National MHSPF Mental Health Service Planning Framework

NMHSPF Service Element and Activity Descriptions

01 November 2012


National
MHSPF
Mental Health Service Planning Framework

Document Version Control

Version	Date	Document Reviewer	Nature Of Change/ Comments/ Distribution
1.00	1/11/2012	C King	Combined the three EWG draft activity and service element descriptions into one document.

Contents

A. INTRODUCTION

As the building blocks for care packages, it is important to try and establish a 'standard' range of service elements that reasonably reflect the core service components of the mental health service system. Developing this service framework will not only summarise an agreed range of core service types, but will also result in the development of a consistent language across Australia when describing services.

To inform the development of this service framework, the NMHSPF Project Team conducted a jurisdictional survey of service elements and key data indicators in late 2011. The purpose of the service mapping process was to firstly map the range of service elements currently provided by jurisdictions, including where possible, data measures of the services that will further help identify similarities or differences between service elements. The secondary purpose of the process was to develop a common language across all jurisdictions in relation to services provided.

Initial descriptions for each service element were sourced from the following key documents in use in Queensland and New South Wales:

- Siskind, D.,Harris, M., Buckingham, B., Pirkis, J. & Whiteford, H. (2011) *Planning Estimates for the Mental Health Community Support Sector*, Queensland Centre for Mental Health Research, Brisbane.
- NSW Health (2009) Service Element Definitions from the Appendices of the *MH-CCP Version 2.008c Discussion Document*, NSW Health, Sydney.
- Queensland Health (2010) Models of Service (various) for Queensland Public Mental Health Services, Brisbane.

Since that time, the content has been modified with the more defined boundaries and relationships between elements. The current NMHSPF taxonomy of mental health service elements is shown in Section D and is structured according to:

Service Group – E.g. Population based universal services or services tailored to individuals;

Service Stream – E.g. Specialised Clinical Mental Health Care Services;

Service Category – E.g. Acute Inpatient Services

Service Element – E.g. Child Acute inpatient Service.

B. MODELLING INDIVIDUAL PROVIDERS AS SERVICE ELEMENTS

There are many situations where the care to be prescribed is simply a set of one-to-one encounters of various durations with doctors, nurses, psychologists, social workers, or other appropriately qualified staff, operating as individual providers. When care packages are prescribed in this way, all we need is a model of how many hours can be expected from each provider, to know how many providers need to be paid (by someone) to do the job. The typical example would be a GP or a psychologist in private practice, and their services are prescribed in Care Packages as encounters of various durations.

For example, EWG members have had a presentation of the Primary Mental Health Care project being conducted by Dr Meredith Harris and her colleagues at the Queensland Centre for Mental Health Services Research. In that project, a wide range of evidence has been assembled on the working hours and "outputs" of GPs and other providers, so that it is possible to convert a total "output" demand into an estimate of the number of providers needed to produce it.

C. MODELLING GROUPS OF PROVIDERS/TEAMS AS SERVICE ELEMENTS

Mental health service systems are not just a collection of individual providers each doing what they think best for whoever comes to see them. Providers are often grouped. The most common reason for grouping providers together is to deliver inpatient care. The providers are grouped together to staff a particular type of facility (for example, a Child/Adolescent acute inpatient unit in a hospital). When that happens, the providers are not operating individually, they are only providing one type of service (inpatient care), and they only provide it for one group of consumers (Children and Adolescents who need acute hospital care). Any structured group of providers who collectively deliver a particular type of service to a particular group of consumers can be represented by a "Service Element" in the modelling. However, operation from a defined facility is not an essential feature of a Service Element as defined here. There may also be structured community-based "Teams" which provide ambulatory care of a particular kind to a particular group of consumers. **Provided that an ambulatory care "Team" is as clearly structured as a facility-based Service Element, it can be represented as a Service Element**.

We will also need to look at how we quantify the activities such as:

- FTE per place
- Average Case Load
- Average Tx Days per quarter
- Hours
- Staffing profile

D. TAXONOMY OF SERVICE ELEMENTS

Insert later.

E. WORKFORCE CATEGORIES

At some point in the development of the care packages the EWG will also need to decide which activities must be performed by certain *Workforce Categories/Types*, those that can be performed by any/all clinical specialists and those that fit somewhere in between.

The Workforce Categories/Types identified by the combined meeting of the Modelling Group and the EWGs in September 2012 are:

1. Medical and only if necessary specify:
   a) Medical - GP
   b) Medical - Specialist Psychiatrist
   c) Medical – Other Specialist ie. Geriatricians & Paediatricians
   d) JMO - Junior Medical Officer
2. Tertiary Qualified and only if necessary:
   a) Tertiary Qualified Nurse
   b) Tertiary Qualified Social Worker
   c) Tertiary Qualified Psychologist
   d) Tertiary Qualified Occupational Therapist
3. Vocationally Qualified Mental Health Worker
4. Peer Worker (PW)
   (Being a consumer & carer with lived experience and experience of the service type)
5. Other

1 Primary and Specialised Ambulatory Mental Health Care Services Stream

1.1 AGREED ACTIVITIES FOR THE PRIMARY & SPECIALISED CLINICAL AMBULATORY MENTAL HEALTH CARE SERVICES STREAM

Activity
1. Acute Care Services
2. Assessment - Brief mental health
3. Assessment - Comprehensive mental health
4. Assessment - Brief Physical
5. Assessment - Comprehensive physical
6. Brief (Ultra) Intervention - Individual
7. Brief Intervention – Individual
8. Brief Intervention – Family
9. Brief Intervention – Group
10. Case Finding
11. Care Coordination and Liaison - General
12. Care Coordination and Liaison - Medico Legal
13. Early Intervention
14. Emergency Response
15. Extended Intervention -Individual
16. Extended Intervention - Family -
17. Extended Intervention – Group
18. Intensive Community Treatment Services
19. Monitoring - Centre Based
20. Monitoring– Home Based
21. Monitoring - General Physical Health Monitoring
22. Pharmacotherapy Prescription
23. Pharmacotherapy Review
24. Physical Therapies – Outpatient Electro-Convulsive Therapy (ECT)
25. Physical Therapies - Transcranial Magnetic Stimulation - TMS
26. Physical Therapies - Other Evidence Based
27. Web Based Psychological Interventions
28. Structured Day Programs

1.2 ACTIVITY DESCRIPTIONS FOR THE PRIMARY & SPECIALISED CLINICAL AMBULATORY MENTAL HEALTH CARE SERVICES STREAM

1.2.1 Case Finding

Case-finding occurs when a test is offered to an individual for a disease not directly related to their reason for presentation to the health professional.

Modified from the original source: http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/pop-based-screening-fwork/$File/screening-framework.pdf

1.2.2 Brief mental health assessment

(new term – modified from AIHW MH intervention classification definition)

Definition

This includes at least two elements of comprehensive assessment, which may include triage. It involves the gathering, evaluation and recording of information by a mental health professional relative to the consumer's problem(s), strengths, functional status or situation and must include (but is not limited to) at least two of the following assessment components:

- Mental status assessment
- Mental health history assessment
- Triage/emergency assessment
- Risk assessment
- Medication assessment
- Social assessment
- Environmental assessment
- Assessment summary and clinical formulation
- Review of care plan
- Developmental or observational assessment
- Functional assessment
- Cognitive assessment
- Psychological assessment
- Rehabilitation assessment
- Administer an outcome measurement tool

1.2.3 Comprehensive mental health assessment

Definition

This involves the gathering, evaluation and recording of information by a mental health professional relative to the consumer's problem(s), strengths, functional status or situation and must include (but is not limited to) at least four of the following assessment components:

- Mental status assessment;
- Mental health history assessment;
- Triage/emergency assessment;
- Risk assessment;
- Medication assessment;
- Social;
- Environmental assessment;
- Assessment summary and clinical formulation;
- Development of a further care plan (even if the plan includes provision of no further services);
- Developmental or observational assessment;

Source – draft doc in confidence via Bill Buckingham from Australian Institute of Health and Welfare 2012. Development of a Prototype Australian Mental Health Intervention Classification 2012 Canberra

Addition of:

- Development and Review of a Recovery Plan.

1.2.4 Brief Physical Assessment

Brief physical assessment is a term developed by the PCCNH EWG. We have applied the definition from "Physical assessment MHIC code 1041.00" AIHW MH intervention classification definition in italics - plus some other additional descriptors.

Definition

This involves the collection and assessment of information relating to a mental health consumer's physical state. A physical assessment is usually conducted as part of the general mental health assessment because it is important to assess a mental health consumer's physical state to determine appropriate interventions, especially those involving medications. Some physical conditions may create the appearance of mental health conditions.

This is a targeted assessment that includes at least 1 of the components of a comprehensive physical assessment. This may include but is not limited to:

- Monitoring of medication side effects
- Preventative health review
- Monitor metabolic syndrome risk factors
- Monitor abnormal in voluntary movements
- Monitor basic physical observations (pulse, BP, temperature, respiratory rate)
- Physical examination
    - Cardiovascular
    - Respiratory
    - Gastrointestinal
    - Neurological (brief and comprehensive)
    - Other

1.2.5 Comprehensive physical assessment

Comprehensive physical assessment is a term developed by the PCCNH EWG. We have applied the definition from "Physical assessment MHIC code 1041.00" AIHW MH intervention classification definition in italics - plus some other additional descriptors.

Definition

This involves the collection and assessment of information relating to a mental health consumer's physical state. A physical assessment is usually conducted as part of the general mental health assessment because it is important to assess a mental health consumer's physical state to determine appropriate interventions, especially those involving medications. Some physical conditions may create the appearance of mental health conditions.

The health assessment must include:

- information collection, including taking a patient history and undertaking examinations and investigations as clinically required;
- making an overall assessment of the patient's health, including the patient's readiness to make lifestyle changes;
- initiating interventions and referrals as clinically indicated;

- providing advice and information about lifestyle modification programs to the patient including strategies to achieve lifestyle and behaviour changes;
- keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and
- offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

** http://www.health.gov.au/internet/main/publishing.nsf/Content/mha_resource_kit

Components of a health assessment for a person aged 75 years and older
The health assessment must include:

- information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;
- making an overall assessment of the patient;
- recommending appropriate interventions;
- providing advice and information to the patient;
- keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and
- offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.
- Specific components of the health assessment for older people include:
- measurement of the patient's blood pressure, pulse rate and rhythm;
- an assessment of the patient's medication;
- an assessment of the patient's continence;
- an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus;
- an assessment of the patient's physical function, including the patient's activities of daily living, and whether or not the patient has had a fall in the last 3 months;
- an assessment of the patient's psychological function, including the patient's cognition and mood; and
- an assessment of the patient's social function, including the availability and adequacy of paid and unpaid help, and whether the patient is responsible for caring for another person.

The health professional undertaking the health assessment may also consider:

- any need the patient may have for community services;
- whether the patient is socially isolated;
- the patient's oral health and dentition; and
- the patient's nutrition status.

1.2.6 Monitoring - Centre Based

Harvey: Someone asked if we discussed brief and extended monitoring as well? I don't think so - do you?

The nature of the centre based support will depend on consumer/client needs. Services provided by clinicians will:

- include
  - supportive psychotherapy;
  - MH Status;
  - Risk Assessment
  - Medical review
  - Social and environmental assessment
  - Review action plan

- be responsive and flexible to the likely changing needs of the client. It should be able to provide assistance to overcome critical episodes or pressing needs and.
- Be goal focussed – while it is recognised that on occasion it may not be possible, or more usually will take a significant period of time, to develop an Individual Program Plan it is expected that both the worker and the client will be clear about the purpose of the support.
- Be needs focussed, including providing at times 'hotel' type services (meals, cleaning) when required.
- Be culturally, age and gender sensitive, taking account of issues of privacy.
- Be encouraging of individuals' participation in decisions regarding their use of services and enhancing their own capacity to manage their health and welfare needs.

Adapted from: http://health.vic.gov.au/mentalhealth/pdrss/intensive-homebased-pdrss.pdf

1.2.7 Monitoring– Home based

The nature of the home/outreach will depend on client needs. However, it is expected that the clinician will be:

- responsive and flexible to the likely changing needs of the client. It should be able to provide assistance to overcome critical episodes or pressing needs.
- goal focussed – while it is recognised that on occasion it may not be possible, or more usually will take a significant period of time, to develop an Individual Program Plan it is expected that both the worker and the client will be clear about the purpose of the support.
- needs focussed, including providing at times 'hotel' type services (meals, cleaning) when required.
- culturally, age and gender sensitive, taking account of issues of privacy.
- encouraging of individuals' participation in decisions regarding their use of services and enhancing their own capacity to manage their health and welfare needs.
- Provision of interventions to avert an admission
- Post discharge aftercare
- Provision of support for families and carers

JBs adaptation from: http://health.vic.gov.au/mentalhealth/pdrss/intensive-homebased-pdrss.pdf

1.2.8 Monitoring - General Physical Health Monitoring

Monitoring required as part of good mental health treatment, including metabolic screening (weight, BP, blood tests etc.) and screening to comply with treatment guidelines (e.g. haematological testing required with clozapine)

1.2.9 Care Coordination and Liaison

Care coordination and liaison includes working in partnership with and liaison with other government agencies, NGOs, primary care providers, acute and emergency services, rehabilitation services and families and carers that occurs outside of the clinical encounter. Care Coordination and Liaison includes:

- Case Conferences
- Liaison with carers and/or consultation with family members
- Liaison with other professionals including schools – verbal and written
- Transition Planning / Handover / Referral / Discharge Planning
- Multi-Disciplinary Team Reviews**
- Medical records if outside of the clinical encounter.

Harvey: Note that the following definition for "Service Coordination Interventions" from the MHIC is very similar. If I recall correctly the Commonwealth is planning to allocate considerable amounts to this item. As there are potential sources of funding I think we should leave it in or rename it to "Care and Service Coordination Interventions" so that the funding to services would still be available. Harvey do you know anything about this?

Service Coordination Interventions For some consumers, the progression of an effective treatment plan includes interventions involving consultation with others, for example, case conferencing, liaison with other professionals, and secondary consultations.

It is planned that this category will also include those consultative processes involving the new 'care facilitator' role which was specified in the national mental health reform budget statement.

Definition

This involves consultation with others, for example, case conferencing, liaison with other professionals, and secondary consultations. This category will also include those consultative processes involving the new 'care facilitator 'role which was specified in the national mental health reform budget statement.

The following components are included:

- Case conferencing
- Liaison with other professionals
- Secondary consultations
- Service coordination for consumers with severe, persistent mental illness and complex care needs involving care facilitator
- Other service coordination.

Source – draft doc in confidence via Bill Buckingham from Australian Institute of Health and Welfare 2012. Development of a Prototype Australian Mental Health Intervention Classification 2012 Canberra

1.2.10 Medico-Legal

- Medico-Legal Review includes second opinion
- Medico-Legal - Attendance at Tribunal

1.2.11 Emergency Response

First point of contact with mental health services (emergency response is in place 24 hours / 7 days). The key functions of the emergency response are facilitation of:

- 24 hour, 7 days a week access to the most appropriate mental health care;
- timely assessment and clinical interventions that lead to initial recovery planning, including relapse prevention and implementation for community consumers presenting with acute mental health needs.

1.2.12 Acute Care Services (ACS)

NOTE: there was debate as to what differentiates this from Emergency Response. This needs to be resolved.

Acute Care Services (ACS) provide services to people known to the service or practitioner. (Harvey – I added the yellow highlighted section but I am not confident it was agreed to insert here) They function as the first point of contact to public mental health services 24 hours, 7 days a week. Following triage, they facilitate the most appropriate type of care (eg. in patient, community, crisis interventions) for the individual.

Not all health services will have a designated ACS however, all health services (Harvey - is this feasible in a rural/remote area?) will have a mechanism for providing 24 hour, 7 days a week access to mental health care.

The ACS provides a multidisciplinary mental health service to consumers with acute care needs in a community setting.[1] The majority of ACS service provision occurs in the consumer's home, a community clinic, a general practice (GP) or other nominated place. In exceptional circumstances, service provision may be delivered by an emergency department (ED).

The key functions of the ACS are:-

- Facilitation of 24 hour, 7 days a week access to the most appropriate mental health care;
- Provision of a centralised co-ordinated triage component to the mental health service;
- Timely assessment and clinical interventions that lead to initial recovery planning, including relapse prevention and implementation for community consumers presenting with acute mental health needs;

Depending on the local organisational structure of the health service area and mental health service, these functions may be delivered by a single service or several sub-services.

The service(s) will have strong partnerships with the local ED. Clear pathways of care will be defined by local protocol, ensuring the locally defined team structure is efficient and effective in its intentions.

Source: Acute Care Team - Model of Service, QLD Public Mental Health Services (Endorsed EDMHAODD 02/07/2010/Review Date 02/07/2011).

Structured Psychological Therapies NOT SURE WHERE TO PUT THIS TEXT?

Interventions which include a structured interaction between a mental health consumer and a qualified mental health professional using a recognised, psychological method - e.g., CBT, family therapy or psycho-education counselling. Psychological interventions are designed to alleviate psychological distress or emotional disturbance, change maladaptive behaviour and foster mental health.

Source – draft doc in confidence via Bill Buckingham from Australian Institute of Health and Welfare 2012. Development of a Prototype Australian Mental Health Intervention Classification 2012 Canberra

These may be face to face; telephone; video conferencing and/or Skype.

1.2.13 Ultra brief Intervention - individual

Need a definition

1.2.14 Brief Intervention – Individual

Need a definition
These may be face to face; telephone; video conferencing and/or Skype.

1.2.15 Brief Intervention – Family

Family interventions focus on building personal capacity, resilience, coping skills and mutual support for families and carers. Services such as access to education and information, individual advocacy, intensive support to assist in navigating the mental health and community care systems.

These may be face to face; telephone; video conferencing and/or Skype.

[1] Taking into consideration safety issues, and clinical and individual needs.

1.2.16 Brief Intervention – Group

Need a definition
These may be face to face; telephone; video conferencing and/or Skype.

1.2.17 Extended Intervention -Individual

Need a definition
These may be face to face; telephone; video conferencing and/or Skype.

1.2.18 Extended Intervention - Family interventions -

Family/carer-focussed therapy and interventions can be defined as therapeutic processes which promote, improve, and sustain the effective functioning of the family/carer, and/or work with the family/carer to achieve improvement in the mental health status of the consumer. The scope of interventions is limited to family/carers. It should be noted that in this context, - family/carers' includes people who have a significant emotional connection to the consumer, such as friends and partners, and those who have a formal role as the consumer's carer.

