Department of Health

health

Mental health service delivery

Acute Community Intervention Service guidelines

July 2014

State Government Victoria

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Overview

Community awareness about the impact of mental illness on consumers, their family and carers is growing. It is important for people to know where and how to get help when someone is experiencing a mental illness. It is also important that mental health consumers, family and carers know what can be expected from specialist clinical public mental health services, particularly at times of crisis.

While the majority of mental health treatment and care is provided by primary care services such as general practitioners (GPs), public specialist clinical mental health services provide information and assistance when people are experiencing acute mental illness. Providing urgent mental health assessment and acute short-term treatment and care has been a long-standing core function of all specialist public clinical mental health services.

Consumers, family members and carers alike recognise the importance of a welcoming and professional response when they need help. Telephone contact about personal concerns, or on behalf of a family member or friend, is for many people their first experience of a mental health service.

Timely assessment and active, supportive and evidence-based treatment in the most appropriate setting is critical at this 'front end' of service delivery. This includes short-term interventions for those whose illness can be readily managed, as well as seamless engagement with longer-term care for those with relapsing or enduring conditions.

Clinical responses for people with complex needs need to be well coordinated, both between other services and with carers and families. Helping people achieve their recovery goals is critical and should include consideration of employment and education, community activities, housing and social participation.

Good practice also means taking account of the impact of a crisis or illness on family members. Recognising and enlisting early support, including parenting needs for people with mental illness and their dependent children, is a critical priority.

Clinicians in Victoria's public mental health service system provide highly specialised assessment and integrated care planning for individuals and families. These *Acute Community Intervention Service guidelines* provide guidance for specialist clinical mental health services to implement Victoria's new three-tiered response to calls for help from people with mental illness.

The guidelines are also relevant for emergency services, such as Victorian Police and Ambulance Victoria.

Contents

Introduction

Since the *Psychiatric crisis assessment and treatment services: guidelines for service provision* (the CAT guidelines) were developed in 1994, practice changes and service reform have resulted in new service types including mental health triage, emergency crisis assessment and treatment (ECAT), psychiatric assessment and planning units (PAPU), prevention and recovery care (PARC) units and, more recently, bed coordination approaches.

These initiatives provide a range of 'front-end' assessment and treatment options that can be tailored to the individual needs of people experiencing acute mental illness.

Significant service innovations and reforms are underway in the sector. These activities focus on enabling better integrated and coordinated responses, including promoting more flexible care options for those in acute psychological distress, underpinned by a strong recovery focus.

Victoria's *Mental Health Act 2014* (the Act) commenced on 1 July 2014. The Act promotes recovery-oriented practice by supporting mental health patients to make decisions about their treatment and determine their individual path to recovery. It also seeks to minimise the use and duration of compulsory treatment and creates safeguards to protect the rights and dignity of people with mental illness.

Taken together, these factors mean there is a need for a revised approach to how Victorians, across all ages and areas, access urgent mental healthcare. In this context, responses previously described as CAT functions are now incorporated into a broader set of individually tailored responses collectively called the **Acute Community Intervention Service** (ACIS).

ACIS incorporates a three-pronged approach to front-end mental health care:

1. telephone triage (over-the-phone advice and referral)
2. emergency department care (which may include the urgent assistance of a mental health team, police or ambulance)
3. acute assertive community outreach (face-to-face assessment and treatment).

These guidelines state the principles and requirements that guide ACIS interventions. They fulfil a number of functions, including:

- providing a framework for delivering acute community-based mental health services across Victoria's clinical designated mental health services, in line with sound practice and planned service reforms
- providing information and practice guidance that is consistent with the requirements of the *Mental Health Act 2014*.
- describing the functions of acute assessment and community treatment as part of a suite of specialist clinical mental health services
- articulating the expectations of specialist clinical mental health services when working with external organisations.

The ACIS approach has been developed in accordance with the principles of the *Victorian Health Priorities Framework 2012–2022* (VHPF), which reflects the government's commitment to delivering the best healthcare outcomes possible and ensuring people are as healthy as they can be.

The VHPF outlines the agenda for the future of the entire Victorian health system. It guides decision making, innovation, investment and actions, emphasising consultation with services, consumers and carers. For more information see: http://hwww.health.vic.gov.au/healthplan2022

The Acute Community Intervention Service

ACIS is provided by specialist public mental health services that respond to requests for urgent assistance (assessment and acute treatment) from members of the public, service providers or other stakeholders.

