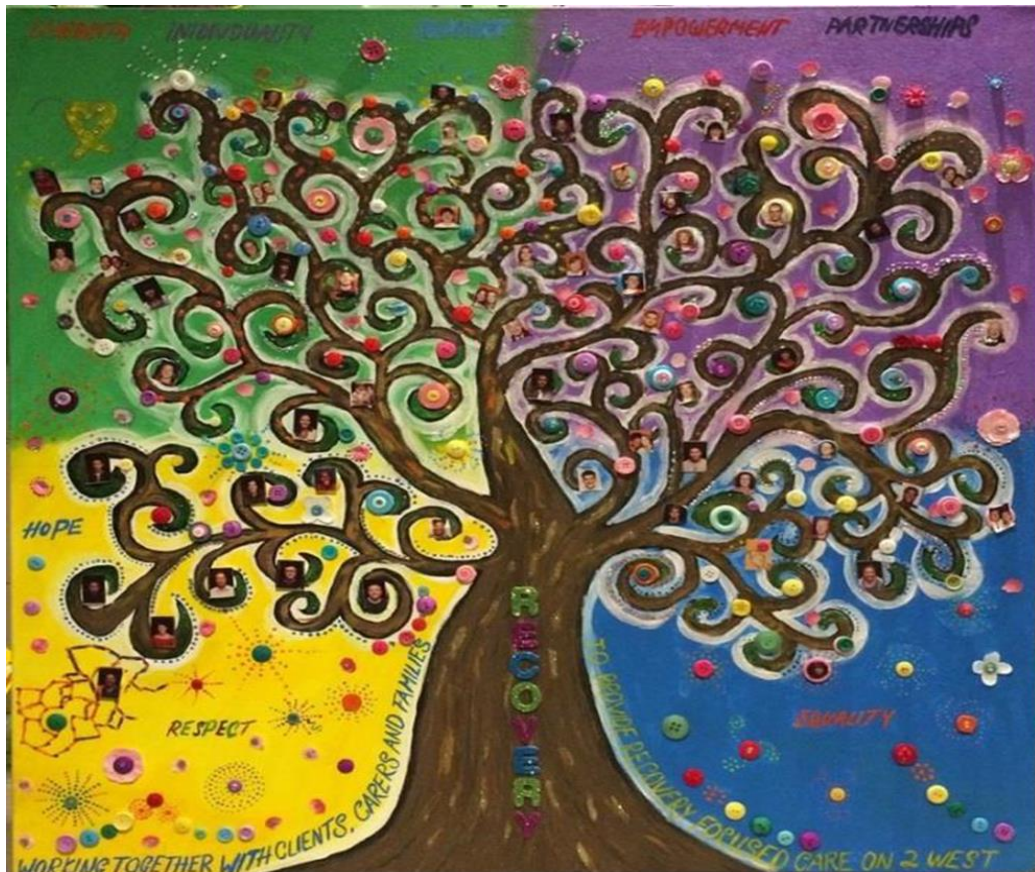


# Peninsula Health Mental Health Service Model of Care – Overview

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*“Peninsula Health Mental Health Service will acknowledge and appreciate the lived experience of our clients and carers and support their individual resourcefulness, strengths and abilities through the provision of excellent specialized mental health care.”*  
*Vision statement 2016*

## **Limitations**

Given the limitations of available information, consultation, understanding and data sets the detail set out in this paper is considered to be correct and as up to date as possible at the time of draft finalisation. Work on further and final improvements will continue and be presented in additional papers of the same name noting different version numbers.

## **Note**

This paper refers the reader to a range of documents saved to the internal Peninsula Health prompt document site. Readers who do not have access to the Peninsula Health ePulse page, will not be able to access the documents stored on the prompt document site. Requests to view documents can be made to a PHMHS Program and/or Team Manager.



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## 1 Background

The Model of Care - Overview forms part of a suite of strategic quality documents completed by the Peninsula Health Mental Health Service (PHMHS) in 2016 and subsequently updated. The documents provide a framework for service provision, governance, operations and strategic planning priorities and directions.

PHMHS papers supporting Quality Systems, Quality Improvement and Quality Governance:<sup>1</sup>

- PHMHS Service Plan;
- PHMHS Managers Quality Governance Manual;
- PHMHS Evaluation Framework;
- PHMHS Model of Care – Overview;
- Functional Briefs – by service type; and
- PHMHS Operational Manual - incorporating
  - Adult;
  - Aged; and
  - Youth.

## 2 Purpose of the Model of Care - Overview

The purpose of the Model of Care – Overview is to provide a broad description of the PHMHS service types or different parts of the service. The Model of Care – Overview provides detail on the multifaceted integrated service provision of PHMHS and broadly defines the way mental health services are delivered at Peninsula Health.

The various Functional Briefs describe the scope, role and function of the service type and the PHMHS Operational Manual is to guide the PHMHS Teams/Units and all staff of the operational and clinical responsibilities and tasks of each Team/Unit.

## 3 Policy Context

The Department of Health and Human Services sets out the policy and principles underlying the organisation of Victoria's mental health services as well as the legislative framework governing treatment and care. The DHHS has developed a number of policy and reference documents to guide service reform and address structure, growth and principles of the Victorian mental health service system. PHMHS is committed to providing treatment and care consistent with these frameworks and in accordance with their funding and service agreement.

Documents detailing specialist clinical mental health services role and responsibility in providing

- acute inpatient; and
- acute community intervention including assessment and short term treatment

are located at <https://www2.health.vic.gov.au/mental-health/mental-health-services/services-by-type>.