These may be face to face; telephone; video conferencing and/or Skype.

1.2.19 Extended Intervention – Group

Psychotherapy administered in a group setting (other than of a multiple-family group) with a trained group leader in charge of several patients. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight and support.

Clinician led group interventions vary. The basic format is a small group of consumers/patients meet on a regular basis to discuss their feelings and problems and provide mutual support. The session is guided by a clinician therapist who is specially trained in group therapy. The therapist acts as moderator and may suggest a "theme" or topic for the group's discussion. Sometimes, the therapist will allow the group members to pick the topic for the session.

As part of the group therapy session, members try to change their old ways of behaving in favor of newer, more productive ways. Typically, there is a great deal of interaction and discussion among the members of the group. The members may also undertake specific activities, such as addressing certain fears and anxieties.

These may be face to face; telephone; video conferencing and/or Skype. (Is this applicable for groups?).

Some of this is from:

http://www.webmd.com/anxiety-panic/guide/mental-health-group-therapy

These interventions embrace the following three approaches: Psychosocial therapy; Education: Counselling. And can include:

Cognitive and/or behavioural therapy

MHIC codes 3011.xx (Individual) & 3012.xx (Group)

Techniques often used within cognitive and/or behavioural therapies include:

- Cognitive restructuring:
  - MHIC code 3011.01 (Individual)
  - MHIC code 3012.01 (Group)
- Desensitisation (graded exposure or exposure therapy):
  - MHIC code 3011.02 (Individual)
  - MHIC code 3012.02 (Group)
- Relapse-prevention:

– MHIC code 3011.03 (Individual)
– MHIC code 3012.03 (Group)
• Relaxation :
– MHIC code 3011.04 (Individual)
– MHIC code 3012.04 (Group)
• Response-prevention :
– MHIC code 3011.05 (Individual)
– MHIC code 3012.05 (Group)
• Rational emotive therapy:
– MHIC code 3011.06 (Individual)
– MHIC code 3012.06 (Group)
• Role play/rehearsal:
– MHIC code 3011.07 (Individual)
– MHIC code 3012.07 (Group)
• Structured problem solving:
– MHIC code 3011.08 (Individual)
– MHIC code 3012.08 (Group)
• Treatment adherence:
– MHIC code 3011.09 (Individual)
– MHIC code 3012.09 (Group).

Examples include but are not limited to cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT).

Insight-oriented therapy
MHIC codes 3021.00 (Individual) & 3022.00 (Group)
Psychoeducation
MHIC codes 3031.00 (Individual) & 3032.00 (Group)
Couple therapy
MHIC codes 3041.00(Individual) & 3042.00 (Group)
Supportive psychotherapy
MHIC codes 3051.00 (Individual) & 3052.00 (Group)
Skills training
MHIC codes 3061.00 (Individual) & 3062.00 (Group)
Play therapy
MHIC codes 3071.00 (Individual) & 3072.00 (Group)
Interpersonal psychotherapy
MHIC codes 3081.00 (Individual) & 3082.00 (Group)
Narrative therapy
MHIC codes 3091.00 (Individual) & 3092.00 (Group)
Family/carer-focussed therapy and interventions
MHIC codes 3101.00 (Individual) & 3102.00 (Group)

1.2.20 Web Based Psychological Interventions

Clinician mediated e-Interventions include:

1. Sole use of e-Interventions through establishment of an online clinic providing online counselling and/or prescription of e-Interventions and communication via email/skype. Offering an e-Intervention as the 'low intensity' treatment modality alternative.
2. Offering the e-intervention component of a mixed service delivery model integrating other treatment modalities (e.g., provide a client with six face-to-face sessions and six e-Intervention sessions).
3. Use of e-Interventions as adjuncts to supplement traditional face-to-face care.
4. Another approach involves employing a stepped care model whereby e-Interventions may become the first major port of call for those with low level or mild mental health symptoms (Christensen, in press).

Source: http://www.psychology.org.au/publications/inpsych/2010/feb/klein/

e-Interventions and Psychology, by Associate Professor Britt Klein MAPS, Co-Director, National eTherapy Centre Faculty of Life and Social Sciences, Swinburne University

1.2.21 Intensive Community Treatment Service

Intensive Community Treatment Services are highly responsive, assertive treatment and recovery oriented multidisciplinary services aimed at improving the quality of life for consumers with complex mental health needs requiring intensive intervention in the community. Intensive Community Treatment Services assist to facilitate the development of re-engagement with meaningful life roles for consumers, with an explicit belief that people can and do recover from mental illness.

Key Functions are:

a) Provision of professional, intensive, specialist mental health interventions for those consumers who require the most assistance to recover from mental illness;
b) Planning, co-ordinating and supporting a range of internal and external services with consumers;
c) Working with consumers to develop their sense of self efficacy, personal support systems and live independently within their chosen community.

The service would :

- Provide an extended hours service, on a mobile outreach basis, through home visits and other community based interventions, to facilitate the rehabilitative process of transferring learned behaviours to support independent living;
- Provide assessment, recovering planning and intensive mental health psychological rehabilitation services for consumers who have complex mental health needs;
- Provide preventative help for people to manage crisis situations and provide support to keep crises from turning into unnecessary hospitalisations;
- Provide education to the consumer, their family and carers and support services;
- Engage, develop and maintain partnerships with local services and community groups.

Source: modified from QLD Public Mental Health Services – Acute Care Team Model of Service

1.2.22 Early Intervention

Early interventions are interventions targeting people displaying the early signs and symptoms of mental disorders or a mental health problem. They aim to provide for earlier and more intensive treatment as well as minimising the impact of the disorder including the disorder from the individual and their social network.

Source: original definition from DoHAC (2000) National Action Plan for Promotion Prevention and Early Intervention for Mental Health.- now modified by EWG working group.

1.2.23 Structured Day Program

Harvey: (Heading/title and description need to be finished)
The Mental Health Day Program is a time limited group program. It offers a variety of group programs. There are three types of therapy within the program: supportive, psycho-educational (teaching) psychotherapy (insight-oriented therapy).

The Program is for patients being discharged from Adult Inpatient Mental Health and re-entering the community, patients in the community having difficulty coping and patients potentially suitable for long-term group therapy. After completion, patients are returned to the original referral source; referred to outpatient or community programs.

Source: http://www.albertahealthservices.ca/services.asp?pid=service&rid=5629

OR?

Structured Day Programs/Specialist Groups

Structured day programs are designed to provide chronically mentally ill clients who may need more support than is available through their regular case management program with a safe, supportive environment with opportunities for skill building, social support and structured activities.

Organized activities and regular schedules help clients cope more effectively with their psychiatric symptoms and offer a supportive environment where clients can meet and develop friendships. The treatment process emphasizes self-responsibility, independence, and psychiatric stability.

Source: http://www.cpcwa.org/Services/sdpmh.html

Physical Therapies (ECT, TMS, Other) NOT SURE WHERE TO PUT THIS TEXT

Three types physical therapies will be modelled in the NMHSPF project. They are Electro-Convulsive Therapy, Transcranial Magnetic Stimulation and Other Evidence Based Physical Therapies.

1.2.24 Electro-Convulsive Therapy (ECT)

Description being developed by other EWG – insert when done.

1.2.25 Transcranial Magnetic Stimulation - TMS[2]

Transcranial Magnetic Stimulation (TMS) is a potential new treatment for depression and other psychiatric disorders. There is an emerging consensus that TMS does have antidepressant activity and may play a useful role in the treatment of patients with depression.

TMS uses a very focused magnetic field to activate specific areas of the brain. Repeated TMS stimulation progressively alters brain activity improving depression in some patients. TMS requires no anaesthesia or medication and generally you may go about normal activities immediately following the treatment.

Source: http://www.thevictoriaclinic.com.au/index.php/our-services/innovative-treatments-for-depression-tms/

1.2.26 Other Evidence Based Physical Therapies

Such as light therapy.

1.2.27 Pharmacotherapy Prescription

Pharmacotherapy prescription encompasses the clinical assessment and subsequent judgement that pharmacotherapy is appropriate and indicated for the consumer. It typically will also involve the prescribing of an appropriate pharmacological agent and may include the preparation and administration of oral or depot intramuscular injection (IMI). As well as details of the medication prescribed, the administration route and whether the prescription is new or a repeat, is collected.

Source: Annex B: Psychopharmacotherapeutic Drug for the MHIC 1.0 from the document. Source – draft doc in confidence via Bill Buckingham from Australian Institute of Health and Welfare 2012. Development of a Prototype Australian Mental Health Intervention Classification 2012 Canberra

1.2.28 Pharmacotherapy Review

This incorporates a review of a consumer's current medication regime to determine appropriateness of the regime and an assessment of the consumer's ability to manage medication safely.

[2] Note– this is about to go on the MBS – is there a definition?

A - No additional monitoring/imaging
B - Medium Monitoring
C - High Monitoring

1.3 PRIMARY & SPECIALISED CLINICAL AMBULATORY MENTAL HEALTH CARE SERVICES STREAM

NB: The template for this as a "Service Element" has not yet been populated. TBA

1.3.1.1 Table 1: Service Element Description

Attribute	Details
Services Delivered	Ambulatory care occurs in a range of settings from a GP to a psychologist in private practice right through to a specialist team based in an outpatient setting. Teams can be configured in many ways. The activities will vary depending on the age and severity of the person's mental illness. Ambulatory care in mental health consists of after/extended hours services and ambulatory care services, including appointments with treating doctors, Clozapine and depot clinics, psychological therapies, case management and rehabilitation. A range of case management models and Assertive Community Treatment services. Mental health community service models for adults vary between mental health services. The models of care need to be defined, reviewed and updated. Adult mental health services have a role in responding to mental health risks identified through the universal psychosocial assessment and screen for current depression of pregnant and postnatal women as outlined in the *NSW SAFE START Guidelines for Improving Perinatal Mental Health Outcomes*. They need to identify the issues for children of adults affected by mental illness or disorder.
Key Distinguishing Features	

Service specifications & other useful descriptors to illustrate service elements (EWG to complete at some stage)			
Target Age:	**0-17yrs**	**18-64 yrs**	**65+ yrs**
Diagnostic Profile			
Avg incidence			
Suggested Modelling Attributes			
Average Case Load		10 to 15 per clinical FTE (TBC)	
Average Tx Days per quarter		6 to 18 treatment days. Higher end of this	

		range. (TBC)	
Indicative FTE per 100k		CATT: 11.0 FTE Clinical Staff / 100,000 MITT: 5.5 FTE Clinical Staff per 100,000 total population	
Hours		Extended hours (usually covering 14 hours per day), 7 days per week.	
Suggested Activities			
Activity		**Measure**	**Staff Profile Options**
Assessment Clinical		Eg. 90 minutes	Medical or Nurse/Allied Health
Review & Monitoring			

2 Specialised Mental Health Community Support Services

2.1 AGREED ACTIVITIES FOR THE SPECIALISED MENTAL HEALTH COMMUNITY SUPPORT SERVICES

Activity
1. Brokerage Services
2. Carer Support linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well
3. Carer Support linked to education and employment:
4. Carer Support linked to enhancing relationships and social participation:
5. Carer Support linked to health management:
6. Family Support
7. Peer Support – Carer Focus
8. Peer Support – Consumer Focus
9. Respite - Day Programs
10. Respite - In-home/Out of home
11. Respite - Residential
12. Support & Rehabilitation linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well
13. Support & Rehabilitation linked to education and employment
14. Support & Rehabilitation linked to enhancing relationships and social participation
15. Support and Rehabilitation linked to health management

2.2 ACTIVITY DESCRIPTIONS FOR THE SPECIALISED MENTAL HEALTH COMMUNITY SUPPORT SERVICES

2.2.1 Brokerage Services

Goods and/or services which are procured on behalf of the consumer to purchase additional assistance that is not within the practice of one of the existing service providers. The goods and/or services are provided as part of the person's individual support plan and are related to a goal within the individual support plan. Examples are listed below. Brokerage funds may be part of or separate to the overall funding of the support "package".

Household – For example: buying cleaning equipment, replacing a fridge etc

Activities of Daily Living: For example: paying or helping to pay for a cleaner (either episodic or regularly), paying for driving lessons or bus tickets,

Membership / exercise: For example: entry to swimming pools, gym membership, exercise clothes (such as swimmers), club fees for sports club.

Recreational: For example: art lessons, books for a book club, supplies for a craft group.

Vocational / Training: For example: materials or transport to training / vocational group, clothes for work opportunity.

Other: Expenses that don't fall into the preceding categories.

2.2.2 Carer Support linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well:

General description: Support and rehabilitation services provided specifically towards a carer's personal goals for the establishment and maintenance of safe and secure housing. The services are provided on a one-to-one basis, assisting an individual to maintain or change their housing circumstances (including succession planning for the care of the consumer), remaining sensitive to cultural and multi-generational needs. (eg. Supporting carer's in the practical maintenance of their housing, accessing appropriate housing options as required, multi-generational living arrangements, homeless individuals or for those at risk of homelessness).

Information Gathering: Psychosocial needs assessment and functional assessment identifying housing needs, support available, personal strengths and areas for support and/or development. Also includes the provision of information that identifies different housing options and outlines access issues.

Planning: Development of a person-centred recovery plan driven by the carer that identifies housing goals, referral pathways, housing providers, resource options and advocates as appropriate and associated skill development and action required.

Action: As per the recovery plan, support the carer in establishing and maintaining housing arrangements including:

- Resources: Establish financial resources, legal and tenancy support, practical support (both personally and in relation to property maintenance), processes to support skill development. Engaging assertively with the housing market is critical to establishing safe and secure housing. Particularly in the context of liaising/networking and following up on commitments made, supporting accommodation hunting and development of the housing application. Also support carer to access public housing tenancy support officers and rental assistance schemes, or assist with the installation of security devices, advancing or assisting with bond money and removal costs as indicated in the support issues identified.
- Skill Development (including Rehabilitation Focus): Develop skills to improve competence and confidence in community living, particularly in relation to managing tenancy matters.
- Social/Cultural Context: Ensure housing allocation is safe and appropriate to personal and cultural circumstances.
- Health and Wellbeing: Improve independence and resilience and ensure appropriate support is provided to maintain a healthy home environment.

Issues for consideration relevant to particular carers includes the following:

- Young Carers/COPMI - Is the young carer / COPMI safely & securely housed now?
  Do they need special housing support to attend school, do homework, maintain the house / garden, participate in social activities, pay the rent, manage finances, purchase & prepare food, etc.
  (Identify & quantify the additional actions required to provide the support needed.)
- Parents & families of 0 – 12 yrs. child with mental health problem – Housing location provides access to specialised and/or sympathetic schooling, therapeutic or social programs. Liaison with schools, childcare facilities. Financial support for repairs or additional safety and security features in housing.
- Parents & families of a young person (13 – 24 yrs.) with mental health problem - Supporting carer in setting personal & family boundaries to maintain safe & secure housing (skills development, practical support).

- Carers and families of an ageing person with mental health problems - Supporting the carer to find appropriate separate supported residential accommodation for an elderly frail person with a mental health problem. May include sale or division of property that the carer and ageing person have lived in for many years.
- Ageing Carers > 65 yrs (including frail carers of any age) – Consider need for a ground floor dwelling, ease of access to local shops, transport, support for maintaining the house & yard, home modifications, tenancy / housing succession planning and increased respite services.

Outcomes: Stability of housing, individual housing goals are met and opportunity and right for community participation in accordance to personal goals. Reviews with family or carer to ascertain whether or not desired outcomes have been / are being achieved and how effectively; makes adjustments to or closes episode of support, accordingly. Returns to assessment, planning & implementation phases as indicated, to meet the same or another identified need for support.

Collaboration: Consumer and family/support people, housing providers, income support or management, mental and general health clinical and community support services, financial brokers, succession planning for secure housing for the consumer, legal services, tribunals and other social, health and community opportunities. Supports and encourages the carer to participate in social and community activities.

2.2.3 Carer Support linked to education and employment:

General description: Individual support and rehabilitation services provided specifically towards a carer's personal goals towards education and employment. The services are provided on a one-to-one basis, and generally target the functions of accessing and supporting education and employment opportunities rather than providing the education and employment services themselves.

Information Gathering: Psychosocial needs assessment and functional assessment identifying education and employment targets, motivation to work and/or study, self-identified support needs, support available, personal strengths and areas for development. Also includes the provision of information that identifies different education/employment options and outlines access issues.

Planning: Development of a person-centred plan driven by the carer that identifies education and/or employment goals, referral pathways, service providers, resource options and advocates as appropriate and associated skill development and action required. Particularly need to consider the long term of positive effects of supporting individuals back into school, which further supports post-secondary study and subsequent employment opportunities *(McLaren, K (2004) Work in Practice – Best practice employment support services for people with mental illness, NZ)*.

Action: As per the personal plan, support the carer in accessing and maintaining education and employment through the following activity:

- Resources: Provide career counselling and assistance in course selection and enrolment procedures, linking to other services as required. (VETE)Establish financial counselling and access to financial support, transport services and employment/education practical support. Engage assertively with the employment and education providers to ensure a flexible and supportive environment is established.
- Skill Development (including Rehabilitation Focus): Provide or provide access to, re-skilling, skills development or confidence building courses such as computer training, preparing curriculum vitae, preparing for job interviews, time management, assertiveness training. . Establishing effective employment strategies early in the illness trajectory may have life-long impact on employment outcomes for both consumers and carers, preventing secondary disability and associated economic and social costs. Providing a specialist VETE service ensures employment and education remain a high priority when other issues required addressing by the care coordinator (eg decline in mental or physical health). (VETE)

- Social/Cultural Context: Address stigma, encourage a sympathetic.
- work/education environment able to accommodate circumstances such as unplanned absences to support the person they care for during fluctuating periods of episodic illness. Provide flexible support tailored to individual need, tutoring and flexible delivery of education courses or employment arrangements promotes the likelihood of success. (VETE)
- Health and Wellbeing: Close links and integration with care coordination services, primary care, crisis intervention and accommodation issues will support the stability of health of the person being cared for and support the carer's progress towards achieving their vocational and educational goals. (VETE)

Outcomes: Participation in employment, improved income, sustained or stable involvement in employment and education, greater personal independence / 'space'.