The priority is to help a person to remain in or return to their local community as quickly as possible, if assessed as clinically safe and appropriate given the circumstances.

People who need a service response may be a child, young person, adult or older person. They may be seeking help for themselves or a family member. The service is also available to referrers such as GPs, statutory services such as child protection, and emergency services (police and ambulance).

An ACIS response is generally required when the mental healthcare needs of a person are beyond family, friends or usual care approaches, and when one or more of the following occurs:

- severe and acute psychological distress with risk of serious harm to the person or others
- rapid first onset illness and distress
- acute relapse of a pre-existing mental illness
- an unplanned presentation to a mental health service by an existing or recently discharged consumer because they are in psychiatric crisis
- recurrent presentation to an emergency department as a result of drug or alcohol intoxication and high-risk behaviour in the context of a probable mental illness.

ACIS extends the former CAT approach to three key interventions that are packaged together:

1. initial telephone assessment through a clinical triage function using a triage scale to determine the urgency and nature of the response required
2. face-to-face assessment in emergency departments or community settings
3. short- to medium-term treatment as an adjunct or alternative to acute inpatient treatment or in supporting a transition from inpatient services.

These interventions are tailored to individual consumer and family needs and circumstances.

The service response may be provided by a community team or through a broader integrated care approach, delivered across a number of settings and via a range of clinicians working together to ensure a unified approach.

Principles of service delivery

Mental health services provide care within a set of key principles and practice requirements. These requirements align with the National Mental Health Standards 2010 and relate to government legislation and policies.

Person-centred recovery-oriented practice

The Department of Health's *Framework for recovery-oriented practice* underpins the practice of all Victorian mental healthcare, including interventions provided as part of ACIS. The framework outlines the core principles, key capabilities and practices required for mental health services to operate in ways that support people's recovery efforts.

Clinicians delivering an ACIS will provide care that helps define and support the consumer's personal recovery goals with a clear understanding of the challenges associated with their mental illness.

In providing an ACIS, recovery-oriented practice has the following characteristics:

- flexibility in promoting informed decision making in accord with a consumer's age and stage of development, which encourages choice and is balanced with duty-of-care and clinical risk-management obligations
- documenting consumers' preferences, ambitions, resources and support networks, and working with them to sustain and build existing resources, assets, relationships and community connections
- fostering partnerships between the service, consumers, significant others, different service providers and the community, and negotiating access to other community supports with consumer consent
- supporting staff to tailor their practice and be responsive to consumers' unique values, needs, aspirations and circumstances
- identifying the impact of mental illness on others, in particular dependent children, and taking responsibility to initiate timely responses for children who may be at risk.

During assessment and treatment, the consumer's needs and wishes should inform decisions about treatment and care.

The *Framework for recovery-oriented practice* can be found at:
http://docs.health.vic.gov.au/docs/doc/Framework-for-Recovery-oriented-Practice

Supported decision making

A presumption of capacity is the foundation of the supported decision-making model of care. The *Mental Health Act 2014* (the Act) provides that all consumers are presumed to be able to make treatment decisions.

The Act contains a capacity test and principles to help clinicians determine whether a person can give informed consent to treatment at the time the decision needs to be made. If a consumer is unable to consent they will be supported to be involved in the decision making process to the greatest extent possible.

The Act enables a consumer to make an advance statement to record their treatment preferences in the event they become unwell and require compulsory treatment. Advance statements assist clinicians to understand the consumer's treatment preferences and enable them to make treatment decisions that better align with the consumer's treatment and recovery goals.

The *Mental Health Act 2014* can be can be viewed at: www.legislation.vic.gov.au

More information about advance statements can be viewed, downloaded and printed at: www.health.vic.gov.au/mentalhealth

Responsive: right time, right place mental healthcare

All mental health services provide a timely and responsive 24-hour service for people in the community who need urgent or intensive specialist treatment and support. Mental health clinicians undertaking ACIS functions respond to requests for assistance in a timely way and inform the consumer and, where appropriate, their carers, family or significant others of the outcome, including the type of recommended follow-up and timeframe.

Mental health services have processes that support clinicians to respond to urgent requests for assessment and short-term intervention from individuals or services either in the emergency department or in the community as soon as practicable and without undue delay.

ACIS plays a fundamental role in determining and providing entry and access to the appropriate care pathway for all ages.