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<sup>1</sup> The suite of strategic quality papers also includes the PHMHS Population Health Planning Paper



## Peninsula Health Mental Health Service

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Consistent with DHHS policy and guidelines PHMHS acute community intervention services are provided through an integrated care approach delivered by a number of community teams across a number of settings and by a range of clinicians including medical, nursing, allied health and peer workers. The PHMHS teams include

- Mental Health Telephone Triage
- Mental Health Consultation Liaison (Emergency Department and general medical ward)
- PACER
- PAPU
- Acute assertive community outreach (face-to-face assessment and treatment) through the Access and Assessment Team (assessment, intensive treatment and brief intervention) , Youth, Adult and Aged Persons Community Mental Health Programs (assessment, intensive treatment and brief intervention)

Peninsula Health PROMPT includes a Functional Brief for each of these teams.

<http://prompt.phcn.vic.gov.au/Search/SearchLibrary.aspx>

The PHMHS Model of Care design adheres to the DHHS policy and guidelines, legislative and other governing treatment and care frameworks and works to achieve State and Commonwealth vision and expected outcomes.

In addition to the above, Commonwealth and State policy and planning priorities has emphasized the need for PHMHS to address as a priority:

- increased focus on suicide prevention;
- improved efficiency and responsiveness of mental health telephone triage service;
- improved and smoother access to community based crisis assessment and treatment services;
- a more responsive service system that supports clients early in their illness;
- targeted health promotion and prevention strategies;
- responsiveness to the increasing demand from the aged population; and
- more sustainable, flexible and dynamic workforce and innovation strategies.

Plans for the implementation of these strategies are set out in the PHMHS Service Plan.<sup>2</sup>

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<sup>2</sup> Refer to Appendix 1 for a detailed list of policy and planning document summaries (M:\Mental Health\Current\ZZ. PHMHS Service Plan 2016-26\PHMHS Service Plan.pdf) and Section 14: Themes for Improvement – Strategic Proposals



## 4 The Mental Health Act 2014

The PHMHS strictly abides by the legislation concerning the treatment and protection of people with a mental illness, as per the Mental Health Act 2014.

The Mental Health Act 2014 provides for the assessment, detention and compulsory treatment of people with severe mental illness. It includes checks and balances to ensure that compulsory treatment is only used where necessary to prevent serious harm to the person or another person.

The Mental Health Act 2014 promotes recovery-oriented practice in the public mental health service system. This approach to client wellbeing builds on the strengths of the individual, working in partnership with the treating team. It encompasses the principles of self-determination and individualised treatment and care. The Mental Health Act 2014 also seeks to minimise the use and duration of compulsory treatment to ensure that the treatment is provided in the least restrictive and least intrusive manner possible and establishes a comprehensive suite of safeguards to protect the rights of clients.

Further reference and detail on the Mental Health Act 2014 is available.<sup>3</sup>

## 5 Catchment for PHMHS

For the purposes of acute service planning, Peninsula Health primary catchment is defined as the Local Government Areas of Frankston and Mornington Peninsula.

The Peninsula Health Mental Health Service provision for adult, youth and adolescent and aged communities is defined as the Statistical Local Areas of Kingston South, Frankston West, Mornington Peninsula West, Mornington Peninsula South, Mornington Peninsula East and including French Island unincorporated.

Moreover, PHMHS is responsible for completing immediate assessment and treatment to all patients presenting to the Frankston and/or Rosebud Emergency Department who identify as a mental health client. The patient's residential address is only relevant to ongoing mental health service provision.

In the case where a patient from beyond the PHMHS catchment area presents to Frankston or Rosebud Emergency Department, assessment is completed and treatment initiated and planned for in liaison with the area mental health service responsible for the geographical area the patient resides in/is from.

Full detail of the PHMHS catchment – including postcodes – is set out in the PHMHS Service Plan.

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<sup>3</sup> Mental Health Act Handbook: <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook>

The Chief Psychiatrist's Guidelines: <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/oversight-and-service-improvement/chief-psychiatrist>



## 6 PHMHS Vision and Objectives

### Our Vision

Peninsula Health Mental Health Service will acknowledge and appreciate the lived experience of our clients and carers and support their individual resourcefulness, strengths and abilities through the provision of excellent specialised mental health care.

### Our Values

**Service**

**Integrity**

**Compassion**

**Respect**

**Excellence**

### Our Principles

The provision of excellent clinical care that:

- Promotes optimal quality of life for all our clients;
- Facilitates sustained recovery;
- Supports client engagement and collaboration in all decisions about their treatment and care;
- Encourages and enables clients to include their carers/family members in all aspects of their care;
- Acknowledges carers' roles, capacity, needs and requirements as separate to those of the clients;
- Ensures client and carer participation is integral to the development, planning, delivery and evaluation of our services;
- Ensures treatment, care and support is tailored to meet the specific needs of our clients; and
- Ensures treatment, care and support is provided in the least restrictive manner and according to the needs and preferences of the client, wherever possible.

### Our Objectives

#### Client Recovery

- To provide holistic recovery oriented clinical care with clients in collaboration with other service providers, focussing on empowering clients to identify needs and goals through respect, listening and responding to feedback to achieve optimal recovery.

#### Carer Engagement

- To ensure the essential role of carers and families are recognised, respected and supported;
- To understand carer needs and include carers and families in decisions about assessment, treatment, discharge and recovery where ever possible; and
- Establish opportunities for carer engagement and contribution to service development and delivery.