Collaboration: Establish agreements with the person being cared for and (as indicated) develop a backup plan with other services to provide or increase support during carer's absence at work. Foster a close working relationship with income support services and Job Capacity Assessors to ensure referrals to employment services are processed appropriately. Need to establish mental health carer support positions dedicated to vocational and educational issues to enhance employment and educational outcomes. Enhanced intersectoral links, particularly between mental health, generic employment and education services (eg. Resume production, course content information), Disability Employment Services, TAFE, Universities and other social support services.

Frost, B., Morris, A., Sherring, J. & Robson, E. (2008) Vocational Education, Training and Employment (VETE) Pilot Project Report – Psychiatric Rehabilitation Services 2006-2007, NSW Health, Sydney.

2.2.4 Carer Support linked to enhancing relationships and social participation:

General description: Working with the carer to identify and develop social interests and to identify and manage any potential or actual negative impact from their caring role. Aim is to access activities within the local and broader community and to identify relationships which are important to the carer and work on developing, maintaining and growing those relationships. This may require working directly with the carer to develop their personal skills, or may be a matter of managing the logistics and responsibilities of their caring role (eg provision of respite).

Information Gathering: Identify the individual's social interests are and availability in the community. Work with the carer to identify support people who may be available to assist with accessing and participating in the desired activities. Consider issues such as isolation, previous relationships that have been neglected or otherwise negatively impacted by the caring role, and personal confidence and desire for increased socialisation.

Planning: Work with the carer to develop a personal plan that involves developing the skills to find, access and participate in community activities and develop social relationships. Consider the motivational status of the individual and assist the carer in planning each aspect of participation in social activities including identifying the resources and skill development required.

Action: As per the personal plan:

- Resources: Establish financial resources to assist with funding community activities or access to community activities. Identify and establish support to access and engage in community activities Eg. transport, respite etc. Identify support people to assist with community integration and participation (may include workers).
- Skill Development (including Rehabilitation Focus): Identify and develop skills required to access and participate in community activities. Eg. Self-confidence, social presentation and communication skills.

- Social/Cultural Context: Ensure activities planned are socially and culturally appropriate and relevant to the priorities and desire of the individual.
- Health and Wellbeing: Promote activities that will assist in the development of improved health and well being.

Outcomes: Increasing social participation and community engagement in order to meet goals connected to social inclusion.

Collaboration: Consumer and family / support people, organisations providing courses and activities, educational and vocational providers, community organisations, non government organisations.

2.2.5 Carer Support linked to health management:

General description: Assisting an individual in a caring role to improve or maintain his or her health or wellness. In particular, avoiding self-neglect and actively seeking or establishing strategies and activities that promote good health and wellbeing. Examples might include regular physical health assessment and treatment as appropriate, massage and other forms of relaxation activities, counselling and peer support, recreational activities, skill development in health practices (eg. Cooking, cleaning, fitness) and use of personal support and respite services.

Information Gathering: Engaging the participant in a relationship to develop a plan for health management. Assessing health status (including physical and mental health) and barriers and enablers for good health. Includes review of physical and mental health needs, thorough history and review of medication (both physical and otherwise). Collation of physical and dental health contacts and connection to these services. Assess readiness for change and skills connected with coping, health management, menu planning, shopping, cooking and fitness.

Planning: Prioritise and set health and wellness goals by formulating a health and wellness plan, that is driven by the participant with support in the planning process.

Action: Support the carer in developing healthy behaviours and support access and use of resources as appropriate:

- Resources: Nicotine replacement therapy, brokerage funds (Eg. to assist in accessing gym memberships or exercise clothes), respite and/or personal support services,
- Skill Development (including Rehabilitation Focus): Support the carer in building skills in healthy practices and overall health management and to engage or disengage in activities which assist in improving health. Development of insight to avoid neglecting personal health in favour of their caring role and to establish and maintain positive coping strategies.
- Social/Cultural Context: Utilising support and respite services as required to maintain and promote social relationships in work, education and social/cultural environments.
- Health and Wellbeing: As above.

Outcomes: Prevent deterioration of health status and increase coping and stability of caring role.

Collaboration: General Practice and other health services, community health management organisations (Eg. Gyms, swimming pools, weight management services), other recreational, educational and vocational services and mental health care and related support services.

2.2.6 Carer Support linked to navigating the primary and mental health care systems

General description: Supporting a carer to access, communicate with or maintain their connection to a primary health service or mental health service.

Information gathering: – Refer to the Carer's personal plan and consider the range of services Ensure that all service providers are aware of the others and their role and have an agreed upon method of sharing information.

Planning: As part of the development of the person centred recovery plan, plan for accessing primary health services as required. Plan for the acquiring of skills to access and navigate the primary and mental health care systems.

Action: Providing a care coordination service, assisting the consumer to link to primary and mental health care services, assisting the consumer to link the information from the multiple systems together to enable health providers to have access to information required.

- Resources:
- Skill Development (including Rehabilitation Focus): developing skills in communicating and navigating multiple health services providers and systems, developing assertiveness and being one's own advocate and health expert.
- Social/Cultural Context:
- Health and Wellbeing:

Outcomes:

Better life expectancy stats – people with serious mental illness having decreased rates of smoking, obesity and increased rates of physical exercise – lower rates of cardiovascular disease, respiratory disease etc, lower rates of hospitalisation, presentation to EDs for physical health issues etc

Collaboration:

2.2.7 Family Support:

General description: Mental health care that is provided in a way that recognises the unique role of personal and family relationships in promoting wellbeing, providing care, and fostering recovery across the lifespan and the needs of families and support givers themselves. Families are engaged and helped through e-counselling, education and support programs and services. Wherever possible, families become partners in care and treatment and are integrated into decision-making in a way that respects a person's choice, consent and privacy. (Craze, L. (2012) *National Recovery-Oriented Mental Health Practice Framework - 2nd Consultation Draft,* on behalf of the Safety and Quality Partnership Subcommittee of the Australian Health Ministers' Advisory Council, Mental Health Standing Committee.)

Access: General aim is to reduce the impact of mental illness on all family members

Planning: Encourage and support people to develop advanced care directives and/or plans for the care of their children with their partners and families when they are well. Support people in sharing key elements of recovery goals and approaches with their partners/family members. (Craze, L. (2012) *National Recovery-Oriented Mental Health Practice Framework - 2nd Consultation Draft,* on behalf of the Safety and Quality Partnership Subcommittee of the Australian Health Ministers' Advisory Council, Mental Health Standing Committee.)

Action:

- Resources: Practitioners working in the child protection, non-government welfare, housing and youth sectors do not necessarily have formal training or qualifications that include mental illness symptoms and treatment.
- Skill Development (including Rehabilitation Focus): Address age appropriate factors for risk and resilience, ensuring that the needs of all family members are addressed and included in the development of care planning and delivery. In particular, identify and maximise the strengths within the child and the family unit. Need to talk with children about their experience, worries and fears, parents should be active partners in the process of children receiving information about their illness. Parents may be ambivalent about their child receiving information, thinking that their child is

protected by having little, or no, information or concerned that if they give the information they may be incorrect. Talking with children comprises of giving children age-appropriate information, but also gives them the opportunity to voice anxieties such as 'will I get it?', 'will Mum get better?', 'why did it happen to my dad?' Cowling, V., Edan, V., Cuff, R., Armitage, P., & Herszberg, D. *'Mental health consumer and carer participation in professional education: Getting There Together for children of parents with mental illness and their families',* Australian Social Work, Vol. 59, pp. 406-21, 2007.

Work in partnership with families to support the recovery of a relative and to help them to identify and meet their own support needs. Eg. Support wih own responses, information needs, education to use a recovery approach, family involvement in goal setting, recovery and wellness planning. (Craze, L. (2012) *National Recovery-Oriented Mental Health Practice Framework - 2nd Consultation Draft,* on behalf of the Safety and Quality Partnership Subcommittee of the Australian Health Ministers' Advisory Council, Mental Health Standing Committee.)

- Social/Cultural Context: Potential risk factors that may occur at different ages, such as a lack of attachment in infancy, social isolation, poverty, frequent and unplanned separations from the parent, insecure housing, irregular school attendance and lack of opportunity to participate in school-based, or extra curricular, activities. Similarly, the range of factors that may serve to foster resilience at each age and stage need to be considered, such as coordinated care at the ante and post-natal stages of birth, respite care and peer support groups for children and young people and awareness of developmental issues for adolescents by adults in the young person's family, extended family or school environment as well as identifying the strengths within the child and the family unit. Cowling, V., Edan, V., Cuff, R., Armitage, P., & Herszberg, D. *'Mental health consumer and carer participation in professional education: Getting There Together for children of parents with mental illness and their families',* Australian Social Work, Vol. 59, pp. 406-21, 2007.

  Support people to maintain, establish or re-establish relationships with family, partners, children, friends, cultural networks and significant others. Support people to fulfil their parenting roles and other important relationship roles. (Craze, L. (2012) *National Recovery-Oriented Mental Health Practice Framework - 2nd Consultation Draft,* on behalf of the Safety and Quality Partnership Subcommittee of the Australian Health Ministers' Advisory Council, Mental Health Standing Committee.)

- Health and Wellbeing:

<u>Outcomes:</u>

- Increased resilience and social connectedness of children and young people with a parent with a mental illness, reduced stigma associated with mental illness, and enhanced community capacity to assist these families through partnerships between sectors and services, peer support programs, work force development and whole of community education.
- Parents who have a mental illness are able to access mental health services for treatment and rehabilitation that are also mindful of their parenting role.
- Dependent children and young people, whose parent has a mental illness, will have their needs recognised by their parent's mental health service and so have their own mental health optimised.
- Families where a parent has a mental illness will receive appropriate support to help them manage adverse circumstances and maximise each family member's resilience.
- Each family member, including dependent children and young people, can be involved in networks and service planning so that local policies and service development are relevant to the needs of families where a parent has a mental illness.
- Families where a parent has a mental illness have appropriate access to universal and targeted services that can support their needs.

Maybery, D., Reupert, A., Grove, C., Goodyear, M., Marston N. & Sutton K. (2012). *Targeted preliminary evaluation of Department of Health FaPMI strategy*. Report to Victorian Department of Health, Mental Health, Drugs and Regions Division.

<u>Collaboration:</u> There is a role in referring families and children to health, mental health or leisure and recreational services and activities

2.2.8 Peer Support – Carer Focus:

General description: "In order to be effective, a carer peer support program needs to have built into its structure and philosophy, the dual purpose of learning and support. It is recommended that a carer peer support program be properly integrated in the organisational context, with well structured policies and procedures. That is, carer mentors are properly supported by peers and coordinating staff, so that they in turn can properly support the carer mentees. It is recommended that a carer peer support program includes structured peer worker selection processes and sufficient peer support worker training. It is recommended that a carer peer mentoring program is based on national benchmarks for effective development of mentoring programs in order to coincide with existing programs. Further, that peer support/mutuality is built into the program framework. (Cassar Bartolo, K & Sanders, F. (2008) *Carer Involvement Project Gathering Lived Experience Phase 1,* ARAFEMI, Victoria.)

For the purposes of the NMHSPF Project, Peer Support work is directed at the intended/structured form of peer support, not the incidental/informal mutual support that might occur between individuals.

Information Gathering: Psychosocial and functional needs assessment to identify opportunities for peer support and mentoring.

Planning: As per the carer's prioritised objectives, provide information and facilitate access to carer peer support services where appropriate. Consider enablers and barriers to successful outcomes and assess motivation for change.

Action:

- Resources: Telephone, online and face-to-face access to information and support to reduce emotional and geographical isolation. Resources can be an informal sharing and/or structured information/psycho-education program but all peer workers and mentors should be properly trained.
- Skill Development (including Rehabilitation Focus): Informal support developing coping strategies, and knowledge. Assistance in working through own healing process/counselling, dealing with underlying grief and loss issues. Develop skills in self and systemic advocacy. Emotional impact of caring and strategies for managing everyday life, reduce social isolation.
- Social/Cultural Context: Age appropriate education about mental illness and life skills to enhance coping in children. Peer networking is a key factor to reducing social isolation and promoting emotional support.
- Health and Wellbeing: Promote strategies for coping and regular focus on carer health and wellbeing practices.

Outcomes: Reduces stress through support from people with similar experiences and increases carer satisfaction with support services. Enhances mentor's existing skills and knowledge and encourages learning of new skills/knowledge for the mentee. Opportunity to vent emotions, validation of caregiving experiences, affirmation of coping abilities, encouragement for continuing to provide care and cope with the situation, exploration of alternative caregiving arrangements, mutual support and sharing of information about community resources and coping strategies. Toseland, Rossiter, Peak and Hill, (1990) in Cassar Bartolo, K & Sanders, F. (2008) *Carer Involvement Project Gathering Lived Experience Phase 1,* ARAFEMI, Victoria.

Collaboration: Important to establish links with other services and opportunities.

Cassar Bartolo, K & Sanders, F. (2008) *Carer Involvement Project Gathering Lived Experience Phase 1,* ARAFEMI, Victoria

2.2.9 Peer Support – Consumer Focus:

General description: "People with lived experience of mental illness may work in the mental health sector in a variety of roles, both paid and voluntary. Their experience may be recognised by such titles as peer support worker, peer educator, consumer consultant and others which specifically highlight the peer to peer role and its significance to the recovery of a person experiencing mental illness.

These roles should not to be confused with the work of people with lived experience of mental illness that work in the sector in a variety of positions, and bring the benefit of their experience to their work. Not all people with lived experience choose to share that experience with their employers and/or their clients." *Comment from Mental Illness Fellowship Australia, 2012.*

"Peer support now can mean a range of services: from the most basic form of peer support (the informal mutual support provided by individuals on a one-to-one basis) through to Peer Specialists (trained and employed to provide support to consumers within mental health or addiction services); through to totally peer run standalone services (e.g. peer run respite services, addiction services or alternatives to hospitalisation)". Peters, J. (2010) *Walk the walk and talk the talk - A summary of some peer support activities in IIMHL countries,* Te Pou, NZ

For the purposes of the NMHSPF Project, Peer Support work is directed at the intended/structured form of peer support, not the incidental/informal mutual support that might occur between individuals.

Information Gathering: Psychosocial and functional needs assessment to identify opportunities for peer support and mentoring.

Planning: As per the individual's prioritised objectives, provide information and facilitate access to carer peer support services where appropriate. Consider enablers and barriers to successful outcomes and assess motivation for change.

Action:

- Resources: Telephone, online and face-to-face access to information and support to reduce emotional and geographical isolation. Resources can be an informal sharing and/or structured information/psycho-education program but all peer workers and mentors should be properly trained.
- Skill Development (including Rehabilitation Focus): Informal support developing coping strategies, and knowledge. Assistance in working through own healing process/counselling, dealing with underlying grief and loss issues. Develop skills in self and systemic advocacy. Emotional impact of caring and strategies for managing everyday life, reduce social isolation.
- Social/Cultural Context: Age appropriate education about mental illness and life skills to enhance coping in children. Peer networking is a key factor to reducing social isolation and promoting emotional support.
- Health and Wellbeing: Promote strategies for coping and regular focus on healthy behaviours.

Outcomes: Longer periods of community support between hospital admissions, less re-hospitalisation, increased discharge rates from inpatient services. Promotes choice and finds optimism, role models and motivation to drive personal recovery.

Collaboration: Important to establish links with other services and opportunities.

2.2.10 Respite - Day Programs

General description:

Access:

Planning:

Action:

- Resources:
- Skill Development (including Rehabilitation Focus):
- Social/Cultural Context:
- Health and Wellbeing:

Outcomes:

Collaboration:

2.2.11 Respite - In-home/Out of home

General description: Flexible respite meets both the needs of the carer and the care recipient, matching staff with the care recipient in terms of personality, interest, age and gender.

Adapted from Psychiatric Disability Services of Victoria (VICSERV) (2008) *Partners in Respite – Building Capacity in Community Mental Health Family Support and Carer Respite*, VICSERV, Victoria.

Access:

Planning:

Action:

- Resources:
- Skill Development (including Rehabilitation Focus):
- Social/Cultural Context:
- Health and Wellbeing:

Outcomes:

Collaboration:

2.2.12 Respite – Residential

General description: Respite services provided on a residential/overnight basis for short periods from several days to a few weeks. Respite services are generally non-clinical in nature, but may support some clinical services depending on the need of the individual with mental health issues. Residential respite may also be planned or in response to a sudden need experienced by the individual and their carer/family.

Access:

Planning:

Action:

- Resources:
- Skill Development (including Rehabilitation Focus): Education (information about illness, recovery/ looking after yourself, household management help (shopping, cooking, budgeting, cleaning, personal hygiene), vocational advice (looking for work, resumé preparation, interview techniques), a focus on Indigenous and culturally and linguistically diverse needs, flexibility (such as utilising the whole of-family and/or kinship models), a focus on carers (carer wellbeing, relaxation techniques and local services available).
  Adapted from Psychiatric Disability Services of Victoria (VICSERV) (2008) *Partners in Respite – Building Capacity in Community Mental Health Family Support and Carer Respite*, VICSERV, Victoria.
- Social/Cultural Context:
- Health and Wellbeing:

Outcomes: Improved social networks, improved self-esteem, improved health and quality respite for carers.

Collaboration:

2.2.13 Support & Rehabilitation linked to accessing and maintaining safe and secure housing including practical skills for maintaining a home and living well:

General description: Individual support and rehabilitation services provided specifically towards a consumer's personal goals of the establishment and maintenance of safe and secure housing.

The concept of safe and secure housing encompasses

- Sustainability (security) of tenure or ownership of a dwelling suitable to the needs of the consumer / carer / family
- Financial security through affordable rental or mortgage repayments, budgeting and ongoing ability to pay household bills, including during periods of unwellness
- Physical safety and security through well-maintained property and access to support for managing crises
- Environmental safety and security through social and cultural acceptance and access to neighbourhood facilities.

The services are provided on a one-to-one basis, and may be provided as in-reach for individuals stepping down from residential care, or as community outreach, assisting an individual to maintain or change their housing circumstances (eg. Individuals living with family members or group accommodation, homeless individuals or for those living independently and are at risk of homeless). Mental health services may provide housing support services themselves or connect individuals with the services provided by others for accessing and maintaining housing.

Critical factors to succeed in housing includes the availability of affordable housing, effectively engaging the housing market, maintaining personal wellness, adequate income, housekeeping and budget management skills, the provision of adequate transport and being able to successfully navigate the individual's neighbourhood and access services as required.