Those assessed as at risk of, or are experiencing, the first onset of a severe disorder such as psychosis or an eating disorder should be identified at triage or as soon as possible thereafter, and placed on a care pathway appropriate to the stage of their illness, their age and their life circumstances and preferences.

For those presenting with a more enduring illness, ACIS provides an entry pathway and links into a more streamlined response that draws on consumer-generated plans for recovery or advance statements.

Least-restrictive care

The *Mental Health Act 2014* set out the principles of care in the least-restrictive environment. These serve as a foundation for all professionals working with people who have a mental illness.

Any restrictions on a person's liberty and any interference with the rights of a person who is the subject of any actions authorised under the Act should be kept to a minimum.

At times, engaging a person in an ACIS response may require assessment in an emergency department or at a mental health facility. If required, transport arrangements should be appropriate to the person and their circumstances and should use the least-restrictive transport option possible.

The *Protocol for the transport of people with mental illness 2014* provides guidance on the transport of people with mental illness. The protocol can be found at www.health.vic.gov.au/mentalhealth

Patient rights

People receiving ACIS have the same rights as all consumers receiving care through public health services including mental health services. The Mental Health Act 2014 establishes a comprehensive suite of safeguards to protect the rights of consumers.

People receiving compulsory treatment must be given a statement of rights booklet and be provided information that clearly explains their rights under the *Mental Health Act 2014*, using interpreters if necessary.

Explaining consumers' rights in an acute situation may need to account for the circumstances, and where appropriate consider including a support person such as peer support worker, advocate, nominated person, family, friend, and/or carer depending on the individual's needs.

Copies of the statement of rights booklets can be found at: www.health.vic.gov.au/mentalhealth

Practice that includes families, carers and significant others

Family members, significant others and/or carers are often involved in the everyday enduring care needs of consumers with mental illness. They are engaged from the outset as active participants in a person's care, and should be supported through carer support staff and other mechanisms.

A therapeutic partnership between mental health clinicians and significant others, as well as those involved in their longer-term care, helps with managing and responding to illness, and is associated with improved outcomes.

Planning for transition to other mental health services or discharge involves family or carers to the extent possible and with the consent of the consumer. Young people who are carers should be respected for their knowledge and role within the overall care planning for the person with mental illness. At the same time, the needs and expertise of family and carers are taken into account during the assessment process.

Mental health services provide both the consumer and their family and significant others with written and verbal information about their rights, responsibilities and the consequences of the assessment and treatment decisions made that can be clearly understood by everyone involved in their care. At times of acute distress or illness, information processing can be compromised and the information needs of the person with a severe mental illness and significant others are regularly assessed. Communication should be provided regularly, in a way that recognises the consumer's capacity to understand at the time and using interpreters (if required).

As an example of family and carer engagement, the clinical practice guideline *Working with the suicidal person* identifies the importance of working with significant others and ensuring a history is taken as part of assessing people in crisis or emergency.

It can be found at: www.health.vic.gov.au/mentalhealth

Respecting and responding to diversity

The *Mental Health Act 2014* principles require mental health clinicians to recognise, respect and respond to the diverse needs, values and circumstances of each person. This includes their gender, family circumstances, culture, language, religion, sexual/gender identity, age and disability.

The nature and onset of disorders, their impacts and lived experience, is different for each individual.

The service guideline for gender sensitivity and safety can be found at:
http://docs.health.vic.gov.au/docs/doc/Service-Guideline-for-Gender-Sensitivity-and-Safety

For further discussion regarding responding to specific population groups, or groups with specific needs, see Appendix 1.

Integrated service responses

Partnerships and collaboration underpin integrated service delivery. Collaboration between the health system and other sectors engaged in meeting the needs of people with coexisting disorders and a coordinated approach to care is critical.

ACIS responses take account of immediate clinical treatment requirements, the likelihood of serious harm to self or others and broader psychosocial needs as part of both short- and longer-term packages of care. Activities are integrated with the mental healthcare pathway to promote continuity of care.

As the first part of a consumer's care pathway, ACIS responses provide not only appropriate short-term treatment, but the foundation for seamless transition into more comprehensive longer-term care over time if required.

Services conduct a holistic assessment of initial and urgent needs, based on the principles and practices of service coordination, in order to identify broader social problems, such as housing or drug and alcohol issues, and facilitate access to other appropriate supports..

Collaboration between government-funded services is critical to assist people with mental illness to receive treatment, be supported in recovery, and to participate fully in the community. This requires effective and documented working arrangements between police, ambulance, clinicians and other service providers, such as mental health community support services (MHCSS) child protection and family welfare services, within existing legislative and policy guidelines.