#### Governance and workforce

- That the PHMHS Model of Care and service delivery framework is based on quality outcomes, monitoring and continuous/ongoing work to develop and improve clinical services; and
- To support and develop skilled, capable and valued staff teams who focus on high quality positive outcomes and ensure the clients, carers and families experience an excellent mental health service.



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# Peninsula Health Mental Health Service

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## Access and Inclusion

- That clients, carers and their families have easy access to coordinated assessment, treatment and support as and when needed. Equally responsive and committed to all, including socio economically disadvantaged communities, Lesbian, Gay, Bisexual, Transgender, Intersex and Questioning and clients of Aboriginal and/or Torres Strait Islander descent.

## Promotion and education

- That the PHMHS is the leader in promoting, preventing and educating our local community on the importance of mental health and well-being.

## Safety

- PHMHS will provide a safe environment for clients, visitors and staff.

## Suicide Prevention

- Establish strengthened approaches to assertive outreach and individual care to persons who are identified as at-risk of suicide and/or repeated intentional self-harm with suicide intent.

## Collaboration and Partnerships

- Continually strive to enhance a more integrated community orientated delivery approach that facilitates timely client and carer planning, inclusive of discharge planning through:
  - working together to build ongoing relationships; and
  - developing collaboration and establishing service delivery models for coordinated treatment and support – across housing, alcohol and other drugs, primary health providers and community mental health services.

## 7 Fundamental Core Beliefs

The PHMHS vision, values, principles and objectives govern practice and ensure that service provision is person centred, holistic and evidence based. We strive to achieve better outcomes for clients, for mental health advocacy in the community and for a current and sustainable healthier and passionate workforce. PHMHS endeavours to be accessible, responsive and importantly to provide intensive mental health support as needed for clients in their own homes, to ensure clients' valued connections to their families, carers, and community support networks are maintained and strengthened.

Our core beliefs include:

### Client Centred Care

The PHMHS works as an integrated, comprehensive service in order to best meet the needs of the client. The PHMHS ensures the client is always at the centre of their care and receives systematic, holistic and expert assessments and treatments. We work effectively with other health providers and health and support partners identified by the client as crucial to their recovery, in order to address clients' social, emotion and physical wellbeing.





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# Peninsula Health Mental Health Service

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## Recovery Focus

Recovery is personally defined by the client and involves a holistic approach that addresses a range of factors that impact on a person's wellbeing, such as housing, education, employment, family and social relationships. It encourages self-determination and self-management of mental health and wellbeing and works with principles of change. It supports clients to define their goals, wishes and aspirations. It involves tailored, personalised and strengths based care that is responsive to the client's unique strengths, circumstances, needs and preferences, while also supporting other principles of recovery.

## Holistic Care

Built on a bio-psycho-social framework of health care, this core belief assumes the position that working in partnership, and considering all components of a client's social system in their mental health care, promotes mental health and wellbeing. This framework also considers the cultural and spiritual framework of the client and their social system.

## Trauma Informed Care

Trauma Informed Care understands and responds to the impact of trauma and creates opportunities for survivors to rebuild a sense of control and empowerment. A significant proportion of PHMHS clients have histories of trauma and abuse, which can have longstanding adverse impacts in many areas in their lives, including developing autonomy, relationships and broader areas of functioning. It is acknowledged that the experience of trauma may impact on engagement and the treatment approaches used. As a service, PHMHS remains sensitive to this and provides an atmosphere in which trauma is recognised, acknowledged and discussed.

## Healthy multidisciplinary workforce

We strongly support and strive for the development and maintenance of a healthy multidisciplinary workforce, including both physical and mental health well-being. A healthy multidisciplinary workforce will impart the best possible mental health care in partnership with clients and the local community. As role models, PHMHS will demonstrate and advocate for both optimal physical and mental health well-being in the broader local community.

## Inclusion

PHMHS maintains the philosophy of equal opportunity and equal utilisation of resources, irrespective of culture, race, gender, religion and sexual orientation. PHMHS values and acknowledges the lived experiences within the mental health workforce.

## Early, intensive, intervention

PHMHS endeavours to provide assertive and intensive care for clients in the community by intervening early in life, in their illness and in an episode of un-wellness. This is reflective of our commitment to evidence based research that promotes early identification of illness to promote better outcomes and earlier recovery.

To this end, PHMHS is committed to providing targeted evidence based intensive support to clients in their home environment, with the inclusion and partnership of all external care providers and agencies that will facilitate an individual's recovery.



## 8 Mental Health Service Descriptions

### Mental Health Telephone Triage

The Mental Health Telephone Triage service is a 24 / 7 service providing comprehensive and timely telephone screening, triage and a review of the individual's mental health status. It aims to categorise and refer clients to the most appropriate assessment and treatment option within the PHMHS service types activities or through an external service provider.

The Mental Health Telephone Triage takes calls for referrals of individuals of all ages and provides expert review for all age groups drawing on age related expertise. It also coordinates and/or facilitates face to face same day/next day assessment by the Access and Assessment Team (AAT).

The service provides bed management / coordination for PMHS Mental Health inpatient beds after hours on weekdays and on weekends/public holidays. The outcomes include:

- Client linked into the most appropriate service provider in a timely manner;
- Acknowledges and records information provided by caller/carers/others and initiates supports;
- Continued learnings from service and community mapping is a focus for clinicians and shared with callers to assist them to navigate resources;
- Positive identification of young persons who are clients of Child Protection and are placed in Out of Home Care;
- Reduces demand on Emergency Department by presentations of patients with a mental health condition;
- Callers' stress reduced by the provision of phone advice and ongoing referral if required;
- Callers are effectively referred to external providers ; and
- Facilitate coordinated response for non-mental health services within Peninsula Health.

