, regardless of past presentations or other ongoing support services they might be receiving. If the Centres are meeting their goal of providing a 'no wrong door' entry point for adults experiencing distress or crisis, they will need to recognise that people may continue to seek help from a familiar, 'highly visible' and accessible service along their journey to recovery.

The RANZCP supports the recognition that Centres will need some flexibility to meet regional variations, and avoid duplications of existing services. However, given the mix of offerings emerging in this space, for example, Safe Spaces, Safe Haven Cafes and Floresco Centres, the evaluation of these trial sites should be used to develop a nationally consistent, integrated and appropriately resourced approach to community mental health care, including crisis care.

Inclusive support and treatments

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

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

~~Yes~~ No

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

The RANZCP acknowledges that the description of the service model is consistent with the establishment aims of providing inclusive, non-stigmatising and culturally appropriate mental health support. However, the achievement of these establishment aims will be determined by the delivery of these services in a safe, supportive and accessible environment, by a well-trained team of clinicians and peer workers.

Adopting the principle of culturally-informed practice leads to a better understanding of the factors that give rise to mental illness and developing appropriate treatment. The Centres will need to be adequately resourced to ensure that effective, culturally-informed treatment can be provided to all who need them – in particular, Aboriginal and Torres Strait Islander peoples. Treatment plans for Aboriginal and Torres Strait Islander peoples can benefit from the incorporation of traditional healing methods, in partnership with mainstream western medicine, to encourage a sense of environmental familiarity and cultural safety. The Centres will also require expertise in supporting Culturally-And-Linguistically-Diverse and refugee communities as vulnerable groups.

It is unclear how the addition of Adult Mental Health Centres will contribute to an integrated, universally accessible mental health system. The RANZCP is concerned that adding a new ad hoc service to the mix risks fragmenting the mental health system further and potentially compounding existing inequities.

For example, it is unclear how people in rural and remote areas will be supported to access similar services.

The RANZCP has identified that it is also not clear how the Centres might support families, particularly if people under 25 years are excluded. It is possible that presentations to the Centre may be triggered by family violence or relationship breakdowns. The Centres must consider how they will support a parent in distress with accompanying children, who also need support. Strong linkages with children's services will be important. This is in the context of a lack of mother and baby units/ family residential stays to enable parents with severe mental illness and children under 5 years to stay together in a supported environment. A truly inclusive and integrated service would need to have the capacity to provide support to families, not just individuals.

The Centres will need to be accessible to people with disabilities; there is currently no mention of how the Centres will support people with intellectual disabilities.

The most significant risk of the proposed model arises if there is a lack of integration with existing public and private mental health services, which leads to fragmentation, and potentially creates a three-tier mental health system and its associated complexities and gaps for consumers and practitioners. The aim should be to build a service that complements existing public and private mental health services, with embedded structures to ensure integration without relying solely on the development of 'good working relationships' at the local level.

National branding

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

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

The RANZCP would suggest that the addition of another type of service in the mental health space could be confusing to the community and mental health professionals. Careful planning and communication will be important, particularly in relation to local branding to promote the pathways for accessing care to consumers.

Both clinicians and consumers should be involved in the development of a communication strategy. Communication will require clinical leadership and spokespeople.

Ultimately, the RANZCP encourages the Government to develop a nationally consistent and adequately resourced public mental health system, of which crisis care is an inevitable and important part.

Other comments

The RANZCP recognises the importance of this trial in shaping the primary model of crisis care in Australia in the coming years. We would welcome the opportunity to be involved in further discussions on the purpose, governance and design of the proposed Centres, including via membership on the Technical Advisory Committee overseeing the trial.

Further targeted consultation on the design of the Centres should be conducted at both a national and local level, and ideally must be considered in conjunction with other initiatives and the integration of the system as a whole.

More comprehensive information on the RANZCP's position on mental health system reforms, is available in the RANZCP response to the Productivity Commission Inquiry into Mental Health in Australia Draft Report.