Victoria Police, Ambulance Victoria and ACIS services work together in the best interests of the person with mental illness. This means communicating all relevant information at the earliest opportunity, respecting professional judgement and independence, and applying a problem-solving approach to requests for assistance.

ACIS activities are documented in an integrated management/care plan that encompasses the full range of a person's needs. With the consent of the person, the plan is then shared across the mental health service and also with relevant external services where appropriate.

The plan should consider maintaining or restoring engagement in age-appropriate activities, social participation and meaningful activity such as education and employment as part of the medium- to longer-term goals.

How ACIS works

Aims and objectives

An ACIS response aims to minimise the risks and impact of acute significant psychological distress, first episode and recurrent mental illness in people of any age. It provides quick access to assessment and short-term evidence-based treatment and care in the least restrictive environment.

The objectives of ACIS interventions are therefore to:

- provide timely, comprehensive, age-appropriate, evidence-based mental health assessment and short-term treatment for consumers who are in the acute phase of a mental illness or disorder, including those who are at risk of self-harm or suicide, and require urgent assessment and/or short-term treatment
- facilitate access to the most appropriate services consistent with the consumer's needs, wishes and goals after the initial contact or brief intervention
- ensure family, carers or significant others are engaged (where appropriate) in the assessment and treatment of a person in the community who is experiencing a first onset or acute mental illness or disorder, including a psychiatric crisis
- work in partnership with other services, such as police, ambulance, child protection and community services, involved in the response to a person and their family in the community who is experiencing an acute mental illness or disorder, including a psychiatric crisis
- facilitate entry to a psychiatric assessment and planning unit (PAPU), acute inpatient or prevention and recovery centre (PARC) for people for whom short-term, intensive treatment and support in a community setting is not assessed as sufficient or appropriate
- facilitate timely discharge and deliver quality community-based mental health care for those leaving a PAPU, an inpatient setting or a PARC service and still needing acute mental health treatment
- attend to the safety and support needs of family members, carers and dependent children.

As outlined, ACIS comprises three inter-related front-end functions – telephone triage, mental health in emergency departments and acute assertive outreach assessment and treatment.

Collectively, ACIS functions ensure all-hours access to specialist mental health care, for all people of all ages, including:

- screening and initial assessment
- acute assessment and treatment responses in the community[1] and in emergency departments
- support for police, ambulance and other emergency services such as child protection.

An ACIS response is prioritised by clinical need, the likelihood of serious harm to self or others, and the specific circumstances of the contact.

1. In the context of this guideline, 'community' means locations such as place of work, education setting or a person's place of residence.

Mental health services have developed clearly defined ACIS pathways and processes from the point of initial contact or presentation through to ongoing clinical treatment in inpatient or community settings or closing an episode of care.

The ACIS treatment and care processes are consistent with the overall processes used by the service. The process should be seamless and integrated.

The departmental publications *Mental health triage circular* and *Mental health in emergency departments care framework* will be updated in line with this guideline.

A. Telephone triage

Anyone can make unplanned contact with mental health services. Mental health telephone triage is generally the first point of contact for people seeking a specialist mental health response. Some callers simply need some information or advice they can act on independently; others need to be referred to further assessment and care.

This subsequent care may be with public, private, specialist or primary mental health services. Telephone triage services provide triage screening, preliminary assessment for all age groups, drawing on age-appropriate responses and situation-relevant expertise as required.

If children or young people present as out-of-home care consumers, the service's Priority Access Service Response (PASR) is activated. For further information about PASR see: www.health.vic.gov.au/mentalhealth

When communicating with a caller, the telephone triage clinician undertakes screening and a preliminary assessment as to whether the consumer is likely to have a mental illness or disorder. Triage practice integrates social, health and clinical risk assessment in order to deliver a quality response. The person's need for service is ascertained, and the nature and urgency of the response is then determined.

The Department of Health's Mental Health Triage Scale is used to guide decision making about the level of urgency. For further information about the Mental Health Triage Scale see: www.health.vic.gov.au/mentalhealth

Given that a telephone response is provided to people with a wider array of mental health issues than the target group for specialist mental health services, the service also recommends and facilitates access to other services for mental health and related assistance appropriate to clinical need.

If an emergency service calls the telephone triage (such as police, ambulance and child protection services), the call will be prioritised, on the understanding that there has been a preliminary assessment regarding immediate risk and that a mental health assessment may be required.