### Mental Health Consultation Liaison

The Mental Health Consultation Liaison Emergency Department service is located at the Frankston Hospital and is available 24 / 7 for people of all ages in the Frankston Hospital Emergency Department.

The preferred pathway for clients and/or their families/carer seeking a mental health assessment is via Mental Health Telephone Triage, unless circumstances are urgent.

Mental Health Consultation Liaison General Hospital services are provided to the General Medical/Surgical Wards, Paediatric, Intensive Care Unit, Coronary Care Unit and Women's Health Unit during business hours, with an after-hours on call service.

Mental Health Consultation Liaison service is the assessment (face-to-face), treatment and planning service for patients with co-morbid mental health and physical health needs who have presented to the Frankston Hospital Emergency Department or are patients in the Frankston Hospital medical wards.

It provides support, advice and guidance to non-mental health staff, clients, carers and families and addresses discharge planning with community mental health and support services to ensure appropriate mental health follow-up. The outcomes include:

- Timely response to requests for mental health assessments;



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## Peninsula Health Mental Health Service

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- Clients have a completed individualised assessment and integrated plan of care that assists their understanding of the care they will receive that which provides the best collaborative service response to meet the needs of the client and carer/family;
- Appropriate referrals are made both internally and externally;
- Carer/family members are included in the assessment and decision making process (with appropriate consent to be sought from the client prior to liaising with any other health professional, carer or family members);
- Where appropriate contact should be made to alert the family/carers to the presentation of the client to the Emergency Department;
- Collateral evidence and further detailed information should be sought from family/carers and other health professionals involved with the client;
- Staff in non-mental health settings are upskilled to better support clients with mental health needs;
- Reduction in restrictive interventions across Frankston Hospital;
- Reduction in inappropriate mental health presentations and representations to Frankston Hospital Emergency Department;
- Care for mental health clients in a general medical setting is more responsive and understanding to their mental health needs; and
- Clients at risk of suicide or have recently attempted suicide will be supported in the short to medium term through the PHMHS intensive service provision, starting with the Access and Assessment Team.

### **Police Ambulance and Clinician Early Response (PACER)**

PACER provides a flexible, client-oriented service that enables accurate identification of people experiencing a mental health crisis and supports a rapid response to police and ambulance requests for consultation and mental health assessment.

It is a collaborative, early intervention service between PHMHS, Victorian Police and the Ambulance Service to support individuals in mental health crisis situations in the community by addressing assessment and treatment planning. The outcomes include:

- An integrated multi-disciplinary response to community based mental health-related situations
- Improved client outcomes;
- Enables easy and responsive access to community based assessment services;
- A streamlined and coordinated response to calls initiated by Victoria Police for assistance with individuals experiencing a mental health crisis in the community;
- Reduced Emergency Department presentations by clients transported for assessment under section 351 of the Mental Health Act 2014;
- Community based dual response will reduce risk of behavioural escalation;
- Enhanced communications between PHMHS, Victoria Police and Ambulance regarding planned integrated approach to clients care;
- Reduced requests for police assistance;
- PACER clinician's base at the Frankston Police Station is to provide easy access to clinical expertise, guidance and knowledge;
- Police assistance requests through Mental Health Telephone Triage are managed, monitored and prioritised;



# Peninsula Health Mental Health Service

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- Skilled multidisciplinary mental health workforce capable of responding to high risk community situations;
- Increased understanding and knowledge of mental health conditions and strategies to better support emergency service response staff in future situations;
- 
- Provides more rapid access to mental health care and information;
- Provides a wider set of possible referral options; and
- Clients receive a comprehensive, holistic assessment and plan for the best integrated service response to meet the needs of the client.

## Psychiatric Assessment and Planning Unit (PAPU)

The PAPU is a 24 / 7 mental health short stay assessment and planning unit. It provides accelerated access to specialist psychiatric assessment and short term treatment to better address planning and partnering support arrangements for the client back in the community on discharge. Ideally the care provided should be of less than 72 hours in duration to allow for the determination of appropriate clinical pathways. The PAPU emphasis incorporates suicide prevention and provides support for clients who are at risk of self-harming. Outcomes include:

- Enables easy access for clients deteriorating in the community. When and as required, community clients will be directly admitted to PAPU, enabling early intervention in an episode of illness or relapse, thereby reducing the risk of escalation and having a positive impact on the pattern of illness;
- Reduces demand on Emergency Department by presentations of patients with a mental health condition;
- Minimises and reduces the use of restrictive interventions in the Emergency Department;
- Minimises the need for an acute inpatient stay by ensuring that clients can be adequately and appropriately supported in the community;
- Allows for early referral to PHMHS community mental health teams and primary care providers. All clients and their carers/families are fully linked into their community upon discharge;
- Coordinated and tailored approach from multiple services, based on the client's needs:
  - Care and support plans developed as a collaborative effort with key service providers;
  - Physical health care components developed, monitored and delivered by primary care providers best able to respond to client's current and changing needs; and
  - Access and participation in social activities to strengthen community connectedness and individuals' sense of self-worth and self-esteem.
- Client and carer/family engagement in decision making for their treatment wherever possible;
- Service provision in the least restrictive environment suitable to the client's needs;
- Clients at risk of suicide or have recently attempted suicide are prioritised for access; and
- Support for carers and families.