Information Gathering: Psychosocial needs assessment and functional assessment identifying housing needs, support available, personal strengths and areas for development. Also includes the provision of information that identifies different housing options and outlines access issues.

Planning: Development of a person-centred recovery plan driven by the consumer that identifies housing goals, referral pathways, housing providers, resource options and advocates as appropriate and associated skill development and action required.

Action: As per the recovery plan, support the individual in establishing and maintaining housing arrangements including:

- Resources: Establish financial resources, legal and tenancy support, practical support (both personally and in relation to property maintenance) and processes to support skill development. Engaging assertively with the housing market is critical to establishing safe and secure housing. Particularly in the context of liaising/networking and following up on commitments made, supporting accommodation hunting and development of the housing application. Also support the individual to access public housing tenancy support officers and rental assistance schemes, or assist with the installation of security devices, advancing or assisting with bond money and removal costs.
- Skill Development (including Rehabilitation Focus): Develop skills to improve competence and confidence in community living, particularly in relation to managing tenancy matters.
- Social/Cultural Context: Ensure housing allocation is safe and appropriate to personal and cultural circumstances. Address stigma in the social environment. Provide flexible support tailored to individual need to promote the likelihood of successful housing arrangements.
- Health and Wellbeing: Improve independence and resilience and ensure appropriate support is provided to maintain a healthy home environment.

Outcomes: Stability of housing and individual housing goals are met along with critical success factors for maintaining that housing.

Collaboration: Consumer and family/support people, housing providers, income support or management, mental and general health clinical and community support services, financial brokers, tribunals and other social, health and community opportunities.

Need to establish mental health support positions dedicated to housing issues to enhance secure housing outcomes and enhance intersectoral links, particularly between mental health, generic and dedicated housing and other social support services.

2.2.14 Support & Rehabilitation linked to education and employment:

General description: Individual support and rehabilitation services provided specifically towards a consumer's personal goals towards education and or employment. The services are provided on a one-to-one basis, and generally target the functions of accessing and supporting education and employment opportunities rather than providing the education and employment services themselves.

Information Gathering: Psychosocial needs assessment and functional assessment identifying education and employment targets, motivation to work and/or study, self-identified support needs, support available, personal strengths and areas for development. Also includes the provision of information that identifies different education/employment options and outlines access issues.

Planning: Development of a person-centred recovery plan driven by the consumer that identifies education and/or employment goals, referral pathways, service providers, resource options and advocates as appropriate and associated skill development and action required. Particularly need to consider the long term of positive effects of supporting individuals back into school, which further supports post-secondary study and subsequent employment opportunities *(McLaren, K (2004) Work in Practice – Best practice employment support services for people with mental illness, NZ)*.

Action: As per the recovery plan, support the consumer in accessing and maintaining education and employment through the following activity:

- Resources: Provide career counselling and assistance in course selection and enrolment procedures, linking to disability liaison or counselling services as required. (VETE)Establish financial counselling and access to financial support, transport services and employment/education practical support. Engage assertively with the employment and education providers to ensure a flexible and supportive environment is established. Ensure mental health staff respond flexibly to the needs and availability of the individual around their work/education commitments and pressures. Regular consumer review meetings with both mental health and employment and/or education services.
- Skill Development (including Rehabilitation Focus): Preventing relapse and coping with work/education pressures. Establishing effective employment or study strategies early in the illness trajectory may have life-long impact on employment outcomes, preventing secondary disability and associated economic and social costs. Providing a specialist VETE service ensures employment and education remain a high priority when other issues required addressing by the care coordinator (eg decline in mental or physical health). (VETE)
- Social/Cultural Context: Address stigma in the work/education environment. Provide flexible support tailored to individual need, tutoring and flexible delivery of education courses or employment arrangements promotes the likelihood of success. (VETE)
- Health and Wellbeing: Close links and integration with care coordination services, primary care, crisis intervention and accommodation issues will support the stability of health without detracting from progressing the vocational and educational goals of the individual. (VETE)

Outcomes: Completion of studies or vocational training. Participation in supported or open employment, independent income, sustained or stable involvement in employment and education.

Collaboration: Consider dedicating a combined caseload to 2-3 employment specialists to foster continuity to consumers. Foster a close working relationship with income support services and Job Capacity Assessors to ensure referrals to employment services are processed appropriately. Need to establish mental health clinical and support positions dedicated to vocational and educational issues to enhance employment and educational outcomes. Enhanced intersectoral links, particularly between mental health, generic employment and education services (eg. Resume production, course content information), Disability Employment Services, TAFE, Universities and other social support services.

A dedicated VETE specialist could carry a caseload of 25-30 consumers at any one time.

[VETE Report: Avg length of time to obtain employment was 14 weeks, Avg length of time in employment was 20 weeks, Avg hours worked per week was 22 hours and Avg rate of pay was 15.74 per hour]

Frost, B., Morris, A., Sherring, J. & Robson, E. (2008) Vocational Education, Training and Employment (VETE) Pilot Project Report – Psychiatric Rehabilitation Services 2006-2007, NSW Health, Sydney.

2.2.15 Support & Rehabilitation linked to enhancing relationships and social participation:

General description: Working with the consumer to identify and develop interests. Work with the consumer to access activities within the community to participate in. Working with the consumer to identify relationships which are important to the consumer and work on developing, maintaining and growing those relationships.

Information Gathering: Identify with the consumer what their interests are and identify what is available in the community. Identifying with the consumer, support people who may be available to assist with accessing and participating in community activities.

Planning: Working with the consumer to develop a person centred recovery oriented plan which involves developing the skills to find, access and participate in community activities. Assisting the consumer to plan every aspect of participation in social activities, this will involve identifying the resources and skill development required.

Action: as per the person centred recovery plan

- Resources: establish financial resources in order to assist with funding community activities or access to community activities. Identify and establish support to access and engage in community activities eg transport, travel skill development etc. Identify support people to assist with community integration and participation (may include workers).
- Skill Development (including Rehabilitation Focus): identify and develop skills required to access and participate in community activities eg ability to catch the bus, social presentation and skills,
- Social/Cultural Context: ensure activities planned as socially and culturally appropriate and safe for consumer.
- Health and Wellbeing: ensure that activities planned will assist with development of improved health and well being.

Outcomes: Increasing social participation and community engagement in order to meet goals connected to social inclusion.

Collaboration: Consumer and family / support people, organisations providing courses and activities, educational and vocational providers, community organisations, non government organisations

2.2.16 Support and Rehabilitation linked to health management:

General description: Assisting a person to improve or maintain his or her health or wellness. People with serious mental illness experience a life expectancy 25 years less than the general population – this is mainly due to physical health issues related to smoking, obesity and lack of physical activity. (Joe Parks research "25 years too late" http://www.abc.net.au/rampup/articles/2012/09/10/3586516.htm). It needs to

be noted that not all people with a serious mental illness experience issues related to smoking, lack of physical exercise or obesity and therefore not all consumers will require support and / or skills building in these areas. Actively seeking or establishing strategies and activities that promote good health and wellbeing. Examples might include regular physical health assessment and treatment as appropriate, massage and other forms of relaxation activities, counselling and peer support, recreational activities, skill development in health practices (eg. Cooking, cleaning, fitness).

Information Gathering: Engaging the participant in a relationship to develop a plan for health management. Assessing health status (including physical and mental health) and barriers and enablers for good health. Includes review of physical and mental health needs, thorough history and review of medication (both physical and otherwise). Collation of physical and dental health contacts and connection to these services. Assess readiness for change and skills connected with coping, health management, menu planning, shopping, cooking and fitness. Assessing readiness to engage in quit smoking initiatives (where applicable)

Planning: Prioritise and set health and wellness goals by formulating a health and wellness plan, that is driven by the participant with support in the planning process.

Action: Support the individual in developing healthy behaviours and support access and use of resources as appropriate:

- Resources: Nicotine replacement therapy, brokerage funds (Eg. to assist in accessing gym memberships or exercise clothes), respite and/or personal support services,
- Skill Development (including Rehabilitation Focus): Support the carer in building skills in healthy practices and overall health management and to engage or disengage in activities which assist in improving health. Development of insight to avoid neglecting personal health in favour of their caring role and to establish and maintain positive coping strategies.
- Social/Cultural Context: Utilising support and respite services as required to maintain and promote social relationships in work, education and social/cultural environments.
- Health and Wellbeing: As above.

Outcomes:

Better life expectancy stats – people with serious mental illness having decreased rates of smoking, obesity and increased rates of physical exercise – lower rates of cardiovascular disease, respiratory disease etc, lower rates of hospitalisation, presentation to EDs for physical health issues etc.

Collaboration: General Practice and other health services, community health management organisations (Eg. Gyms, swimming pools, weight management services, smoking cessation services), other recreational, educational and vocational services and mental health care and related support services.

2.3 INDIVIDUAL SUPPORT AND REHABILITATION SERVICES

Descriptor

Includes individualised support and psychosocial rehabilitation that might include functions such as assessment, planning, skill development, coaching/mentoring, counselling, facilitation of access and/or negotiation of relationships. The service provided occurs in the context of outreach support and may or may not be linked to an individuals' accommodation. May also include support to access community transport, domestic support, community participation, recreational and health management activities.

Personalised Support is fundamentally a non-clinical service that is performed by appropriately qualified workers (which may include having lived experience as a consumer or carer) generally working in the community environment.

Distinguishing Features

Key distinguishing attributes would be services that are:

- Individualised in their focus of care and intensity of support;
- Provided by suitably qualified service providers that would not be included in the specialised clinical ambulatory services; and
- May or may not be linked to the provision of accommodation.

Inclusions

Services included in this element are summarised as follows (Siskind et al, 2012):

- Living Skills - aim to improve the day to day functioning of consumers through side by side instruction, role-modelling, corrective feedback and positive reinforcement (Eg. Shopping, cooking, budgeting, personal hygiene, public transport)
- Therapeutic Services – includes psychoeducation, family therapy, grief therapy, mediation, recovery programs.
- Social Inclusion - includes support in engaging in communities of meaning and choice, such as engaging in community events, peer based activities, recreation, music, art, physical activities and accessing health management/GP care.
- Early Intervention – intensive outreach and assertive psychosocial support to consumers in crisis with an aim to avoid hospitalisation. Aims to provide extra support to resolve psychosocial stressors, symptom management and medication adherence.
- Psychosocial rehabilitation – range of support and skill development activities oriented towards empowerment, recovery and individual capacity.
- Emotional support - aims to assist consumers in addressing acute and ongoing psychosocial stressors through activities including befriending, listening, providing practical problem solving and management of stressors.
- Advocacy - is to build capacity in a person to advocate on their own behalf or speaking, acting or writing on behalf of a person to improve their welfare.

Housing linked support may also include:

- Coordinated housing and support
- Cluster housing programs
- Long term supported housing

Exclusions

These services exclude employment and education personalised support, carer support and brokerage as these services are incorporated under other elements.

Example Services

- Personal Helpers and Mentors Service (PHaMS)
- Home Based support (HBOS) Victoria
- Individual Psychosocial Rehabilitation and Support Services (IPRSS) SA.
- Housing and Accommodation Support Initiative (HASI) NSW
- Housing and Support Program (HASP) Qld
- Housing and Accommodation Support Partnership (HASP) Program SA
- Individualised Community Living Strategy (ICLS) WA.

Taxonomy

- Individual Support & Rehabilitation
- Individual Peer Support

.References

Siskind, D., Harris, M., Pirkis, J., & Whiteford, H. (2012) "Personalised support delivered by support workers for people with severe and persistent mental illness: a systematic review of patient outcomes." *Epidemiology and Psychiatric Sciences,* **21**, 97-110

AIHW Non-Government Organisation Establishment (NGOE) National Minimum Dataset (NMDS) Service Taxonomy (draft April 2012)

2.3.1 Individual Support & Rehabilitation

Attribute	Details
Services Delivered	Includes individual support services provided to the person wherever they are living, this can include people who are homeless. Examples of services delivered are: o assist people to self manage their own recovery and build on their interests, aspirations and strengths to live full and active lives o develop skills to improve competence and confidence in community living o improve health and well-being o improve independence and resilience o prevent relapse and limit severity of any crisis o engage the consumer with desired community and social activities o reduce social and physical dislocation by assisting people to sustain suitable housing and to develop improved social relationships o increase opportunities to participate in the workforce o reduce demand on acute and emergency services. Rehabilitation at its most basic form refers to assisting a person to build or rebuild skills that enable them to engage in their lives more independently. Anthony and Farkas are quite specific about all workers having an understanding and knowledge of rehabilitation. "Regardless of the discipline or background of the practitioner, the source of funding or the setting in which people are working, people who help people with severe mental illnesses improve their functioning and gain valued roles in the community should be aware of the essentials of the psychiatric rehabilitation process, its program models and the principles underlying its practice." The services may be delivered in partnership between clinical and non clinical staff. Rehabilitation specialists with clinical training and experience provide individually tailored rehabilitation assessments, interventions and services. They are likely to have undergone post graduate study and training to develop their expertise. Some of the services that clinicians may deliver are summarised below: **OTs** o Functional assessment (independent living skills, functional cognition, social skills) o Assessment of motivation, routines, roles, skills and environment o Assessment of community support needs

	○ Sensory processing / Modulation ○ Task analysis ○ Graded skills acquisition interventions **Clinical Psychology** ○ Provision of specialised evidence-based therapies for specific disorders in individual and / or group based formats **Vocationally trained staff** ○ Provide practical rehabilitation interventions in their everyday work that aim to support the person to regain skills, independence and self-determination. They are likely to have undergone rehabilitation specific training and engage in supervision with a focus on rehabilitation. (Anthony W, Farkas M. *The Essential Guide to Psychiatric Rehabilitation Practice*. Boston: Boston University Center for Psychiatric Rehabilitation, Boston 2011.) Action
Key Distinguishing Features	Individual support is delivered to people wherever they are living. Rehabilitation needs to be distinguished from support. Both activities usually happen at the same time with a coordinated approach by workers, however rehabilitation is goal focussed and often time limited (ie once the person has built or rebuilt the skill/s required then either another skill or set of skills is targeted or rehabilitation is no longer required). Can occur in a wide variety of settings eg in the person's home, in the community, in residential facilities or in inpatient facilities.

Service specifications & other useful descriptors to illustrate service elements.

Intensity	**LOW**	**MEDIUM**	**HIGH**	**INTENSIVE**
Target Age:	16 +	16 +	16 +	16 +
Diagnostic Profile	Have a diagnosed mental illness and experience mild to moderate level of psychiatric disability. Require assistance in one domain	Have a diagnosed severe mental disorder and experiencing moderate to severe level of psychiatric disability. Require assistance in 1 – 2 domains	Have a diagnosed severe mental disorder and experiencing moderate to severe level of psychiatric disability. Require assistance in more than 2 domains	Have a diagnosed severe mental disorder and experiencing moderate to severe level of psychiatric disability. Require intensive assistance in more than 2 domains
Avg incidence				
Suggested Modelling Attributes				
Avg contact hours per individual support activity (timeframe)	Emotional Support – Low 1 hour/week (1 to 12 weeks) Individual Advocacy – Low-Medium 1-4 hours/week (1 hour to 12 weeks)	Living Skills – Medium 1-4 hours/day (2 weeks to lifetime) Emotional support – Medium 1-4 hours/day (2 weeks to life) Social Inclusion– Medium 1-4 hours/day (1 to 12 weeks)	Early intervention – High 4-24 hours/day (2 weeks to 3 months)	
Avg contact hours per rehabilitation activity	1.5 hours (one weekly session)	6 hours (1.5 X 4 times a week)	12 hours (1.5 X 8 times a week)	21 hours (1.5 session twice a day, 7 days a week)
Avg contact hours per activity re housing	2.5 hours a week (range is between 1 – 4 hours a week)	8 hours a week (range is between 5 – 12 hours a week)	16 hrs / week	28 hrs / week
NDIS hrs/week % Severe rating No. Clients	1.5 hrs/wk 55% 31,000 people	5 hrs / week 10% 26,000 people	10 hrs / week 25% 14,000 people	28 hrs / week 10% 6,000 people
Indicative number of places per 100k	VIC: Low $7,000 pkge 71.5	Medium $14,000 package- 11.7 places/ 100K	High $75,000 package - 2.2	

Eg. From VICTORIA: Home Based Outreach-Intensive	places/100K. QLD:	QLD: 120/100K places not tied to housing across all severity	places /100K	
Indicative FTE per 100k Eg. From QLD	Low support = 6.7	Medium support = 2.3	High support = 3.7	
Hours – individual support	Predominantly business hours, some weekend (?20%)	70% business hours 30 % after hours / weekend		25% would be on weekends, 25% would be after hours
Hours – Individual Rehabilitation	Business hours	75% business hours 25% after hours / weekend hours	75% business hours 25% after hours / weekend hours	50% business hours 50% after hours / weekend hours
Hooks				

Suggested Activities

Activity	Measure/ Parameters for modelling	Staff Profile Options
Individual Support & Rehabilitation linked to accessing and maintaining safe and secure housing.	• Contact hours per week • FTE per 100K • Staffing Profile • After hours costs / proportion	1. Vocationally Qualified Mental Health Workers / Associate Professional 2. Consumer & Carer (includes Peer Workers) 3. Nurse 4. Psychologist / Social Worker / OT
Individual Support & Rehabilitation linked to education and employment.	•	5.
Individual Support & Rehabilitation linked to social participation.	•	6.
Individual Support & Rehabilitation linked to practical skills for maintaining a home and living well.	•	7.
Individual Support & Rehabilitation linked to navigating the primary and mental health care systems.	•	8.
Individual Support and Rehabilitation linked to health management.	•	9.
Brokerage	• FTE • Funding ($)	10.