The next step – after a telephone triage ACIS response

If mental health telephone triage contact determines that the person does not need a specialist mental health response, they are directed to other services such as a community-managed psychosocial support provider (for help with broader psychosocial needs such as housing or access to employment support), primary care (for example, GPs, headspace, community health), private counselling/support, alcohol and drug services, education or vocational services.

In the case that a mental health triage contact indicates specialist mental health services may be required, a more comprehensive assessment is provided. The triage clinician will decide where to direct the person in the mental health service system. This may be for further assessment and short-term treatment at home or in the community, via special clinical community services, in an emergency department, or for admission to an inpatient setting.

B. Mental healthcare in emergency departments

A dedicated assessment and treatment response is available in major Victorian metropolitan and regional hospitals. In developing ACIS pathways and processes, specialist mental health services ensure a senior mental health practitioner is available to emergency departments for consultation and advice.

Individuals of all ages and backgrounds can access a mental health clinician, assessment and appropriate short-term care in a major emergency department at any time of the day or night.

While treatment and care in a community setting is a priority, at times (such as when there are safety concerns) people with a broad range of possible mental illnesses are referred to an emergency department by telephone triage. They might also present independently or by other means, for example by ambulance or with police. Depending on the severity, acuity and risks observed in the person's presentation, the ACIS response may lead to an admission to an inpatient unit, referral to a community mental health service, or to another service.

Mental health services in emergency departments provide assessment and appropriate interventions for all age groups, drawing on age-relevant expertise as required. People who are referred but not admitted are linked to appropriate follow-up care and, if necessary, short-term management until appropriate follow-up can be organised. Where a child or young person who is in out-of-home care presents at an emergency department, a Priority Access Service Response (PASR) is activated.

Specialist mental health clinicians working in emergency department settings also provide ongoing education and training for emergency department staff in identifying, assessing and managing people who are suicidal or are experiencing a mental illness.

The next step – after an ACIS response in an emergency department

Following the initial face-to-face assessment and short-term responses developed within an emergency department, mental health services in emergency departments document a plan to guide treatment. This plan has clear goals and timelines, and identifies staff, consumer and family responsibilities.

If mental health contact in an emergency department determines that the person does not need a specialist mental health response, they are directed to other services such as a community-managed psychosocial support provider (for help with broader psychosocial needs such as housing, access to employment support), primary care (for example, GPs, *headspace*, community health), private counselling or support, alcohol and drug services, education or vocational services.

Where mental health triage contact indicates specialist mental health services are needed, a more comprehensive assessment is provided. This assessment and plans are linked to long-term care strategies and approaches, which are shared (with consumer consent) with extended care teams and providers.

C. Community mental health

All specialist mental health services provide a range of community treatment and care components, located across a spectrum of continuing care.

Some services have separate teams for each function; however, increasingly services are innovating to implement and operate integrated teams that perform a number of functions by rostering staff to undertake all required activities within a continuous-care framework for a given period.

Community mental health service components include urgent community-based assessment and short-term treatment interventions for people with mental illness in crisis, intensive long-term support for people with prolonged and severe mental illness and associated high-level disability, and non-urgent continuing care services for people with mental illness, and their families or carers in the community.

Community mental health responses use an assertive outreach approach that may result in clinical staff being involved with people for extended periods of time or providing more episodic care. Continuing care clinicians frequently liaise with, and refer to, generalist services including GPs for ongoing support and to provide services to people with mental illness.

In the case of a consumer known to a mental health service, either subject to ongoing support and case management or involved in transition from bed-based to community-based care mental health clinicians anticipate when a person may make after-hours contact with triage and possibly require an ACIS service as part of their regular treatment planning and clinical review processes. At a minimum, clinicians charged with triage and ACIS functions have access to the person's up-to-date care/treatment plans so they can provide treatment and care for the person as clinically indicated and agreed.

The next step – after a community mental health ACIS response

As with all components of an ACIS response, community team interventions are consistent with relevant legislation and policy requirements, engage and link with consumer and carer needs and are consistent with long-term care approaches and plans. Actions and plans resulting from a community mental health ACIS response have clear goals and timelines, and identify staff, consumer and family responsibilities.

As part of mental health contact in the community, consumers are supported to access other services such as a community-managed psychosocial support provider (for help with broader psychosocial needs such as housing, access to employment support), primary care (for example, GPs, headspace, community health), private counselling/support, alcohol and drug services, education or vocational services.