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# Peninsula Health Mental Health Service

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## Access and Assessment Team

The Access and Assessment Team is a community based initial comprehensive assessment service that responds in a timely manner according to the mental health triage scale. The team conducts face-to-face holistic assessments in the Frankston, Mornington or Rosebud community clinics, and or the client's home, providing subsequent referral and integrated planning strategies to both PHMHS service programs and external service providers, ensuring the needs of the carer/family supporting the client are included.

The AAT also has the capacity to provide brief, time-limited intervention treatment services with a particular focus on suicide prevention. The team provides extended hours of service for assessment from 08.30 to 23.00 and provide services to all persons aged 16 to 64 years. Outcomes include:

- An integrated ongoing plan across PHMHS service activities and community based services that best meets the needs of the client and carer/family;
- Initiates and finalises client comprehensive mental health assessments that have been started by either Mental Health Consultation Liaison (Emergency Department and General Hospital) and/or PACER that still require additional work;
- Reduces demand on Emergency Department by presentations of patients with a mental health condition;
- Increased range of treatment and care interventions, responding early in client's illness pathway and increasing hours of service provision should increase levels of voluntary engagement and decrease levels of compulsory engagement;
- Referral and detailed treatment plan to external service providers;
- Brief intervention;
- Collaborative integrated care back into client's own community with clear pathways back into the service if required;
- Decrease in clients re-presenting to PHMHS service types with same and/or unresolved issues;
- Decreased Emergency Department presentations by patients with a mental health condition, decreased mental health assessments in Emergency Department and increased mental health assessments in the community;
- Suicide prevention; three months of service provision for people who have identified as at high risk of suicide and/or repeated self-harm with suicide intent;
- Referrals to the appropriate community mental health services and other external service providers; and
- Plan for discharge follow-up.

## Adult Community Mental Health Program

There are two Adult Community Mental Health Programs (for adult clients 26 – 64 years)

- Frankston Adult Community Mental Health Program (supporting clients residing in the Statistical Local Areas of Kingston South and Frankston West); and
- Mornington Adult Community Mental Health Program (supporting clients residing in the Statistical Local Areas of Mornington Peninsula West, Mornington Peninsula South, Mornington Peninsula East and including French Island unincorporated).



# Peninsula Health Mental Health Service

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The programs provide extended hours of service for intensive treatment and community treatment services – from 08:30 to 23:00. They comprise three service activities:

## *Intensive Treatment*

Intensive Treatment is an assertive community outreach (short-term) service. It is an alternative to inpatient treatment and supports clients in a transition from inpatient services, clients in crisis and/or clients who are experiencing an acute phase of illness. This service is for clients with severe mental illness who require purposeful clinical therapeutic interventions such as medication initiation and titration; adherence and or psychosocial supports to reduce risk to them and their families. Intensive treatment includes working with the client on their comprehensive assessment and care plan to provide community based short-term intensive treatment interventions that best meet the client's needs.

The Adult Community Mental Health Programs only accept and/or nominate clients for Intensive Treatment service who require a minimum of daily or second daily visits/direct face to face interventions (second daily = 3 or 4 visits per week for a client). The Intensive Treatment service provides purposeful clinical therapeutic interventions such as medication initiation and titration, adherence and/or psychosocial support. All clients receiving Intensive Treatment will have a discharge plan.

## *Community Treatment*

Community Treatment (for adult and youth clients 16 – 64 years) is a short to medium-term support service for people and their families with prolonged and severe mental illness. The service includes a broad range of treatment, case management and care interventions of the right intensity and duration, early in the illness pathway and in the illness episode.

This service includes weekly (minimum fortnightly) engagement by mental health clinicians/case managers and/or peer workers along with quarterly medical and clinical reviews.

Community Treatment services include liaison with and referral to generalist services including General Practitioners, specialist private providers and community mental health and other support services for ongoing support and provision of services to people with a mental illness.

## *Access Planning and Suicide Prevention*

The Access Planning and Suicide Prevention service is for adults (18 years +) with moderate to mild mental illness who have either attempted suicide or been identified as at-risk of suicide. The target group will likely be experiencing severe psychological distress and may have a diagnosed mental illness (as per ICD-10-AM)<sup>4</sup>. Eligible clients for the Access Planning and Suicide Prevention service are those who do not require ongoing or immediate specialist clinical mental health service provision and who are willing to engage with our Access Planning and Suicide Prevention service.

## *General Practitioner Shared Care (Clozapine Program)*

Clozapine Shared Care Program facilitates and supports collaborative primary care management of clients prescribed clozapine with General Practitioners. The program is available to all PHMHS clients (16 years and over). Outcomes include:

- Increases the number of new clients with severe and enduring mental illness to the access of high quality specialist community based treatment and support services;

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<sup>4</sup> **ICD-10-CM** (International Classification of Diseases, Tenth Revision, Clinical Modification) is a system used by physicians and other healthcare providers to classify and **code** all diagnoses, symptoms and procedures recorded in conjunction with hospital care



# Peninsula Health Mental Health Service

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- Increases the number of new clients with moderate mental illness to the access of high quality specialist community based treatment and support services;
- Easy access to community based treatment services;
- Smooth transition from acute inpatient to community based services as and when client needs are best suited to community. Early discharge management and review for clients transferred to community based mental health teams;
- Active participation of clients and carers in their treatment and care;
- Improved continuity of care;
- Reduction in unique client ED presentations and representations, as well as other crisis interventions;
- Increased number of external service providers working with the Adult Community Mental Health Programs, client and carer/family for the client's integrated ongoing care plan;
- Referral and detailed treatment plan to internal and external service providers;
- Safe and efficient transfer of care at the end of episode; and
- Improved capacity within community support agencies and primary care providers to work with the client.