2.3.2 Individual Peer Support

Attribute	Details
Services Delivered	Individually oriented services that share a common interest, share lived experiences that are led and self managed by peer workers. Includes services that aim to empower and support individual consumers or carers by sharing life experiences with people who have similar experiences and to help develop support networks for crisis situations. Have a mental health promotion and prevention function through 'wellbeing' benefit. Includes consumer self help or individualised peer support services. The components of effective mentoring programs includes: • The agency having structures and procedures to support the mentor program. Eg. Agency support for the coordinator, regular monitoring/reinforcing agency guidelines by coordinator for mentor (being a role model for the mentor by demonstrating consistency, reliability, interest, engagement, availability and responsiveness); • Mentor and mentee are matched on the basis of shared experience. Eg. Caregiver status; gender and relationship to care recipient; language, culture and ethnicity; or characteristics of the person cared for; • The mentor is selected for the program and paired with a mentee based upon having more experience than the mentee; • There are various group formats that can be used; where there are multiple mentors

	(business models), multiple mentees (eg. Education) or where a group of mentor-mentee dyads meet regularly (eg. School context); • The act of mentoring can be that of supporter, consultant, trainer, a reflective process, observing and giving feedback, buddy and tutor, listener; • Meetings between mentor and mentee can be face-to-face, telephone-based, in-home, involve structured activities, tailored to individual needs, mentee following mentor doing normal day-to-day activities; and • A resource library, website of mentor/mentee participants. A dedicated meeting place provided by the agency where they can feel safe, welcome and understood. Therefore, a carer peer support program should include: Is this reasonably the same for consumer peer support? • Monitoring of program implementation and during the running of the program (keeping in touch with mentors and mentees); • Screening of prospective mentors (expectatiosn, place in one's caring journey) • Matching of mentor-mentee pairs (gender, residential area, relationship to person with the mental illness and type of illness); • Mentor training (initially and ongoing) in mental health issues and peer support training; • Offering peer support for carer mentors (mentor peer support group, for debriefing, for training refresher/updates). *Cassar Bartolo, K & Sanders, F. (2008) Carer Involvement Project Gathering Lived Experience Phase 1, ARAFEMI, Victoria.*
Key Distinguishing Features	Key distinguishing attributes are that the service must be delivered by a peer worker (Note that the organisation providing the service may or may not be a peer operated entity) and the service provided is predominantly focused on individual support. **(CONSIDER PEER SUPPORT WORK BY MHWAC, ALSO ONLINE PEER SUPPORT PROGRAMS)**

Service specifications & other useful descriptors to illustrate service elements.

Intensity:	LOW	MEDIUM	HIGH	INTENSIVE
Target Age:				
Diagnostic Profile		Mental health consumers at all levels of severity of disorder (mild, moderate and severe)		
Avg incidence				
Suggested Modelling Attributes				
Average support hours				
Indicative number of places per 100k		QLD: 4.1% total NGO budget (total Mutual support services)		
Indicative FTE per 100k				
Hours What proportion are business hours and after hours?				

Suggested Activities

Activity	Measure/ Parameters for modelling	Staff Profile Options
Individual Consumer Peer Support	• Contact hours per week • FTE per 100K • Staffing Profile • After hours costs / proportion	1. Peer Support Workers
Individual Carer Peer Support	•	2.

2.4 GROUP SUPPORT AND REHABILITATION SERVICES

Descriptor

Group support activities are services that aim to improve the quality of life and psychosocial functioning of mental health consumers, through the provision of group-based social, recreational or prevocational activities. With the exception of peer support services, Group support activities are led by a member of the community managed organisation.

Distinguishing Features

- Delivered to groups of consumers simultaneously
- Primarily engage consumers in one or more social, recreational, prevocational or physical activities
- Centre-based or conducted in community environments
- Led by an NGO employee or representative that may or may not be a peer worker.
- Structured or unstructured group support and activities

Inclusions

- Neighbourhood, community & drop-in centres
- Structured community day programs
- Leisure & recreation activities
- Psychoeducational progams
- Clubhouses
- Support for day-to-day living

Exclusions

- Self-help and mutual support activities delivered on a group basis.

Example Services

- Helping Hands
- Pananga Clubhouse

Taxonomy

- Group Support & Rehabilitation Services
- Group Based Peer Support

Source

AIHW Non-Government Organisation Establishment (NGOE) National Minimum Dataset (NMDS) Service Taxonomy (draft April 2012)

2.4.1 Group Support & Rehabilitation Services

Attribute	Details		
Services Delivered	Group based services that aim to improve the quality of life and psychosocial functioning of mental health consumers. Included in this element are psychosocial group programs, recovery oriented groups (eg. Exercise/Sport/Recreational, Community Access, lifeskills, health management, volunteering, opportunity programs, consumer/carer education, arts based therapeutic services, leadership programs, relaxation/mindfulness and groups for specialised populations). Note that these groups may or may not be run by peer workers, but exclude groups that are specifically delivered by peer workers.		
Key Distinguishing Features	Key distinguishing attributes would be services that may or may not require a specific facility but could be hosted in a number of environments and would generally be of short duration (eg. Group program of 2 hours). The group programs may or may not be structured (eg. two hour session for 6 weeks) and might be time limited or ongoing. Note that dedicated peer support services are included in the Group Based Peer Support Element and are out of scope for this element. Also excludes groups with the specific focus of employment and education objectives.		
Service specifications & other useful descriptors to illustrate service elements.			
Target Age:	**0-17yrs**	**18-64 yrs**	**65+ yrs**
Diagnostic Profile		Severe and persistent mental Illness.	
% Client target Pop'n		Structured Day Programs – 30% Drop in Centres – 25%	
Avg contact hours per activity & timeframe		Structured Day Programs – Medium Support – 3hrs per day, 3x days per week, 25 weeks per year = 225hrs/client/year Drop in Centres – Low Support – 2 hrs per day, 1.5 days per week, 15 weeks per year = 45 hours per client per year.	
Total client participation hours available per year, pre place.		Structured Day Programs – 6 hrs per day, 5 days per week, x 46 wks per year = 1380 hrs / year Drop in Centres – 6 hrs per day, 5 days per week, x 46 wks per year = 1380 hrs/year	
Suggested Modelling Attributes			
Average provider hours			
Indicative number of places per 100k		Structured Day Programs – 12.26 Drop in Centres – 2.04	
Indicative FTE per 100k		Structured Day Programs – 3.07 / 0.25 Drop in Centres – 0.31 / 0.15	
Overhead Costs			

Hours		Drop In Program – Flexible Structured Day Program – Business hrs	
Suggested Activities			
Activity		**Measure/ Parameters for modelling**	**Staff Profile Options**
Group Support & Rehabilitation linked to accessing and maintaining safe and secure housing		• Average Provider Hours	Oversight: Clinician Group leader would be vocationally qualified professional.
Group Support & Rehabilitation linked to education and employment.		•	
Group Support & Rehabilitation linked to enhancing relationships and social participation		•	
Group Support & Rehabilitation linked to practical skills for maintaining a home and living well.		•	
Group Support & Rehabilitation linked to navigating the primary and mental health care systems.		•	
Group Support and Rehabilitation linked to health management.		•	
Facility Operational Costs		• Operational Cost per hour	

2.4.2 Group Based Peer Support

Attribute	**Details**
Services Delivered	Group based services that share a common interest and are led and self managed by peer workers. Includes services that aim to empower and support individual consumers or carers by working through group processes and sharing life experiences with people who have similar experiences and to help develop support networks for crisis situations. Have a mental health promotion and prevention function through 'wellbeing' benefit. Include Voice Hearing Group, Symptom Management Group, arts based/recreation based programs and Grow.
Key Distinguishing Features	Key distinguishing attributes would be services that may or may not require a specific facility but could be hosted in a number of environments and would generally be of short duration (eg. Group program of 2 hours). The group programs may or may not be structured (eg two hour session for 6 weeks) and might be time limited or ongoing. Also excludes groups with the specific focus of employment and education objectives. **(CONSIDER PEER SUPPORT WORK BY MHWAC, ALSO ONLINE PEER SUPPORT PROGRAMS)**

Service specifications & other useful descriptors to illustrate service elements.			
Target Age:	**0-17yrs**	**18-64 yrs**	**65+ yrs**
Diagnostic Profile		Mental health consumers at all levels of severity of disorder (mild, moderate and severe)	
Avg incidence			
Avg contact hours per activity (timeframe)			
Suggested Modelling Attributes			
Average provider hours			
Indicative number of places per 100k		QLD: 4.1% total NGO budget (total Mutual support services)	
Indicative FTE per 100k			
Hours		Flexible	
Suggested Activities			

Activity	Measure/ Parameters for modelling	Staff Profile Options
Group Based Peer Support Program	• Average Provider Hours • Places per 100K • FTE per 100K • Hours	Susan to follow up with Frances from Arafmi.
Facility Operational Costs	• Operational Cost per hour	

2.5 OTHER RESIDENTIAL SERVICES – NON-CLINICAL

Descriptor

A residential mental health service is a service established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability.

Distinguishing Features

The service also has the following characteristics:

- Has the workforce capacity to provide specialised mental health services; and
- Employs suitably trained mental health staff to provide rehabilitation, treatment or extended care on-site:
    - To consumers residing on an overnight basis;
    - In a domestic-like environment;
    - Encourages the consumer to take responsibility for their daily living activities; and
    - Staff are on –site for a minimum of 6 hours per day and at least 50 hours per week.

Inclusions

- These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing (but the trained staff must be on site for a minimum of 6 hours a day and at least 50 hours per week).
- Residential Respite
- Crisis residential services
- Supported Hostels

Exclusions

- Note that residences occupied by admitted patients located on hospital grounds, whether on the campus of a general or stand-alone psychiatric hospital, should be counted in the category of admitted patient services and not as community based residential services;
- Services that are visited via in-reach services provided by Community Sector Organisation staff, but where the residence is not regarded as the CSO worker's place of employment; and
- Clinical residential services.

Example Services

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Taxonomy

- Other Residential Services

Source

- National Health Data Dictionary V.15
- AIHW Non-Government Organisation Establishment (NGOE) National Minimum Dataset (NMDS) Service Taxonomy (draft April 2012)

2.5.1 Other Residential Services

Attribute	Details
Services Delivered	Very brief community based supported residential service providing a secure environment and access to psychosocial services. The service may be provided in the context of emergency/crisis housing, transition between inpatient and community living (stepping up or down), or as a respite option for carers. Includes Step-Up/Step-Down services, Residential respite and very short term crisis accommodation. Medium term supported residential services with objectives towards rehabilitation, recovery planning, relapse prevention and improvement in independent living skills for consumers at risk of homeless. Includes residential transitional support and rehabilitation services. Long term supported residential services provided in a home like environment. Focus of care includes long term recovery planning, skill development, rehabilitation, relapse prevention and development of community living skills. Includes long term supported accommodation and hostels. List Indicative Activities
Key Distinguishing Features	Service provides staffed residential mental health care with length of stay less than 28 days. These services are not primarily staffed by specialised clinicians, but may include visits from clinicians.

Service specifications & other useful descriptors to illustrate service elements.			
Intensity:	**LOW INTENSITY**	**MEDIUM INTENSITY**	**HIGH INTENSITY**
Target Age:	16+ years	16+ years	16+ years
Diagnostic Profile			Consumers who no longer require acute inpatient treatment who would benefit from short-term, intensive treatment and support (Step Down) and consumers who are living in the community who require short term residential support to prevent the risk of further deterioration and relapse (Step Up)
Avg incidence			
Avg contact hours per activity	Brokered Housing – 2-10 hours /week Transitional Support – 10 hours/week Supported Hostels – 2-10 hours per week	Residential Respite –16-24 hour/day Residential Rehabilitation – 8-23 hours/day Long Term Support – 5-27 hours/week	Residential Respite –24 hour/day, Crisis Accommodation 24 hours/day, Step-Up/Step-Down services. Residential Rehabilitation – 24 hours/day Long Term Support – 24 hours/day
Staff Hours on site	Staffed <8 hours/day	Staffed 8-24 hour/day	Staffed 24 hours/day
Suggested Modelling Attributes			
% Occupancy			
Avg length of stay			
Beds per 100K	Supported Hostels 35	Residential Rehabilitation -	Crisis Accommodation– 3 beds per 100K

	beds per 100K	<24 hrs/day – 10 beds per 100K.	Residential Rehabilitation 24 hr – 5 beds per 100K
Indicative staffing FTE/Bed	Supported Hostels 4.7 per 100K	Residential Rehabilitation - <24 hrs/day – 4.2 FTE / 100K.	Crisis Accommodation 3.5FTE/100K 24 hr Residential Respite 3.5FTE/100K Residential Rehabilitation 24 hr – 5.9 FTE/100K
Staff : Consumer Ratio			
Avg Staff Hours on site			
Hooks			

Suggested Activities		
Activity	**Measure/ Parameters for modelling**	**Staff Profile Options**
Crisis Accommodation 24 hr	Per day	
Residential Respite 24 hrs	Per day	
Crisis Accommodation <24 hrs	Per day	
Supported Hostel	Per day	

2.6 FAMILY AND CARER SUPPORT SERVICES

Descriptor

Family and carer support services are services that provide families and carers of people living with a mental illness support, information, education and skill development opportunities to fulfil their caring role, while maintaining their own health and wellbeing (Mission Australia 2012). Recognises that Carers and families have their own life and experiences that are affected by the consumer experience of mental illness. Have a right to pursue their own goals and life outside of their caring responsibilities.(Carer Recognition Act). Recognition that the consumers' goals may be in conflict with Carer's goals.

Succession issues – is the accommodation stable for the consumer after the carer's demise?

Distinguishing Features

- Explicitly targeted at carers and families
- Includes all services focused on family and carer support except staffed residential respite services. Therefore, this includes services that, if they were not targeted at families and carers, would be reported in other service types

Inclusions

- Carer and family programs
- In-home and or day respite for carers
- Family-focused early intervention services
- Day respite

Exclusions

- Residential respite services

Example Services

- National Respite for Carers Program
- Young Carer Program
- Family Mental Health Support Services
- ARAFEMI

Taxonomy

- Responsive Respite
- Family and Significant Other Support Services
- Individual Carer Support

- Group Based Carer Support

Source

- AIHW Non-Government Organisation Establishment (NGOE) National Minimum Dataset (NMDS) Service Taxonomy (draft April 2012)

2.6.1 Responsive Respite

Attribute	Details
Services Delivered	Responsive respite "should also have the capacity to directly respond to carer needs. This can be achieved through the provision of resources to the carer in order for them to continue in their caring role. The guiding principles underpinning this approach are flexibility and responsiveness. *Cassar Bartolo, K & Sanders, F. (2008) Carer Involvement Project Gathering Lived Experience Phase 1, ARAFEMI, Victoria.* Flexible respite care responsive to carer/consumer needs. Would include crisis respite, short term or regular respite services, young carers respite and working carers' respite. Two way flexibility of consumer/carer respite (ie consumer may be cared for within the home or taken out to an activity). Centre based respite care, (eg. Day to Day Living program) and overnight care are included.
Key Distinguishing Features	Key distinguishing attributes would be that these services are specifically engaged to provide a respite function in the carers home or by taking the consumer out to another activity. Note that this excludes community based respite as this is dealt with in other categories. The respite service is centre based and does not involve any overnight care.

Service specifications & other useful descriptors to illustrate service elements.			
Target Age:	**0-17yrs**	**18-64 yrs**	**65+ yrs**
Diagnostic Profile			
Avg incidence		Community Day Respite – 15%	
Avg contact hours per activity (timeframe)		Community Day Respite – Medium Support – 6hrs per day, 5x days per week, 2 weeks per year = 60 hrs/client/year	
Total client participation hours available per year, per place.		Community Day Respite – 6 hrs per day, 5 days per week, x 46 wks per year = 1380 hrs / year	
Suggested Modelling Attributes			
Average individual support hours			
Average provider hours			
Indicative number of places per 100k		Community Day Respite – 1.64	
Indicative FTE per 100k		Community Day Respite – 0.41 / 0.25	

Suggested Activities		
Activity	**Measure/ Parameters for modelling**	**Staff Profile Options**
In-home/Out of home Respite	• Average Individual Support Hours	
Day Respite	• Places per 100K • FTE per 100K • Average provider hours	

Facility Operating Costs	• Facility Operational Costs per hour	

2.6.2 Family and Significant Other Support Services

Attribute	Details
Services Delivered	Services targeted at the family community in contrast to the individual and may be directed towards re-engagement of the individual with the family (ie family members currently not in a caring role because of disengagement). Would include information, family mediation and re-engagement, COPMI, and family oriented counselling.
Key Distinguishing Features	Key distinguishing attributes would be services that may or may not be provided by a peer worker and are specifically focused on the needs of the family (ie parents, siblings, other caregivers). **BOUVARIE FAMILY CENTRE IN MELBOURNE, PART OF LA TROBE.**

Service specifications & other useful descriptors to illustrate service elements.			
Target Age:	**0-17yrs**	**18-64 yrs**	**65+ yrs**
Diagnostic Profile			
Avg incidence			
Avg contact hours per activity (timeframe)			
Hours			
Suggested Modelling Attributes			
Average support hours per family?			
Indicative number of places per 100k			
Indicative FTE per 100k			

Suggested Activities		
Family Support	• Contact hours per week • FTE per 100K • Staffing Profile • After hours costs / proportion	1. Vocationally Qualified Mental Health Workers / Associate Professional 2. Consumer & Carer (includes Peer Workers) 3. Nurse 4. Psychologist / Social Worker / OT / Dieticians/ Speech Pathologists / Physical Therapists
Facility Operating Costs`	• Facility Operational Costs per hour	1.

2.6.3 Individual Carer Support

Attribute	Details		
Services Delivered	Needs identified by carers include: • Increased community awareness about the signs and symptoms of mental illness to facilitate detection, early intervention and support; • Increased recognition of the experiences and needs of carers and provision of information and referral for support; • Increased recognition and assistance to overcome the impact of living with a person with mental illness (relationships, family dynamics, reduced level of intimacy, social and emotional distancing, restricted social relationships); • Assistance with significant financial costs related to caring (accessing treatment, demands of specific aspects of the illness, time from work and ability to continue employment; • Increased access to effective treatment via better knowledge and awareness, availability of information, increased awareness and skills among health professionals and effective early intervention or crisis management. • Better inclusion of carers' needs and concerns – voice – and more inclusive approaches to treatment and management." *Victorian Mental Health Network (2004) in Cassar Bartolo, K & Sanders, F. (2008) Carer Involvement Project Gathering Lived Experience Phase 1, ARAFEMI, Victoria.*		
Key Distinguishing Features	Key distinguishing attributes would be services that may or may not be provided by a peer worker, are specifically focused on the needs of the carer (in contrast to personalised support for the consumer) and are provided in a group format.		
Service specifications & other useful descriptors to illustrate service elements.			
Target Age:	**0-17yrs**	**18-64 yrs**	**65+ yrs**
Diagnostic Profile			
Avg incidence			
Avg contact hours per activity (timeframe)			
Suggested Modelling Attributes			
Average individual support hours			
Average Provider hours			
Indicative number of places per 100k			
Indicative FTE per 100k			
Hours			
Suggested Activities			
Activity		**Measure/ Parameters for modelling**	**Staff Profile Options**

Individual Support & Rehabilitation linked to accessing and maintaining safe and secure housing.	• Contact hours per week • FTE per 100K • Staffing Profile • After hours costs / proportion	1. Vocationally Qualified Mental Health Workers / Associate Professional 2. Consumer & Carer (includes Peer Workers) 3. Nurse 4. Psychologist / S.Worker / OT
Individual Support & Rehabilitation linked to education and employment.	•	5.
Individual Support & Rehabilitation linked to enhanced relationships and social participation.	•	6.
Individual Support & Rehabilitation linked to practical skills for maintaining a home and living well.	•	7.
Individual Support & Rehabilitation linked to navigating the primary and mental health care systems.	•	8.
Individual Support and Rehabilitation linked to health management.	•	9.
Brokerage	•	10.