Additional ACIS considerations and requirements

Working with emergency services

If an emergency service transports a person in need of urgent or intensive specialist treatment to an emergency department, or a facility of a mental health service, the local mental health service will implement established processes that prioritise handover and support emergency service personnel being released as soon as practicable. This is consistent with the *Mental Health Act 2014* and the *Department of Health and Victoria Police protocol for mental health* (accessible at: health.vic.gov.au/mentalhealth).

Mental Health and Police Response

The Mental Health and Police Response (MHaP Response) involves an initial investment of $15.1 million over four years. It will deliver a more targeted and timely response to a person needing urgent mental health support, while also reducing pressure on police, ambulance and emergency department resources. Once fully operational, area mental health services will be better resourced to work in partnership with police in the community to deliver earlier responsive shared mental healthcare.

Each of Victoria's 21 area mental health services will receive recurrent funding to deliver MHaP Response. There will be a staged rollout, with 12 area mental health services chosen to deliver MHaP Response in the first year (2014–15). Another six will be selected in the second year of rollout (2015–16) and three in the third year (2016–17).

MHaP Response builds on the earlier trial of the Police Ambulance and Clinical Early Response (PACER) pilot in Southern Metropolitan Region, regarded positively by stakeholders and independently evaluated, as well as similar partnership projects that are being tested or piloted in other mental health catchments across Victoria.

Health services will have an additional resource to deliver clinical mental health services while also providing a flexible response to local need and the local service delivery environment through the MHaP Response initiative.

In line with the *Mental Health Act 2014*, consumers and their families will be involved in decisions about their assessment, treatment and recovery and supported to make or participate in those decisions as part of MHaP Response.

Risk management

ACIS clinicians (across all contact points – telephone triage, emergency department or the community) are initially responsible for ascertaining whether there is any risk of serious harm within the situation on the basis of information provided and their clinical assessment. They will ensure risk factors are taken into account when deciding how the assessment will be managed.

'Risk of serious harm' covers three domains:

- risk of serious harm to self (for example due to suicidal ideation, acts of self-harm, significant self-neglect, non-adherence to medication, impaired judgement or impulse control, or high-risk behaviours)
- risk of serious harm to others (for example homicidal, aggressive or destructive acts or ideation; impulsivity or behaviour endangering others)
- risk of serious harm from others (for example neglect, violence, exploitation, and physical or sexual abuse or vulnerability).

ACIS monitoring and evaluation

As part of ACIS, services regularly review via a commitment to continuous quality improvement, monitoring and evaluation processes, the appropriateness, responsiveness and local relevance (in conjunction with key stakeholders, including service consumers, carers and partners) of the ACIS approach. Subsequent to review, required adjustments should be implemented for further evaluation.

The Department of Health and health service mental health program meetings provide an opportunity to discuss ACIS approaches and the impact of ACIS responses on consumer and carer outcomes, as well as enhancing service coordination during routine organisational update and liaison discussions.

Further, an ACIS approach is linked to timelines established by the Mental Health Triage Scale. Implementation, evaluation and monitoring should be linked to the timeliness of responses and outcomes required within the triage categories defined and access measures and community care targets within health service performance frameworks.

Hours of operation

As a core component of the mental health pathway, ACIS responses are available 24 hours a day, seven days a week through an appropriate mix and locally relevant application of the three approaches (telephone triage, emergency department, or community response). The type of response is determined by clinical need. Mental health services anticipate peak demands as part of their planning, recognising occupational health and safety standards.

Out-of-hours services

Services have protocols that outline the process for after-hours access. The level of response offered is determined by clinical need and assessment, occupational health and safety standards and workforce capability.

Responses can range from telephone advice and/or an initial clinical assessment (which might include a direction to provide transport to an emergency department where a face-to-face assessment is indicated but not available in the community within the required response time) through to an initial triage clinical assessment followed by an out-of-hours acute assessment and subsequent treatment in a community setting.

Referral processes

People with mental illness, their families and supporters can always contact mental health services and a range of other services directly. Specialist mental health services through ACIS make the initial decision about whether a person requires a clinical response, another type of mental health service, information, advice and/or referral.

The response provided by ACIS may result in services being provided by agreement with the consumer or as compulsory treatment in accordance with the *Mental Health Act 2014*.