## **Aged Persons Community Mental Health Program**

The Aged Persons Community Mental Health Program (for clients 65 years and over) provides service for assessment, intensive treatment and community treatment services seven days a week.

The Aged Persons Community Mental Health Program is made up of four service activities:

### ***Assessment***

The Aged Persons Community Mental Health Program provides a community based initial comprehensive assessment service that responds in a timely manner according to the mental health triage scale. Face-to-face holistic assessments for aged persons across the PHMHS catchment are provided in client's home environment and/or in PHMHS clinic sites, likewise subsequent referral and integrated planning strategies to both PHMHS service programs and external service providers, which includes the needs of the carer/family supporting the client.

### ***Intensive Treatment***

Intensive Treatment is an assertive community outreach (short-term) service. It is an alternative to inpatient treatment and supports clients in a transition from inpatient services, clients in crisis and/or clients who are experiencing an acute phase of illness. This service is for clients with severe mental illness who require purposeful clinical therapeutic interventions, such as: medication initiation and titration; and adherence and or psychosocial supports to reduce risk to them and their families. Intensive treatment includes working with the client on their comprehensive assessment and care plan to provide community based, short-term intensive treatment interventions that best meet the client's needs.

The Aged Persons Community Mental Health Program only accepts and/or nominates clients for Intensive Treatment service who require a minimum of daily or second daily visits/direct face to face interventions (second daily = 3 or 4 visits per week for a client). The Intensive Treatment service provides purposeful clinical therapeutic interventions, such as medication initiation and titration, adherence and/or psychosocial support. All clients receiving Intensive Treatment will have a discharge plan.



# Peninsula Health Mental Health Service

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## *Community Treatment*

Community Treatment is a short to medium-term support service for people (and their families) with prolonged and severe mental illness. The service includes a broad range of treatment, case management and care interventions of the right intensity and duration, early in the illness pathway and in the illness episode.

This service includes weekly (minimum fortnightly) engagement by mental health clinicians/case managers and/or peer workers along with quarterly medical and clinical reviews.

Community Treatment services include liaison with and referral to generalist services including General Practitioners, specialist private providers and community mental health and other support services for ongoing support and provision of services to people with a mental illness.

## *Access Planning and Suicide Prevention*

This service is for aged persons with moderate to mild mental illness who have either attempted suicide or who have been identified as at-risk of suicide. The target group will likely be experiencing severe psychological distress and may have a diagnosed mental illness (as per ICD-10-AM<sup>5</sup>). Eligible clients for the Access Planning and Suicide Prevention service are those who do not require ongoing or immediate specialist clinical mental health service provision (and who are willing to engage with the Access Planning and Suicide Prevention service).

The Aged Persons Community Mental Health Program also provides:

## *General Practitioner Shared Care (Clozapine Program)*

This program facilitates and supports collaborative primary care management of clients prescribed clozapine with General Practitioners. The program is available to all PHMHS clients.

## *Residential Support Team*

This team is also a part of the Aged Persons Community Mental Health Program and is responsible for clients residing in aged care facilities who are referred due to mental health or behavioural issues resulting from neurocognitive disorders. This client group generally reside in aged care facilities, with consistent staff supervision and support, and regular General Practitioner input. The Aged Persons Residential Support Team, therefore, takes a 'consultation-liaison' approach with these clients, and provides a short-term service with specific treatment goals.

Outcomes include:

- Increases the number of clients with severe and enduring mental illness to the access of high quality specialist community based assessment, treatment and support services;
- Increases the number of clients with moderate mental illness to the access of high quality specialist community based assessment, treatment and support services;
- Easy access to community based assessment and treatment services;
- Active participation of clients and carers/families in their treatment and care;
- Improved continuity of care;
- Reduction in unique client Emergency Department presentations and representations as well as other crisis intervention;

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<sup>5</sup> **ICD-10-CM** (International Classification of Diseases, Tenth Revision, Clinical Modification) is a system used by physicians and other healthcare providers to classify and **code** all diagnoses, symptoms and procedures recorded in conjunction with hospital care





# Peninsula Health Mental Health Service

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- Increased number of external service providers working with the Aged Persons Community Mental Health Program, client and carer/family for the client's integrated ongoing care plan;
- Referral and detailed treatment plan to internal and external service providers;
- Safe and efficient transfer of care at the end of episode;
- Improved capacity within community support agencies and primary care providers to work with the client; and
- Decreases requests to provide integrated ongoing care addressing the mental health needs of the Aged Care Residential Services clients (Aged Persons receiving Intensive Treatment only) from residential services staff through comprehensive and targeted education and upskilling.

## Youth Community Mental Health Program

The Youth Community Mental Health Program provides service for assessment and intensive treatment services five days a week. Young people requiring community treatment and Access Planning and Suicide Prevention service will access the Adult Community Mental Health Program

The Youth Community Mental Health Program is made up of two service activities:

### *Assessment*

The Youth Community Mental Health Program provides a community based initial comprehensive assessment service that responds in a timely manner according to the mental health triage scale. Face-to-face holistic assessments for young persons (16 – 25 years inclusively) across the PHMHS catchment are provided in the client's home environment and/or in PHMHS clinic sites, subsequent referral, and integrated planning strategies to both PHMHS service programs and external service providers, which includes the needs of the carer/family supporting the client.