2.6.4 Group Based Carer Support

Attribute	Details
Services Delivered	Would include group based counselling or post suicide support, includes young carers and COPMI. Would include psychoeducation and training services, group based peer support, including young carers and COPMI.
Key Distinguishing Features	Key distinguishing attributes would be services that may or may not be provided by a peer worker, are specifically focused on the needs of the carer (in contrast to personalised support for the consumer) and are provided in a group format.

Service specifications & other useful descriptors to illustrate service elements.			
Target Age:	**0-17yrs**	**18-64 yrs**	**65+ yrs**
Diagnostic Profile			
Avg incidence			
Avg contact hours per activity (timeframe)			
Suggested Modelling Attributes			
Average individual support hours			
Average Provider hours			
Indicative number of places per 100k			
Indicative FTE per 100k			
Hours			

Suggested Activities		
Activity	**Measure/ Parameters for modelling**	**Staff Profile Options**
Group Support & Rehabilitation linked to accessing and maintaining safe and secure housing	• Average Provider Hours	Oversight: Clinician Group leader would be vocationally qualified professional.
Group Support & Rehabilitation linked to education and employment.	•	
Group Support & Rehabilitation linked to	•	

enhanced relationships and social participation		
Group Support & Rehabilitation linked to practical skills for maintaining a home and living well.	•	
Group Support & Rehabilitation linked to navigating the primary and mental health care systems.	•	
Group Support and Rehabilitation linked to health management.	•	
Facility Operational Costs	• Operational Cost per hour	

3 Specialised Bed Based Mental Health Services

3.1 SERVICE ELEMENTS FOR THE SPECIALISED BED BASED MENTAL HEALTH SERVICES

Acute Inpatient Services (Hospital Based)

- Perinatal and Infant Mental Health
- Child (0- 13 years)
- Youth (14-17 years)
- Youth-Early Psychosis (16-24 years)
- Adult (18-64 years)
- Older Adult (65+ years)
- Adult Eating Disorders
- Intensive Care Units
- Psychiatric Emergency Care Units
- Same day admission for the administration of ECT
- Consultation Liaison - General
- Consultation Liaison - Emergency Department

Sub-Acute Services (Residential and/or Hospital/Nursing Home Based **)

- Step up/down – Youth
- Step up/down – Adult
- Step up/down – Older Adult **
- Rehabilitation – Youth
- Rehabilitation – Adult
- Rehabilitation – Older Adult **
- Intensive Care Services**

Non-Acute Services (Residential and Hospital or Nursing Home Based **)

- Intensive Care Services**
- Adult (<24 hour support)
- Adult (24 hour support)
- Older Adult **
- Specialised services **

1.1 ACUTE INPATIENT SERVICES

Descriptor

Acute inpatient treatment is driven primarily by the need to respond to risk associated with a consumer's symptoms, behavioural disturbance and/or distress which are associated with the recent onset or exacerbation of a mental illness.

Distinguishing Features

- The primary goal of care is reduction in severity of symptoms and/or distress associated with the recent onset or exacerbation of a mental illness.
- Services are delivered by a multidisciplinary team of health care professionals operating as part of a local integrated mental health service system.
- Acute care average lengths of stay are measured in days or weeks.
- Specialist stand alone units or sub-units of larger units may be provided for mothers and infants, children, youth, adults and for older adults.
- Units may be gazetted or declared to allow for involuntary detention.

Inclusions

- Acute mental health inpatient units co-located with acute general hospitals and private hospitals.
- In a small number of cases services are still provided by units located on psychiatric hospital campuses.
- Acute care provided in specialist acute units in prisons and/or forensic units (out of scope for this stage of the project).
- Acute or crisis care provided in specialist units described as psychiatric emergency care centres (PECCs) or psychiatric assessment and planning units (PAPUs) in emergency departments in general hospitals.
- Acute care provided in intensive or high dependency units operating as part of an acute mental health inpatient service. Between 10 and 20 percent of acute inpatient beds are usually provided as secure intensive care units.
- Acute care provided for mothers and infants in a designated perinatal and infant mental health unit.
- Acute care provided for adults with eating disorders in a specialist mental health inpatient unit.
- Day only admission for the administration of Electro-convulsive therapy (ECT).
- Consultation-Liaison services provided to generic wards and emergency departments in general hospitals.

Exclusions

- Acute care provided in homes or other places in the community (considered as part of ambulatory services).

Example Services

- Inner West AMHS-Royal Melbourne Hospital Acute Inpatient Unit and Parkville Orygen Youth Health Acute Inpatient Unit. Victoria.
- WMIMHS - Ipswich General Hospital Acute Mental Health Unit and Older Persons Acute Unit. Queensland.

- RBH-PECC Unit. Queensland.
- Birunji Youth Unit (16-28) Campbelltown Hospital. New South Wales
- Bank House Infant and Child Mental Health Unit. New South Wales.
- The Mother Baby Unit – Austin Hospital, Victoria.
- The Perth Clinic – Western Australia.

Taxonomy – Acute Inpatient Services

- Perinatal and Infant Mental Health
- Child
- Youth
- Youth-Early Psychosis
- Adult
- Older Adult
- Adult Eating Disorders
- Intensive Care Units
- Psychiatric Emergency Care Units
- Same day admission for the administration of ECT
- Consultation Liaison - General
- Consultation Liaison - Emergency Department

1.1.1 Perinatal and Infant Acute Mental Health Inpatient Service

Attribute	Details
Status	Gazetted
Services Delivered	Short to medium term, and intermittent voluntary and involuntary, inpatient care for mothers and their infants, where the mother exhibits signs and/or symptoms of severe mental illness that have not responded adequately to less intensive interventions in the community and/or the safety and treatment needs of the dyad/family warrant admission.
Key Distinguishing Features	Units are located on general hospital campuses and designed and operated to meet the special needs of mothers and babies. The inpatient unit works as part of an integrated model which includes specialist day centre, consultation liaison and ambulatory care services which may be delivered across a number of area or district services.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Mothers in the third trimester and Mothers and infants up to 36 months.
Diagnostic Profile	Majority of consumers may present with a primary diagnosis of major depression. Consumers with a variety of other disorders can also be treated. This may include schizophrenia and related disorders; affective disorders; anxiety disorders, personality and behaviour disorders and substance use disorders.
Avg incidence	6 admissions per 1000 deliveries
Average unit size and bed rate/100k	A mother-infant unit with a fully integrated community mental health team requires 0.5 beds per 1000 deliveries. If no such complementary services are available then 0.75 beds per 1000 deliveries. 6-9 beds for every 1-1.5 million of the population (annual birth rate 12,500 – 18,000)
Hours	24hrs / 7 days.
Suggested Modelling Attributes	
% Occupancy	87% (MH-CPP)
Avg length of stay	Less than 12 days
28 day readmission rate	Within range 7 to 10 percent
Indicative staffing FTE/Bed	2.7 clinical FTE per bed assuming co-location with other acute inpatient mental health services and access to paediatric and lactation services.
Sources	• Perinatal and Infant Acute Mental Health Services Model of Service Delivery, QPMHS, 2011 (Draft). – Primary Source. • Royal College of Psychiatrists, Standards for Mother and Baby Units, UK, 2008

1.1.2 Acute Mental Health Inpatient Services (age related)

Attribute	Details			
Status	Gazetted			
Services Delivered	Short to medium term 24 hour inpatient assessment and treatment services for people experiencing severe episodes of mental illness who cannot be adequately treated in the community. The core business is to provide multidisciplinary specialist assessment, collaborative, recovery oriented treatment and evidence based, best practice clinical interventions and discharge planning in a safe, therapeutic and consumer friendly environment.			
Key Distinguishing Features	Programs primarily provide specialist psychiatric care for people with acute episodes of mental disorder. These episodes are characterised by recent onset of severe clinical symptoms of mental disorder that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that this treatment effort is focused on short-term treatment. Acute services may be focused on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing mental disorder for whom there has been an acute exacerbation of symptoms			
Service specifications & other useful descriptors to illustrate service elements.				
Target Age:	Children. 0-13 yrs	Youth 14-17 and 16-24 yrs	Adults 18-64 yrs	Older Adults 65+ yrs
Diagnostic Profile	Severe behavioural, emotional or stress-related disorders. Children will often present with co-morbid disorders in relation to development issues such as learning and language difficulties, emotional expression and eating disorders.	Youth (14-17) Depression/mood disorders, psychotic disorders, autistic spectrum disorders, post-traumatic stress disorder or disruptive disorders. Issues such as deliberate self-harm, suicidal attempts or ideation, anxiety, aggression or uncontrollable behaviour, drug and alcohol issues and persistent school refusal or suspension. Youth Early Psychosis services (16-24) provide specialist treatment and care for young people who are experiencing or at high risk of, a first episode of psychosis and who are unable to engage in a comprehensive assessment process or who need urgent care to manage risk.	Severe mental illness often with behavioural disturbance which has not responded to treatment in a less restrictive setting. Primary diagnoses usually include schizophrenia, psychosis or severe mood disorder. Co-morbid or concurrent secondary disorders such as substance abuse are common. Consumers with complicated, severe adjustment disorders and personality disorders may also be admitted. Beds by be arranged to provide separate specialist services for younger people.	Severe mental illness or severe behavioural and psychological symptoms associated with dementia (BPSD) for those older people who are unable to be managed in a less restrictive environment. Some younger people with dementia and severe BPSD may also be admitted. Other conditions seen in OPAIU include mood disorders, psychotic disorders, complex anxiety and somatoform disorders and acute stress and adjustment disorders in the setting of personality disorder. Other common characteristics of people referred include polypharmacy and co-morbid acute and chronic medical and surgical conditions.
Avg incidence				
Average unit size and bed rate/100k	• 8 to 12 beds • Provided at the rate of 7 beds	• 12 to 16 beds • Intensive care beds generally represent 10 -	• 24 beds • Intensive care beds generally represent 10 -	• 16 to 24 beds • Intensive care beds generally

	per 100k of population aged 0 to 13.	20% of total beds. • Provided at the rate of 15 beds per 100k of population aged 14 to 18. • **Rate for YEP needs to be determined**	20% of total beds. • Provided at the rate of 15 to 20 beds per 100k of population aged 18 to 64.	represent 10-20% of total beds. • Provided at the rate of 45 beds per 100k of population aged > 65. **This rate may need review**
Hours	24hrs / 7 days	24hrs / 7 days.	24hrs / 7 days	24hrs / 7 days
Suggested Modelling Attributes				
% Occupancy	90%	90%	90%	90%
Avg length of stay	Less than 12 days	Less than 15 days	Less than 12 days	Within range 35 to 50 days
28 day readmission rate	Within range 7 to 10 percent	**Input Required**	Within range 7 to 10 percent	Within range 7 to 10 percent
Indicative staffing FTE/Bed	Multi-disciplinary FTE Clinical Staff per Bed – 2.8. Assumes access to teaching staff, speech therapists and the capacity for overnight accommodation of family members engaged in therapy	Multi-disciplinary FTE Clinical Staff per Bed – 3.01. Assumes access to teaching staff.	Multi-disciplinary FTE Clinical Staff per Bed – 2.05	Multi-disciplinary FTE Clinical Staff per Bed – 2.04
Sources	• National Health Data Dictionary V.15. • MH-CPP 2010. • Models of Service Delivery (Various), QPMHS, Queensland. The acute phase of early psychosis: a handbook of management, Orygen Youth Health, Victoria, 2004. • Youth Early Psychosis Status Report, Dr Ruth Vine, Victorian Government, 2007. • National Benchmarking Project, Review of Key Performance Indicators, NMHS, 2008.			

1.1.3 Adult Eating Disorder Mental Health Inpatient Service

Attribute	Details
Status	Gazetted
Services Delivered	Short to medium term voluntary and involuntary, inpatient care for adult consumers with an eating disorder that meet defined medical and/or psychological risk factors who cannot be managed safely or effectively in a community setting. Clinical treatments include medical monitoring, weight restoration and supportive meal therapies, individual and group therapies and recovery oriented discharge planning.
Key Distinguishing Features	Units are located on general hospital campuses and designed and operated to meet the special needs of people with eating disorders. Units operate independently of general adult inpatient units. This arrangement reflects the unique challenges of managing the needs of the client group. The inpatient unit works as part of an integrated model which includes specialist day programs and consultation liaison and ambulatory care services. Staffing profiles include dieticians.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Adults.
Diagnostic Profile	Consumers with Anorexia Nervosa, Bulimia Nervosa, Eating Disorder Not Otherwise Specified or Binge Eating Disorder who meet defined physical, mental and eating disorder signs and symptoms. Key criteria include, BMI <14, BP < 90/60, level of suicide risk, severity of clinical depression and presence of substance misuse.
Avg incidence	Adult life time prevalence 1.9% for AN. For women 4.3% for AN and 4 to 7% for BN
Average unit size and bed rate/100k	6 beds Probably low >.25 beds per 100k of total population.
Hours	24hrs / 7 days.
Suggested Modelling Attributes	
% Occupancy	87% (MH-CPP)
Avg length of stay	< 28 days
28 day readmission rate	Within range 7 to 10 percent
Indicative staffing FTE/Bed	Multi-disciplinary FTE Clinical Staff per Bed – 2.6. Assumes collocation with acute inpatient mental health unit and dietician engaged as part of unit staffing profile.
Sources	• Eating Disorders Services Model of Service Delivery, QPMHS, 2011 (Draft). Primary source. • ANZAED Position Statement, Inpatient Services for Eating disorders, 2007. • Service Model: South Australian Statewide Specialist Eating Disorder Services, SA Health, 2011. • Clinical mental health service responses for people with eating disorders in Victoria, Department of Human Services, Victorian Government, 2009

1.1.4 Intensive Care Units

Attribute	Details
Status	Gazetted
Services Delivered	Intensive Care Units (ICU) provide support to consumers who require containment, stabilisation and engagement in a therapeutic relationship. In general terms consumers admitted to an ICU suffer a high level of behavioural disturbance and mental illness complexity such that management in a general mental health acute unit is not suitable. A specific risk assessment and management plan is developed to respond to consumer distress and any associated behavioural disturbance. The plan usually identifies predictors, triggers and signs and symptoms of increasing agitation/impending aggression. The plan identifies preventative strategies, de-escalation strategies, and if required, the use of prescribed medication.
Key Distinguishing Features	An ICU is a lockable area within a mental health unit designed to provide short term safe, secure low stimulus care for involuntary consumers experiencing severe/complex behavioural disturbance. The emphasis is on immediate control of this high level disturbance with transfer/step down to acute inpatient unit asap. When in use the ICU is staffed. Treatment in an ICU should not be confused with seclusion.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Adults young people and older adults.
Diagnostic Profile	A consumer who meets the criteria for involuntary admission to an acute mental health inpatient unit and who exhibits levels of clinical risk, including potential risk of harm to themselves or others to a degree that they cannot be safely supported with other consumers on the unit.
Avg incidence	Between 10% and 20% of all acute beds will be occupied by consumers requiring intensive care.
Average unit size and bed rate/100k	6 beds 1.75 to 3.5 beds per 100k of total population
Hours	24hrs / 7 days.
Suggested Modelling Attributes	
% Occupancy	90% (MH-CPP)
Avg length of stay	7 days
28 day readmission rate	Not applicable.
Indicative staffing FTE/Bed	Multi-disciplinary FTE Clinical Staff per Bed – 3.0
Sources	• Adult Acute Inpatient Model of Service Delivery, QPMHS, 2011. • MH-CPP 2010 • Guidelines for Operation of Mental Health High Dependency Units in Queensland. Queensland Government, 2004.

1.1.5 Psychiatric Emergency Care Units

Attribute	Details
Status	Gazetted
Services Delivered	To provide mental health triage, assessment and brief treatment in a safe environment for people presenting to hospital emergency departments with acute mental health problems. Psychiatric Emergency Care Units (PECU'S) provide a short term alternative to admission, support effective use of available inpatient acute beds and support Emergency Department staff to safely and effectively respond to the needs people with mental health problems and associated behavioural disturbance and distress.
Key Distinguishing Features	The PECU is located within or adjacent to the Emergency Department. It is designed to provide a low stimulus environment with combinations of open bays and single rooms with controlled entry and egress. Also referred to as Psychiatric assessment and planning units (PAPU) and Mental Health short stay observation units (MHSOU).
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Adults, older adults and young people.
Diagnostic Profile	A person with an acute mental health problem and associated behavioural disturbance and distress who is medically stabilised and requires assessment, brief treatment and support to return to the community or to transition to inpatient care.
Avg incidence	10% of total presentations to Emergency Departments may be referred to the PECU.
Average unit size and bed rate/100k	4 to 6 beds One unit for each hospital with > 500 general hospital beds.
Hours	24hrs / 7 days.
Suggested Modelling Attributes	
% Occupancy	90% (MH-CPP)
Avg length of stay	< 48 hours
28 day readmission rate	**Input Required**
Indicative staffing FTE/Bed	Multi-disciplinary FTE Clinical Staff per Bed – 3.3
Sources	• Emergency Department Mental Health Service Mapping Project (Report B), Department of Human Services, Victorian Government, December 2007. • MH-CPP 2010 • Mental Health Care, framework for emergency Department Services, Victorian Government, 2007. • Review of Emergency Mental Health Services in North Metropolitan Perth, Department of Health, Western Australia, 2007. • Development of Australia's first Psychiatric Emergency Centre, Australasian Psychiatry, Vol13, September 2005.