Where required, responses are delivered in partnership with emergency services (police and ambulance). Police should be supported and responded to as a primary partner to the ACIS and

the *Department of Health and Victoria Police protocol for mental health*[2] should guide all interactions and activities. Particular attention to this partnership is evident in triage and ACIS functioning and a focus on regular liaison and review meetings between the mental health services and police and emergency services.

The ACIS response designates and describes clear referral processes and pathways into and out of the service, including responding to emergency services (police and ambulance) and child protection services.

Effective workforce

All staff employed to deliver an ACIS response should have the appropriate skills and knowledge to fulfil their role and responsibilities. They should receive the required support to perform the tasks. The staff should understand the role of clinical governance within the organisation.

Care transitions

Consistent with principles of coordinated and integrated care, transitions between inpatient and community care are critical periods in the care pathway. A plan that articulates how services ensure continuous care for an individual and their family during and after transition is developed from the beginning of an episode of care, and subject to regular review and updating.

In addition, appropriate brief interventions via a timely and responsive ACIS can prepare an individual for care or treatment in the community, and enhance links to treatment and care services while reducing the risk of disengagement with care, which is higher in early stages of contact. Considered approaches to improving engagement between consumers and services place the consumer at the centre of care, and can positively impact people's participation in their treatment.

The most common services providing support in the community will include:

- community mental health teams
- PARC services
- MHCSS
- GPs and primary care services
- private psychiatrists
- alcohol and other drug services
- social and community services
- housing and homelessness services.

External services are part of the care pathway and are considered when delivering an ACIS response and developing a care plan. Appropriate engagement of services is supported by the use of sound and agreed service coordination practice and protocols.

With the consent of the person concerned, the plan is negotiated and shared with the relevant external services. Consultations with the person concerned their family or carer and service providers, including actions taken, are clearly documented in the clinical record.

2. Accessible at www.health.vic.gov.au/mentalhealth/publications/police-mh-protocol0910.pdf

Appendix 1: Particular consumer groups

Aboriginal and Torres Strait Islander people

Aboriginal health is viewed in a holistic context that encompasses mental, physical, cultural and spiritual health. Land, family, community and spirituality are central to wellbeing. The impact of history, and ongoing trauma and grief related to the effects of colonisation and dispossession, contribute to a higher prevalence of mental health-related issues among Aboriginal people.

The chance of an Aboriginal person receiving compulsory mental health treatment is three to five times higher than for non-Indigenous people,[3] and more than one in three Aboriginal people in Victoria has had a lifetime prevalence of doctor-diagnosed depression or anxiety.[4] Despite this overrepresentation of mental health-related issues, many Aboriginal people are reluctant to seek help in hospitals. When they do, they generally have more acute and complex health issues.

As such, it is important that services providing care and treatment to Aboriginal people are culturally aware and responsive. Further information and tools relating to culturally appropriate care for Aboriginal people are available in the Department of Health's ICAP resource kit: www.health.vic.gov.au/aboriginalhealth/access/icap.htm

Government policy and legislation relating to the health and wellbeing of Aboriginal people is available for on the Department of Health website: www.health.vic.gov.au/aboriginalhealth

3. Australian Bureau of Statistics and Australian Institute of Health and Welfare 2010, *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples*, Oct 2010, ABS cat. no 4704.

4. Department of Health 2011, T*he health and wellbeing of Aboriginal Victorians: Victorian population health survey 2008 supplementary report,* State Government of Victoria, Melbourne.

Parental mental illness and dependent children

If a parent who is the primary carer for a dependent child is unwell, the needs of and risks to the child needs to be assessed and acted on. This may also involve the assessment of other family members and care providers In many families, extended family members take up the primary caring role, but in vulnerable families with limited resources and social connections this is less likely.

It is understandable that parents want the best for their children. With this in mind, parents may become distressed when they are unable to provide adequate care for a child. Concerns about parenting capacity can be both a reason and a deterrent for seeking help with a mental health problem or disorder. Developing an ACIS response for a consumer with dependent children provides a unique opportunity to ameliorate actual or likely harms to children and others, and to enlist timely parenting supports and protective interventions.

Some parents with mental illness are unable to protect their children from neglect and abuse. Parental mental illness when combined with concurrent drug and alcohol abuse and family violence places a dependent child at notably increased risk. Both the *Mental Health Act 2014* and the *Child, Youth and Families Act 2005* require mental health services and practitioners to ensure that children are protected from such harms and to take account of and act in the best interests of the child.