### *Intensive Treatment*

Intensive Treatment is an assertive community outreach (short-term) service. It is an alternative to inpatient treatment and supports clients in a transition from inpatient services, clients in crisis and/or clients who are experiencing an acute phase of illness. This service is for clients with severe mental illness who require purposeful clinical therapeutic interventions, such as: medication initiation and titration; and adherence and or psychosocial supports to reduce risk to them and their families. Intensive treatment includes working with the client on their comprehensive assessment and care plan to provide community based short term intensive treatment interventions that best meet the client's needs.

The Youth Community Mental Health Program only accepts and/or nominates clients for Intensive Treatment service who require a minimum of daily or second daily visits/direct face to face interventions (second daily = 3 or 4 visits per week for a client). The Intensive Treatment service provides purposeful clinical therapeutic interventions such as medication initiation and titration, adherence and/or psychosocial support. All clients receiving Intensive Treatment will have a discharge plan. Outcomes include:

- Increases the number of clients with severe and enduring mental illness to the access of high quality specialist community based assessment, treatment and support services;
- Supports clients with mental illness through access to high quality specialist community based access planning and suicide prevention services;
- Easy access to community based assessment and treatment services;
- Active participation of clients and carers/families in their treatment and care.
- Improved continuity of care;



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- Reduction in unique client Emergency Department presentations and representations, as well as other crisis interventions;
- Increased number of external service providers working with the Youth Community Mental Health Program to address an integrated ongoing care planning approach to all client work;
- Increased numbers of clients' carers and/or family members working with the Youth Community Mental Health Program to address an integrated ongoing care planning approach to all client work;
- Referral and detailed treatment and discharge planning to all internal and key/relevant external service providers involved with the individual client's mental health care;
- Safe and efficient transfer of care at the end of episode; and
- Improved capacity within community support agencies and primary care providers to work with the client.

## Adult and Aged Acute Mental Health Inpatient Units

The Inpatient Units are specialist, multidisciplinary teams that provide treatment and interventions that are recovery oriented and focussed on transitioning clients safely back into the community with ongoing mental health support in a timely fashion. Treatment includes, but is not limited to, innovative approaches such as sensory and environmental modulation, de-escalation, therapeutic engagement and medication management.

PHMHS acute adult and aged inpatient services provide 24 hour bed based voluntary and compulsory short-term inpatient treatment and care during an acute phase of mental illness. Staff on the inpatient units endeavour to minimise the use of restrictive interventions as part of PHMHS best practice philosophy. Outcomes include:

- Assists clients in their recovery to achieve their premorbid level of functioning, wherever possible and to assist where this objective cannot be met;
- Clients and their carer/families are included in decision making about their care and treatment and service goals are aligned and directed by client's personal goals;
- Acute care and treatment is based on evidence based practice and excellence.
- The units are set out as a warm, welcoming therapeutic space, with capacity to segregate clients with different risk profiles if required;
- The maintenance of restrictive interventions to the lowest possible levels for client and staff safety;
- Client deterioration in mental state is reviewed and noted regularly and care and treatment considered accordingly;
- Collaborating and developing recovery/treatment plans for all clients in order to ensure ongoing mental health support and management arrangements are in place:
  - Clarity on PHMHS ongoing service activity/activities provision or response, that best meets the needs of the client and carer/family; and
  - Clarity on ongoing relationships and responsibilities with external service providers;
- Improved system processes that further enable clients and carers to participate in the decision making processes regarding their care;
- Support for carers and families;
- Collaborative integrated care back into their own community with clear pathways back into the service if required;
- Clear identification of clients who are at risk of suicide/self-harm and alerts and strategies incorporated into their treatment and discharge plans;



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- Clients are admitted and discharged as their clinical need dictates; and
- Discharge planning commences at admission and involves collaboration with client, carer/family and follow up supports, prior to discharge from inpatient unit.

## Adult –Prevention and Recovery Care (A-PARC) and Youth - Prevention and Recovery Care (Y-PARC)

Y-PARC and A-PARC are supported residential services for people experiencing significant mental health conditions who need clinical treatment and short-term residential support (but who do not need or no longer require a hospital admission).

The PARC services are community based 24 / 7 services with an early intervention and recovery focus. PARC services provide early intervention for clients, in accordance with the following strategy<sup>6</sup>:

- Early in life - The older adolescent and young adult years offer unique opportunities to promote, recover and prevent mental health problems and disorders that can have lifelong impacts if not identified and treated early;
- Early in illness - A growing body of research points to the benefits of addressing mental health conditions in their early stages; and
- Early in episode - Focusing on recognition and timely response to re-emerging problems for those with reoccurring difficulties can substantially reduce their duration and impact on health and development.

Each PARC works as a collaborative partnership with external service providers. The partnership between PHMHS and external service providers recognises the unique opportunity to provide clients and their carers/families with support during the early stages of an illness or episode and to provide them with treatment and strategies to manage mental health concerns and engage them in recovery focused interventions and activities. Outcomes include:

- Provision of timely clinical treatment and short-term residential support;
- Provision of recovery focussed interventions and activities that strengthen a client's resilience and develop individualised strategies to support them in their daily lives;
- Reduces demand in inpatient units by enabling/facilitating early discharge planning to PARC services;
- Reduces demand on acute mental health inpatient services by providing alternate pathways of care;
- Reduces demand in Frankston Hospital's Emergency Department by educating PHMHS clients how to access and re-engage with mental health services;
- Service provision in the least restrictive environment suitable to the client's needs;
- Support for carers and families;
- Integrated health promotion initiatives that assist understanding and access to PARCs; and
- An individualised client plan of care to assist a client's understanding of what care they will receive going forward, their role and the role of other providers.