1.1.6 Same day admission for the administration of ECT

Attribute	Details
Status	Day Hospital
Services Delivered	Electroconvulsive Therapy (ECT) for day patients
Key Distinguishing Features	Day only admission for the administration of ECT in a day surgery unit or an ECT suite operated as part of an Acute Mental Health Inpatient Unit. ECT will often be a coordinated treatment procedure jointly managed by the Acute Mental Health Inpatient Unit and Operating Theatre.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Adults, older adults and young people.
Diagnostic Profile	The principal indication for ECT is Major Depressive Disorder. It may also be given in certain circumstances for Mania, Schizophrenia or Schizoaffective disorder, and other indications such as Catatonia, and Neuroleptic Malignant Syndrome. Indications for day treatment include those consumers with a low risk of suicide, no impairment of nutrition or hydration, no unstable concurrent medical illness, low anaesthetic risk, adequate social supports, ability to fast, and minimal cognitive impairment during treatment.
Avg incidence	In Australia in 2010-2011 there were 12,700 same day separations from public hospitals for the administration of ECT. This represented .45% of all same day admissions to public hospitals in Australia.
Average unit size and bed rate/100k	If accept above data it means that in public system there are approx 55 administrations of same day ECT per day across the country.
Hours	Business hours.
Suggested Modelling Attributes	
% Occupancy	N/A
Avg length of stay	Same day
28 day readmission rate	N/A
Indicative staffing FTE/Bed	Staffing includes Anaesthetist and appropriately credentialed Consultant Psychiatrist, Registrar, ECT Coordinator - Anaesthetist Assistant (RN), Recovery Nurse (1:5 max) and Medical Receptionist for stand alone service.
Sources	• Guidelines for the Administration of ECT, Director of Mental Health, Queensland Government, 2006. • Royal Australian and New Zealand College of Psychiatrists. Clinical memorandum 12. • The Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia, Department of Health, Western Australia, 2006 • ECT Policy, South Eastern Sydney Illawarra Area Mental Health Program, NSW Health, 2009. • Australian Hospital Statistics 2010-2011, Australian Institute of Health and Welfare, Australian Government, November 2011.

1.1.7 Consultation Liaison (CL) - General

Attribute	Details
Status	Delivered in generic hospital beds
Services Delivered	Provides specialist mental health services to patients within the general hospital setting. Conducts mental health assessments and provides advice on clinical management and early recognition of symptoms relating to mental health to the general health treating team. Facilitate linkages between the general hospital, primary care and other health services for patients whose physical health care is complicated by their mental health problems. Also provides teaching, training and mental health promotion support for general hospital staff.
Key Distinguishing Features	Consultation liaison teams are multidisciplinary and while operating as part of the local area or district mental health service are embedded in the work of the general hospital. As well as local services CL teams may use telemedicine services to support smaller 'satellite' hospitals. CL teams have an important role in maintaining continuity of care between general hospital and mental health services and are actively involved in teaching and research programs within the hospital.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	All
Diagnostic Profile	Patients of the general hospital (including obstetric units) who may have significant mental health problems or have clinically significant distress associated with their medical illness.
Avg incidence	**Input requirred**
Average unit size and bed rate/100k	N/A
Hours	Mon-Fri - Business hours with after hours on call emergency service provided by local mental health or in larger services by the CL team.
Suggested Modelling Attributes	
% Occupancy	N/A
Avg length of stay	N/A
28 day readmission rate	N/A
Indicative staffing FTE/Bed	Multidisciplinary - 50% consultation role and 50% liaison role. 1.8 FTE per 100 hospital beds although specialised hospitals and/or units may require high intensity support.
Sources	• Consultation Liaison Psychiatry Model of Service, QPMHS, Queensland, 2011. • Mental Health Responses in Emergency Departments, Program Management circular, Victorian Government, 2008. • Delivering the Governments Mental Health Policies, Services, Staffing and Costs, Boardman and Parsonage, the Sainsbury Centre for Mental Health, UK, 2007.

1.1.8 Consultation Liaison – Emergency Department

Attribute	Details
Status	Delivered in generic hospital/emergency department beds
Services Delivered	Provides specialist mental health services to patients within the emergency department. Conducts mental health assessments and provides advice on clinical management and early recognition of symptoms relating to mental health to the emergency department treating team. Facilitate linkages between the general hospital, primary care and other health services for patients whose physical health care is complicated by their mental health problems. Also provides teaching, training and mental health promotion support for emergency department staff.
Key Distinguishing Features	Consultation liaison teams are multidisciplinary and while operating as part of the local area or district mental health service are embedded in the work of the emergency department. They are located in or new the emergency department. As well as local services CL teams may use telemedicine services to support staff in smaller 'satellite' emergency departments. CL teams have an important role in maintaining continuity of care between emergency department and mental health services and are actively involved in teaching and research programs with emergency department staff.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	All
Diagnostic Profile	May include presentations of people with depression and other mood disorders, anxiety conditions, behavioural disturbances associated with substance misuse, attempted suicide and other deliberate acts of self harm and reactions to personal crises. People may also present with associated or unrelated physical problems.
Avg incidence	**Input requirred**
Average unit size and bed rate/100k	N/A
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	N/A
Avg length of stay	N/A
28 day readmission rate	N/A
Indicative staffing FTE/Bed	Multidisciplinary - 50% consultation role and 50% liaison role. Provided as part of 1.8 FTE per 100 hospital beds for CL. May operate as part of PECU staffing in larger hospitals.
Sources	• Consultation Liaison Psychiatry Model of Service, QPMHS, Queensland, 2011. • Mental Health Responses in Emergency Departments, Program Management circular, Victorian Government, 2008. • Delivering the Governments Mental Health Policies, Services, Staffing and Costs, Boardman and Parsonage, the Sainsbury Centre for Mental Health, UK, 2007.

1.2 SUB-ACUTE SERVICES

Descriptor

Sub-acute services comprise three categories:

- **Step up/step down services**

  These community based residential services are provided for consumers who have recently experienced, or are at risk of experiencing, an acute episode of mental illness and who require treatment and care to reduce symptoms and/or distress that cannot be provided in the person's home but does not require the treatment intensity provided by acute inpatient units.

  Typically, consumers enter facility-based sub-acute care through one of two pathways:

  - By *'stepping down'* from a period of treatment in an acute inpatient unit to allow continued treatment in a supportive environment that is aimed at achieving further symptom reduction and recovery from the acute episode

    OR

  - By *'stepping up'* from the community after becoming unwell to receive treatment in a supportive environment designed to prevent further deterioration and relapse and avoid admission to hospital.

- **Rehabilitation services**

  These community based residential services have a primary focus on interventions to improve functioning and reduce impairments that may limit the person's independence. Rehabilitation services are focused on addressing the disability dimension of mental illness and promoting personal recovery.
  They are characterised by an expectation of improvement over the short to mid-term. Consumers admitted to rehabilitation services have high and complex needs associated with a mental illness. Consumers clinical symptoms are usually relatively stable allowing them to engage in rehabilitation activities.

- **Intensive Care Services**

  Intensive care services are provided as collocations with other mental health inpatient services on hospital campuses. They provide medium term recovery oriented treatment and rehabilitation in a safe, secure, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes them receiving support safely in a less restrictive environment. Services include, specialist behavioural and symptom management programs, individualised and group rehabilitation programs aimed at maximising individual functioning and recovery oriented pre-discharge and community placement planning to support safe transition to more independent living.

Distinguishing Features

- Sub-acute step up/down and rehabilitation services for adults (18-64) and youth (16-25) populations are delivered in community residential settings.

- Sub-acute step up/down and rehabilitation services for older persons (65+) are usually co-located with aged care residential or inpatient services. They are usually delivered as a combined program.
- Intensive care services are provided for ages 16 to 65+ as collocations with other inpatient services on general hospital campuses or in some cases nursing homes or psychiatric hospital campuses.
-
- Sub-acute rehabilitation services are often provided as collocations with non-acute residential services.
- Services are delivered by multidisciplinary teams operating as part of a local integrated mental health service system.
- Services are delivered as collaborations between specialist clinical and community support sector services with staff available on site 24 hours per day.
- Consumers' needs for care are complex and require significantly higher levels of support from clinical and specialist rehabilitation staff than would normally be provided in the community.
- Improvements are expected to occur in the short to medium term and stays are measured in weeks and months, not years.
    - Step up/step down care has an average length of stay of 14 days with an expected length of stay of less than 30 days
    - Rehabilitation care and Intensive care have expected lengths of stay of up to 6 months
- In contrast, non-acute services have expected lengths of stay greater than 6 months.
- Sub-acute and non-acute intensive care units are provided as secure units gazetted to allow for involuntary detention.

Inclusions

- Community based residential units which provide sub-acute services.
- Sub-acute community residential units are defined as bed-based facilities (usually around 5 to 20 beds) that provide overnight care with mental health trained staff available on site 24 hours per day.
- While sub-acute rehabilitation services are optimally delivered in community residential settings, this service category may include inpatient units located on general or psychiatric hospital campuses.
- Sub-acute services may be provided as a collocation with or sub-program of a residential non-acute service.
- Includes intensive care sub-acute services which are generally provided as co-locations with the non-acute hospital based intensive care program.
- Older person's mental health sub-acute units located in nursing homes and on general or psychiatric hospital campuses.

Exclusions

- Intensive treatment and rehabilitation provided by specialist community mental health teams in homes or other places in the community.
- Personalised support with varying levels of intensity linked to housing or otherwise provided by a support worker in the persons home. These services are generally provided by the community support sector.
- Hospital based inpatient care in units which have been arranged to respond to the varying acuity needs of consumers admitted and continuing to require acute inpatient care.
- Support provided by older person's mental health teams to consumers with complex needs in generic nursing home beds.

- Non-acute services. While non-acute services also have a focus on recovery and rehabilitation, the expectation is a length of stay of more than 6 months
- Crisis accommodation and respite accommodation generally provided by the community support sector which does not meet criteria for a non-acute staffed residential service (i.e. not staffed for a minimum of 6 hours per day).

Example Services

- Adult prevention and recovery care (PARC) units in Victoria.
- Youth prevention and recovery care (Y-PARC) units in Victoria.
- Transitional Recovery Program, Queensland
- Sutherland Hospital sub-acute mental health unit. New South Wales.
- Sub-Acute treatment and rehabilitation provided in Community Care Units and Secure Rehabilitation Units in Queensland and Victoria.
- Intermediate Care and Community Rehabilitation centres in South Australia
- Barrett Adolescent Unit – TPCMH. Queensland
- Older person's mental health sub-acute unit, Calvary Hospital. Australian Capital Territory.

Taxonomy Sub-Acute Services (Residential and/or Hospital and Nursing Home Based**)

- Step up/down – Youth
- Step up/down – Adult
- Step up/down – Older Adult**
- Rehabilitation – Youth
- Rehabilitation – Adult
- Rehabilitation – Older Adult**
- Intensive Care Services**

1.2.1 Sub-Acute Step Up/Down Service – Adults

Attribute	Details
Status	Not gazetted although consumers may be subject to community treatment or forensic orders.
Services Delivered	Intensive clinical treatment and support including crisis support planning aimed at improving symptom control and building relapse prevention capacity. Short-term residential care and psychosocial, daily living and practical assistance to build functional capacity to maintain, build or resume independent community living. The service takes an integrated approach to clinical recovery and psychosocial interventions with a focus on maintenance, engagement or reengagement in positive and supportive social, family, educational and vocational connections. Services are aimed at two groups of consumers, first, those who no longer require acute inpatient care but would benefit from short term intensive treatment and support to build on gains made during the period of hospitalisation and secondly, consumers who are living in the community and require short term residential support and intensive clinical treatment and intervention to prevent risk of further deterioration or relapse which may lead to a hospital admission.
Key Distinguishing Features	Services are located in the community, and delivered in a community residential environment. They are delivered as partnerships and/or collaborations between clinical services and the community support sector. These services operate as a component of a district or area integrated mental health system.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Adults (16 to 64).
Diagnostic Profile	Consumers who meet the criteria for admission to an area mental health service inpatient unit but whose level of risk is such that they can be safely supported in a less restrictive environment than an acute inpatient unit.
Avg incidence	**Input required**
Average unit size and bed rate/100k	8 to 20 beds **Input required – part of acute allocation for adults and young people**
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	85%
Avg length of stay	14 days with a maximum of < 30 days
28 day readmission rate	**Input required**
Indicative staffing FTE/Bed	.8 FTE per bed **(to be confirmed)**
Sources	• Adult prevention and recovery care (PARC) services framework and operational guidelines, 2010, Victorian Government. Primary source. • Presentation for EWG, Models of Residential Services, Dr Gerry Naughtin, Mind Australia. • Intermediate Care – summary service model, 2010, Government of South Australia.

1.2.2 Sub-Acute Step Up/Down Service – Youth

Attribute	Details
Status	Not gazetted although consumers may be subject to community treatment orders and forensic orders.
Services Delivered	The aim of the service is prevent further deterioration in mental state and associated disability and so reduce the likelihood of admission to an acute inpatient unit (step up). The service also aims to enable early discharge from acute care through the provision of an intensive safe and supportive residential community residential program (step-down). The service aims to provide short term transitional recovery care and support to minimise the trauma and impact of a first episode or relapse of a mental illness. The service takes an integrated approach to clinical recovery and psychosocial interventions with a focus on maintenance, engagement or reengagement in positive and supportive social, family, educational and vocational connections.
Key Distinguishing Features	Services are located in the community, and delivered in a community residential environment. They are delivered as partnerships and/or collaborations between clinical services and the community support sector. There is a strong focus on early and active engagement of families and carers in a youth friendly environment. Services operate as a component of a district or area integrated mental health system.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Youth (16-24)
Diagnostic Profile	Consumers who meet the criteria for admission to an area mental health service inpatient unit but whose level of risk is such that they can be safely supported in a less restrictive environment than an acute inpatient unit.
Avg incidence	**Input required**
Average unit size and bed rate/100k	8 to 20 beds **Input required – part of acute allocation for adults and young people**
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	85%
Avg length of stay	Up to 28 days
28 day readmission rate	**Input required**
Indicative staffing FTE/Bed	1.1 FTE per bed **(to be confirmed)**
Sources	• Youth prevention and recovery care (Y-PARC) framework and operational guidelines. Victorian Government 2010. Primary source. • Statewide Youth Sub-Acute Unit: An Integrated Service Approach. Government of South Australia. April 2012. • Presentation for EWG, Models of Residential Services, Dr Gerry Naughtin, Mind Australia.

1.2.3 Sub-Acute Step Up/Down Service and Rehabilitation – Older People

Attribute	Details
Status	Gazetted.
Services Delivered	Provides assessment, ongoing specialised clinical treatment and rehabilitation support for consumers who require post acute mental health care in order to regain function lost due to an acute mental illness and to prevent or delay admission to a residential aged care facility. Services are delivered in close collaboration with the general aged care sector.
Key Distinguishing Features	Services may be co-located with acute older adult services, with a geriatric medical ward or with a residential aged care facility. These services operate as a component of a district or area integrated mental health system with that district or area mental health service having continuing responsibility for clinical governance. Should not to be confused with staffed residential support services for older adults which may be supported by area ambulatory clinical mental health services but whose primary function is residential rehabilitation for older adults whose primary needs are associated with functional impairment rather than clinical symptoms.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Older Adults > 64.
Diagnostic Profile	The consumer will have met the criteria for acute admission and have completed their acute treatment phase but still have a need for continued treatment of symptoms of mental illness that may have responded poorly or only partially to treatment. The consumer will also have ongoing functional impairment and a risk profile that precludes living in the community or generic aged care settings .
Avg incidence	**Input required**
Average unit size and bed rate/100k	16 to 20 beds **Input required – part of acute allocation**
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	85%
Avg length of stay	> 30 to 50 days **Input required**
28 day readmission rate	**Input required**
Indicative staffing FTE/Bed	Multidisciplinary 1.9 clinical FTE/ bed
Sources	• Older persons Sub Acute Program Model of Service Delivery (Draft), QPMHS, 2012

1.2.4 Sub-Acute Rehabilitation – Youth

Attribute	Details
Status	Not gazetted
Services Delivered	Programs include an extensive range of therapeutic interventions and comprehensive activities to assist in the development and recovery of the young person provided in a safe, supportive environment. Programs follow structured phases incorporating assessment, establishing a therapeutic alliance and developing therapeutic goals, treatment and rehabilitation, and discharge planning to facilitate independent living in the community. Education programs are provided as an essential component of the rehabilitation program and are provided on site by a local education provider. An adjunct day program is also provided for young people and their families assessed as requiring continuing support during the period of transition to the community.
Key Distinguishing Features	There is a low level of demand for this service. It may be provided as a state-wide or specialist service in smaller jurisdictions. Includes close collaboration with education providers and other government and non-government agencies including particularly child safety and youth justice services. Includes capacity for onsite engagement of families in therapy programs. Services have a strong focus on risk assessment, safety and security.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Young People 13 to 18 (those eligible to attend high school)
Diagnostic Profile	Severe mental illness which has not responded fully to treatment provided in acute inpatient units or in the community. The majority of young people present with severe psychosocial impairment as a result of their mental illness. Their presentations are often complicated by developmental co-morbidities. Many also experience family dysfunction, which serves to exacerbate the severity and persistence of the disorder and associated disability.
Avg incidence	**Input required**
Average unit size and bed rate/100k	8 to 16 beds Very low. Possibly .25 beds per 100k of total population. May be a state-wide or regionalised service.
Hours	24 hours/ 7 days.
Suggested Modelling Attributes	
% Occupancy	85%
Avg length of stay	66 days with a maximum of 6 months.
28 day readmission rate	N/A
Indicative staffing FTE/Bed	Multidisciplinary 2.2 FTE/bed (does not include teaching support).
Sources	• Adolescent Extended Treatment and Rehabilitation Centre Model of Service Delivery (Draft), QPMHS, 2012. Primary source. • Presentation for EWG, Models of Residential Services, Dr Gerry Naughtin, Mind Australia.

1.2.5 Sub-Acute Rehabilitation – Adults

Attribute	Details
Status	Not gazetted
Services Delivered	These services are residential in nature and delivered in a partnership between clinical and community support services. They provide accommodation and recovery oriented treatment and rehabilitation for people whose needs are associated with severe mental illness, the associated clinical symptoms, and unresolved psychosocial or functional disability. Staffing is available on-site 24 hours a day to deliver recovery oriented psychosocial rehabilitation programs, support to achieve agreed outcomes identified in an individualised recovery plan and support to build links with in the community to sustain community integration and social connectedness. Programs have a focus of vocational/employment support, skills development to enable self management of mental and general health care and lifestyle skills that assist with the maintenance of personally meaningful lifestyle and community tenure. Services also include clinical support and treatment including specialist medical psychiatric review and support of people receiving involuntary community treatment under the provisions of the relevant legislation.
Key Distinguishing Features	Residential services are provided as congregate living arrangements (may be 5 to 20 beds per dwelling) in which people may share living spaces such as a kitchen, dining room or family room and may have their own bathrooms and bedrooms. Clinical support is provided on site. This program is often delivered as a collocation with or sub-program of the non-acute adult 24 hour community residential program.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Adults (18 to 64).
Diagnostic Profile	Schizophrenia and related psychosis and mood disorders. Also may have complex presentations including issues with personality disorder, drug and alcohol disorders and significant deficits in psychosocial functioning. Typically consumers have significant needs for community based functional support which make living independently even with high levels of personal support difficult in the context of a severe but relatively stable mental health status. The consumer will have access to a recovery based support program. At the point of referral an individual may be experiencing, severe unremitting clinical symptoms, little or no opportunity for self determination, few or no available informal or formal supports, physical and/or general health issues and a deterioration of independent living skills such as problem solving, organising self care, accessing generic services, maintaining tenure of accommodation and participation in valued roles or community activities.
Avg incidence	May be considered to represent 30% of non-acute adult residential program.
Average unit size and bed rate/100k	Maximum 20 beds. May be considered to represent 30% of non-acute adult residential program, CCU component (10 beds per 100k of total population).
Hours	Staffed 6 to 24 hours per day 7 days per week.
Suggested Modelling Attributes	
% Occupancy	95%
Avg length of stay	Expected length of stay up to 6 months.
28 day readmission rate	N/A
Indicative staffing FTE/Bed	Multidisciplinary 1.12 FTE/ bed.
Sources	• Country Community Rehabilitation Centres, Service Model, Draft, Jan 2012, Government of South Australia. Primary source. • Community Care and Secure Extended Care Units, Program Management Circular, Victorian Government, 2007. Primary source. • Extended Recovery Services (Draft). Mind Australia. October 2012. • Community Care Unit - Model of Service, QPMHS, Queensland, 2011. Primary source. • Overview of Future Directions, Transitional Recovery Program, Queensland Government 2008. • Service Model Guidelines (Draft), Transitional Recovery Program, Queensland government, 2011. • Planning Estimates for the Community Support Sector in Queensland: Harris, Siskind, Buckingham, Pirkis, Whiteford, QCMHR, 2009 • Multi-Site Benchmarking of Community Care Units and Extended Treatment and Rehabilitation Units, Queensland Mental Health Benchmarking Unit, QH, 2010.

1.2.6 Sub-Acute Intensive Care Services

Attribute	Details
Status	Gazetted
Services Delivered	Sub-acute intensive care services provide short to medium term treatment and rehabilitation in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their receiving treatment in a less restrictive environment. Services include, specialist behavioural and symptom management programs, individualised and group rehabilitation programs aimed at maximising individual functioning and minimising the effects of long term care and recovery oriented pre-discharge and community placement planning to support safe transition to more independent living.
Key Distinguishing Features	Sub-acute intensive care services are located on hospital campuses usually operating as a sub-program collocated with non-acute intensive care services. Units are designed to provide a reasonably high level of security. Programs have a strong focus on safety, security and risk assessment and management. They operate as a component of a district or area integrated mental health service system. Not to be confused with low, medium and high security forensic units.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Adults and selected older adults and young people with special needs.
Diagnostic Profile	Schizophrenia and related psychoses and mood disorders. Also may have complex presentations including issues with personality disorder, drug and alcohol disorders, complex trauma and clinically significant deficits in psychosocial functioning. Associated issues of behaviour and risk which indicate a need for rehabilitation include severely disorganised behaviour leading to difficulty in managing activities of daily living, impaired impulse control, vulnerability, ongoing risk of aggression, and significant risk of self harm.
Avg incidence	Approximately 1 bed per 100k or 30% of total non-acute and sub-acute beds
Average unit size and bed rate/100k	8 beds Provided at 1 beds per 100K of total population.
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	95%
Avg length of stay	Less than 6 months
28 day readmission rate	N/A
Indicative staffing FTE/Bed	Multidisciplinary 2.8 clinical FTE/ bed.
Sources	• Community Care and Secure Extended Care Units, Program Management Circular, Victorian Government, 2007. • Secure Mental Health Rehabilitation Unit Model of Service, QPMHS, Queensland, 2011. Primary source. • Multi-Site Benchmarking of Medium Secure Units, Queensland Mental Health Benchmarking Unit, QH, 2010.

1.3 NON-ACUTE SERVICES

Descriptor

Sub-acute and non-acute bed-based services are part of a spectrum of services and, as such, share some characteristics – for example, a focus on rehabilitation. The key difference is that non-acute services provide care over an extended period – with an expected length of stay in excess of 6 months.

Consumers of non-acute services present with a relatively stable pattern of clinical symptoms which may include high levels of severe unremitting symptoms of mental illness and severe levels of functional impairment resulting in a limited capacity to function independently. The goal is to provide treatment and rehabilitation over an extended period, aimed at promoting personal recovery and reducing impairments that limit independence.

Distinguishing Features

- Services are provided over an extended period with an expected length of stay greater than 6 months.
- Includes treatment and rehabilitation services for consumers with high intensity needs for clinical care and treatment over an extended period (needs dominated by positive symptoms and associated problems in context of functional disability).
- Includes residential services for consumers with high intensity needs for psycho-social rehabilitation (needs dominated by negative symptoms and associated functional disabilities in context of unremitting but relatively stable positive symptoms).
- Services are delivered by multidisciplinary teams operating as part of a local integrated mental health service system.
- Services are usually delivered as collaborations between specialist clinical and community support services.
- Consumers' needs for care are complex and require significantly higher levels of support than can be provided at home or in other non residential settings.
- Gains are expected to occur slowly and stays are measured in months and years. Measures of average lengths of stay are often distorted by the need to provide continuing care for some consumers over decades. Four levels of classification have been proposed in MHCPP 2010. These are average lengths of stay of 120, 180, 240 and 365 days per annum.
- Specialist services are generally provided for adults and for older adults. These extended stay programs are not suitable for young people.
- Intensive care inpatient units are provided as secure units gazetted to allow for involuntary detention.

Inclusions

- Non-acute intensive care units located on general or psychiatric hospital campuses.
- Non-acute intensive care units provided in specialist units in prisons and/or forensic units (out of scope for this project).
- Inpatient units located on general or psychiatric hospital campuses or community based units which provide non-acute services.
- Residential services that provide domestic style overnight accommodation staffed with a minimum of 6 hours support per day and at least 50 hours support per week. Residential services may be further categorised by level of intensity of need in terms of those providing < 24 hours support per day and those providing 24 hours of support per day.
- Older person's mental health extended treatment and rehabilitation units located in nursing homes and in some cases on general or psychiatric hospital campuses.

- Specialist extended treatment and rehabilitation inpatient units located on general or psychiatric hospital campuses or collocated with generic specialist services which provide services for consumers with complex co-morbidities (eg acquired brain injury).
- Non-acute services may be co-located with sub-acute services.

Exclusions

- Personalised support with varying levels of intensity linked to housing or otherwise provided by a support worker.
- Facilities that provide an extensive range of hotel services and limited personalised support.
- Intensive treatment and rehabilitation provided by specialist community mental health teams in homes or other places in the community.
- Support provided by older person's mental health teams to consumers with complex needs in generic nursing home beds.

Example Services

- Mind, Victoria
- Mid West AMHS - Sunshine Hospital Secure Extended Care Unit. Melbourne, Victoria
- Townsville Mental Health Services - Medium Secure Unit. Queensland.
- Mid West AMHS - Community Care Unit. Melbourne, Victoria.
- Tasmania MHS – South - Campbell Street Residential Unit. Hobart, Tasmania.
- NWMH Aged Persons MH Program – Westside Lodge NH Sunshine, Melbourne, Victoria.
- WMIMH Older Persons Mental Health Service - Extended Treatment and Rehabilitation Unit - Ipswich General Hospital. Queensland.
- Redcliffe Caboolture MHS – Acquired Brain Injury Unit - Eventide, Queensland.

Taxonomy Non-Acute Services (Residential and Hospital or Nursing Home Based **)

- Intensive Care Services**
- Adult (<24 hour support)
- Adult (24 hour support)
- Older Adult **
- Specialised services **

1.3.1 Non-Acute Intensive Care Services

Attribute	Details
Status	Gazetted
Services Delivered	Non-acute intensive care services provide medium to long term treatment and rehabilitation in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their living in a less restrictive environment. Services include, specialist behavioural and symptom management programs, individualised and group rehabilitation programs aimed at maximising individual functioning and minimising the effects of long term care and recovery oriented pre-discharge and community placement planning to support safe transition to more independent living.
Key Distinguishing Features	Non-acute intensive care services are located on hospital campuses. Units are designed to provide a reasonably high level of security. Programs have a strong focus on safety, security and risk assessment and management. They operate as a component of a district or area integrated mental health service system. Not to be confused with low, medium and high security forensic units. Usually incorporates sub-acute intensive care program beds.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Adults and selected older adults and young people with special needs.
Diagnostic Profile	Schizophrenia and related psychoses and mood disorders. Also may have complex presentations including issues with personality disorder, drug and alcohol disorders, complex trauma and clinically significant deficits in psychosocial functioning. Associated issues of behaviour and risk which indicate a need for rehabilitation include severely disorganised behaviour leading to difficulty in managing activities of daily living, impaired impulse control, vulnerability, ongoing risk of aggression, and significant risk of self harm.
Avg incidence	Approximately 7.5% of all mental health inpatient beds are provided as non-acute intensive care beds.
Average unit size and bed rate/100k	24 beds Provided at 3 beds per 100K of total population.
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	95%
Avg length of stay	Average 792 days, median 537 days. 37% of all admissions had a LOS of less than 1 year. Incorporates sub-acute intensive care beds..
28 day readmission rate	N/A
Indicative staffing FTE/Bed	Multidisciplinary 1.8 clinical FTE/ bed.
Sources	• Community Care and Secure Extended Care Units, Program Management Circular, Victorian Government, 2007. Primary source • Secure Mental Health Rehabilitation Unit Model of Service, QPMHS, Queensland, 2011. Primary source. • Multi-Site Benchmarking of Medium Secure Units, Queensland Mental Health Benchmarking Unit, QH, 2010.

1.3.2 Adult Non-Acute Services

Attribute	Details
Status	Not gazetted
Services Delivered	These services are residential in nature. They provide accommodation and recovery oriented treatment and rehabilitation for people whose needs are associated with severe mental illness, the associated clinical symptoms, and unresolved psychosocial or functional disability. Staffing is on-site up to 24 hours a day to deliver recovery oriented psychosocial rehabilitation programs, support to achieve agreed outcomes identified in an individualised recovery plan and support to build links with in the community to sustain community integration and social connectedness. Programs have a focus of vocational/employment support, skills development to enable self management of mental and general health care and lifestyle skills that assist with the maintenance of personally meaningful lifestyle and community tenure. Services also include clinical support and treatment including specialist medical psychiatric review and support of people receiving involuntary community treatment under the provisions of the relevant legislation.
Key Distinguishing Features	Residential services are provided as congregate living arrangements (may be 5 to 20 beds per dwelling) in which people may share living spaces such as a kitchen, dining room or family room and may have their own bathrooms and bedrooms. Services are provided in flexible arrangements which provide a minimum of 6 hours per day support up to 24 hours per day. Services may be categorised as providing less than 24 hours or 24 hours of support. Clinical support is provided on site and may be supported by a local mental health service.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Adults.
Diagnostic Profile	Schizophrenia and related psychosis and mood disorders. Also may have complex presentations including issues with personality disorder, drug and alcohol disorders and significant deficits in psychosocial functioning. Typically consumers have significant needs for community based functional support which make living independently even with high levels of personal support difficult in the context of a severe but relatively stable mental health status. The consumer will have access to a recovery based support program. At the point of referral an individual may be experiencing, severe unremitting clinical symptoms, little or no opportunity for self determination, few or no available informal or formal supports, physical and/or general health issues and a deterioration of independent living skills such as problem solving, organising self care, accessing generic services, maintaining tenure of accommodation and participation in valued roles or community activities.
Avg incidence	
Average unit size and bed rate/100k	5-20 beds CCU's- Provided at 10 beds per 100K of total population. Staffed < 24 hours per day provided at 10 beds per 100K of total population. Staffed > 24 hours per day provided at 5 beds per 100K of total population.
Hours	Staffed 6 to 24 hours per day 7 days per week.
Suggested Modelling Attributes	
% Occupancy	95%
Avg length of stay	Average 3 months to 2 years. Incorporates sub-acute rehabilitation places. For CCU's average > 2 years although 49% of all admissions had a LOS of less than 1 year. Incorporates sub-acute rehabilitation program places.
28 day readmission rate	N/A
Indicative staffing FTE/Bed	Multidisciplinary < 24 hour staffed 4.2 FTE per 100k = .42 FTE per bed > 24 hour staffed 5.9 FTE per 100k = 1.18 FTE per bed CCU 1.3 clinical FTE/ bed.
Sources	• Presentation for EWG, Models of Residential Services, Dr Gerry Naughtin, Mind Australia. Primary source. • Key Principles Underpinning Residential Services (Draft). Mind Australia. 2012. • Community Care Unit - Model of Service, QPMHS, Queensland, 2011. • Handbook of Psychosocial Rehabilitation: King, Lloyd and Meehan, 2007 • Overview of Future Directions, Transitional Recovery Program, Queensland Government 2008 • Service Model Guidelines (Draft), Transitional Recovery Program, Queensland government, 2011

	• Planning Estimates for the Community Support Sector in Queensland: Harris, Siskind, Buckingham, Pirkis, Whiteford, QCMHR, 2009 • A Domains-Based Taxonomy of Supported Accommodation for People with Severe and Persistent Mental Illness: Siskind, Harris, Pirkis, Whiteford, Submitted for publication December 2011. • Community Care and Secure Extended Care Units, Program Management Circular, Victorian Government, 2007. • Community Care Unit Model of Service, QPMHS, Queensland, 2011. • Multi-Site Benchmarking of Community Care Units and Extended Treatment and Rehabilitation Units, Queensland Mental Health Benchmarking Unit, QH, 2010.

1.3.3 Older Persons' Non-Acute Service (OAETR)

Attribute	Details
Status	May be gazetted
Services Delivered	OAETR units are specifically designed for older adults who have severe and persistent symptoms of mental illness that have responded poorly or partially to treatment, and who have risk profiles often with behavioural disturbance that preclude them from living in either community or aged care settings. They provide care over an indefinite period for people who have a relatively stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. They offer assessment, ongoing treatment, rehabilitation and residential support for consumers who require non-acute mental health care and aged care services.
Key Distinguishing Features	These services are provided as partnerships with the generic aged care sector and are collocated with nursing homes and hostels or provided, as stand alone units in the community or on hospital campuses. Units are designed to meet the special needs of older adults for longer-term accommodation, ongoing assessment, treatment and rehabilitation in a safe environment. Consumers may remain in these units for lengthy periods but opportunities are sought where possible to achieve discharge to a less restrictive environment such as a generic nursing home place.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Older adults.
Diagnostic Profile	Late onset mental illness or, early onset severe mental illness complicated by functional impairments associated with ageing, or, severe mental illness as a complication of dementia or other age-related illnesses. Common diagnoses include schizophrenia and organic and mood disorders
Avg incidence	Approximately 7.5% of all mental health inpatient beds are provided as older adult extended treatment and rehabilitation beds
Average unit size and bed rate/100k	12 to 16 beds Provided at 3 beds per 100K of total population.
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	95%
Avg length of stay	ALOS > 3 years although 32% have an ALOS of > 1 year.
28 day readmission rate	N/A
Indicative staffing FTE/Bed	Multidisciplinary 1.9 clinical FTE/ bed.
Sources	• Older Persons Extended Treatment Inpatient Unit Model of Service, QPMHS, Queensland, 2011. Primary source. • Southern Cross high Dependency Residential Care Service for older Persons – Protocols, Metropolitan Mental Health Services/Mental health commission, Western Australia, May 2012. • Community Care and Secure Extended Care Units, Program Management Circular, Victorian Government, 2007. • Multi-Site Benchmarking of Older Persons Extended Treatment Inpatient Units, Queensland Mental Health Benchmarking Unit, QH, 2011.

1.3.4 Specialised Non-Acute Services

Attribute	Details
Status	May be gazetted
Services Delivered	Specialised extended treatment and rehabilitation services refer to those services which are established to provide a response to consumers who have severe mental illness and co-morbid illnesses which make treatment and rehabilitation in a standard unit impractical, unsafe and/or counter therapeutic. Specialised recovery oriented assessment and treatment is provided by staff with specialised training in the relevant area. Sub-specialities include acquired brain injury or neuro-psychiatry (ABI), intellectual disability (ID) and complicated drug and alcohol problems.
Key Distinguishing Features	These services are provided as partnerships with the relevant sector. For example ABI units may be collocated with generic ABI services or provided, as standalone units on hospital campuses. May be provided as state-wide or regionalised specialist service. Units are designed to meet the special needs of the consumer group for longer-term accommodation, ongoing assessment, treatment and rehabilitation in a safe environment. Consumers may remain in these units for lengthy periods but opportunities are sought where possible to achieve gains in capacity to live independently.
Service specifications & other useful descriptors to illustrate service elements.	
Target Age:	Adults.
Diagnostic Profile	Examples: ABI – Acquired brain damage and associated mental illness and/or severe behavioural disturbance. ID – mental illness and concomitant intellectual disability associated with severe behaviour disturbance.
Avg incidence	Depends on specialist program. ABI 3.75% of all inpatient beds.
Average unit size and bed rate/100k	12 to 16 beds For ABI beds for provided at 1.5 beds per 100K of total population.
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	95%
Avg length of stay	For ABI very long lengths of stay. Generally in excess of 4 years.
28 day readmission rate	N/A
Indicative staffing FTE/Bed	Multidisciplinary 1.9 clinical FTE/ bed.
Sources	• 10 Year Mental Health Strategy for Queensland, 1996. • Multi-Site Benchmarking of Acquired Brain Injury Inpatient Mental Health Services, Queensland Mental Health Benchmarking Unit, QH, 2011.