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<sup>6</sup> [\*'Because Mental Health Matters'- Victorian mental health reform strategy 2009-19.\*](#)



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## Carinya

Carinya is an interim psychogeriatric residential care facility for clients over 65 years of age with dementia, psychiatric illnesses and associated challenging behaviours. Outcomes include:

- Medium term accommodation and treatment for aged clients with a diagnosed neurocognitive illness;
- Provision of timely clinical treatment and rehabilitation to enable clients transfer to a generic aged care facility;
- Service provision in a home-like and least restrictive environment suitable to the client's needs;
- Support for carers and families;
- Integrated health promotion initiatives that assist understanding and access to longer-term residential options;
- An individualised client plan of care to assist clients in the short, medium and longer term; and
- Improved capacity within community support agencies and primary care providers to work with clients.

## Community Care Unit

The Community Care Unit provides medium- to long-term accommodation, clinical care and rehabilitation services to people with serious mental illness. The Community Care Unit is in a safe and supportive community setting where people can learn or re-learn everyday skills necessary for successful community living. The Community Care Unit setting encourages links to clients' natural supports and their participation in community life. Outcomes include:

- Provision of timely clinical treatment and rehabilitation support as an integrated collaborative model with other key health and support service providers;
- Provision of recovery focussed interventions and activities that strengthen a client's resilience and develops individualised strategies to support them in community integration, relapse prevention and transition to community life;
- Improved client social engagement and participation in community life;
- Ongoing development, monitoring and review of a comprehensive, integrated care and support plan for clients during their Community Care Unit stay and as a plan following their discharge;
- Coordinated and tailored approach from multiple services, based on the client's needs, such as:
  - care and support plans developed as a collaborative effort with key service providers;
  - Physical health care components developed, monitored and delivered by primary care providers best able to respond to a client's needs and changing needs; and
  - Access and participation in social activities to strengthen community connectedness and an individual's sense of worth and esteem.
- Reduces demand in Frankston Hospital's Emergency Department by educating PHMHS clients how to access and re-engage with mental health services;
- Service provision in the least restrictive environment suitable to the client's needs;
- Support for carers and families through active engagement and use of peer supports;
- Integrated health promotion initiatives that assist understanding and access to longer-term residential options, but which also builds accessibility and connection for mental health clients to employment, recreational and other social activities;



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- An individualised client plan of care to assist a client's understanding of what care they will receive going forward, their role and the role of other providers; and
- Improved capacity within community support agencies and primary care providers to work with clients.



## Attachment 1: References & Resources

1. Key Victorian government policies that particularly influence this plan include:
  - *Victorian Health Priorities Framework 2012 – 2022: Metropolitan Health Plan, Victorian Government Department of Health, 2011*
  - *Victorian Public Health and Wellbeing Plan 2011-2015, Victorian Government Department of Health, September 2011*
  - *Victorian Suicide Prevention Framework 2016-2025*
  - *Victoria's 10-Year Mental Health Plan November 2015*
  - *Victoria's next 10-year Mental Health Strategy Discussion paper August 2015*
  - *Victorian Mental Health Reform Strategy 2009-19 Because mental health matters Implementation Plan 2009 – 2019*
  - *Victorian public health and Well-being Plan 2015-2019*
  - *Victorian Mental Health Reform Council 2009 – 2012 Workplan*
  - *National Action Plan for Mental Health 2006 – 2011*
  - *Victorian health services Policy and Funding Guidelines 2014 – 15*
  - *Working with general practice: Department of Human Services position statement and resource guide*
  - *Care in your community: A planning framework for integrated ambulatory health care*
  - *The Victorian Service Coordination Practice Manual*
2. World Health Organisation What are social determinants of health?  
[http://www.who.int/social\\_determinants/sdh\\_definition/en/](http://www.who.int/social_determinants/sdh_definition/en/)
3. Victoria In Future 2015 (VIF 2015, August 2015, Estimated Resident Population (ERP) by five year age group and sex, Year ending June 30th
4. *Victoria in the Future 2015 – population and household projections to 2051, Victorian Government Department of Transport Planning and Local Infrastructure August 2015,*  
<http://www.delwp.vic.gov.au/victoria-in-future-2015>
5. Victoria in Future 2015 (VIF 2015) is the state government projection of population and households in Victoria and is used by government and non-government decision makers. It supports government planning for the greater Melbourne area, including Frankston and the Mornington Peninsula.
6. *Victoria's Mental Health Services Department of Health and Human Services:*  
<https://www2.health.vic.gov.au/mental-health>
7. *Department of Health and Human Services, Quickplace*  
<https://hns.dhs.vic.gov.au/collab/QuickPlace/mhi/Main.nsf?OpenDatabase>
8. NACDC: Population projections, 2012 (base) to 2027 for all states and territories at Statistical Area Level 2 (SA2) by sex and age;,  
[https://www.gen-agedcaredata.gov.au/Resources/Access-data/2014/August/Population-projections,-2012-\(base\)-to-2027-for-a](https://www.gen-agedcaredata.gov.au/Resources/Access-data/2014/August/Population-projections,-2012-(base)-to-2027-for-a)
9. Heart health: Improved services and better outcomes for Victorians
10. Peninsula Model: [www.peninsulamodel.org.au/view-model](http://www.peninsulamodel.org.au/view-model)
11. Key Peninsula Health documents that particularly influence this plan include:
  - Peninsula Health Strategic Clinical Service Plan 2015 – 2025
  - Peninsula Health Workforce Plan Towards 2025
  - Peninsula Health Strategies Clinical Service Plan - Renal Services Plan
  - Peninsula Health Research Strategic Plan 2015 – 2025