For ACIS this means actively seeking to identify dependent children early and to incorporate appropriate actions regarding dependent children in the assessment and treatment plan to reduce this risk and associated parental distress.

The principles of the *Child, Youth and Families Act 2005* and responsibilities for mental health practitioners in protecting vulnerable children can be found at: www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection

Out of home care consumers

Infants, children and young people involved with child protection and placed in out-of-home care are a highly vulnerable group. Before their placement, they are likely to have been traumatised by significant abuse and/or neglect. The risk of mental health issues and the emergence of mental illness in this group is notably higher than in the general community.

The Chief Psychiatrist guideline *Priority access for out of home care* frames arrangements for mental health services to give weighted and preferential consideration to referral requests concerning infants, children and young people (to the age of 18) in out of home care:
http://www.health.vic.gov.au/mentalhealth

The guideline directs mental health services (child, youth and adult streams) to establish a service response that ensures the most appropriate and timely assistance is either provided or facilitated for this consumer group. Some mental health assessment and interventions may also require family-focused work to support parents with a mental illness in their parenting role.

Referral path

All referrals of infants, children and young people who are clients of child protection in out of home care will be flagged by the triage/intake service and a streamlined service response will be provided to best meet their needs.

Priority of access service response

The introduction of a service mechanism, priority access service response (PASR), will ensure the most appropriate and timely assistance from the full range of mental health service options is provided or other service options facilitated for this consumer group. In addition, the PASR will encourage designated child protection senior managers/practitioners to access non-urgent consultation services.

The PASR, according to the issues raised, may offer to provide:

- a primary consultation delivering a face-to-face assessment with a child or young person
- a secondary consultation with service providers relating to the wellbeing of a particular child in out of home care who presents significant or increasing concern, or
- a service level consultation to support an out of home care or child protection team in its work.

The designated mental health service will:

- require a senior experienced clinician in a primary role to lead and coordinate the PASR
- ensure crisis assessment and triage/intake functions are well connected for the PASR
- identify and deploy staff who are knowledgeable and skilled to work with children and young people from a developmental framework and who are also trauma-informed in their practice
- meet triage guideline response times for out of home care referrals
- construct a consultation service response to directly cover consultation requests from designated child protection managers or senior practitioners
- communicate PASR arrangements to the relevant child protection regional managers.

Refugees and asylum seekers – including refugee minors

Newly arrived people are at increased risk of significant mental health concerns. Experiences associated with previous trauma, resettlement and the potential constant threat to family and friends still overseas are complicating and challenging factors.

A key issue relates to the need for ongoing and responsive mental health assessment of immediate risk associated with suicide and self-harm.

Refugees and asylum seekers receive support from resettlement organisations, local communities, GPs, public mental health providers, and specialist services such as the Victorian Foundation for the Survivors of Torture (Foundation House) which provides the opportunity for a good breadth of mental health interventions, however acute risk assessment and short-term intervention is an ongoing focus and requirement for ACIS.

The need for acute risk assessment and short-term intervention (an ACIS response) for refugee and asylum seeker populations tends to be evident in emergency department settings.

A specific subpopulation of key interest is participants in the Refugee Minor Program (RMP). The RMP works with young refugees under 18 years old who arrive in Australia without a parent and live within Victoria. These young people are sometimes referred to as unaccompanied humanitarian minors.

The program was established over 30 years ago as a joint initiative between the Commonwealth and states to support these young people and their carers. It was recognised that these young people were usually living with relatives or members of their cultural community who had also experienced the trauma of being a refugee. These arrangements required the appropriate support to ensure they did not breakdown.

The RMP is a statewide service in Victoria, and is part of child protection in the Department of Human Services. In addition to departmental program staff, contracted agencies service consumers throughout regional and rural Victoria. The program uses a consumer-centred approach to help children and young people with their settlement and assist in the establishment of the consumer's life in their new community.

For further information see: **www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/programs/youth-specific/refugee-minor-program**

People presenting with alcohol and/or drug intoxication

Alcohol and drug intoxication may influence a person's mental state presentation and my imitate or mask symptoms of an underlying mental illness. Coronial findings have emphasised the importance of mental health assessment in the presence of alcohol or drug intoxication.

The presence of alcohol and/or drug intoxication does not preclude early assessment, although it may indicate the need for further assessment when the person is no longer intoxicated. When a request for assessment is received, it is not appropriate to insist that the person be free from the effects of alcohol and /or drugs. The coexistence of intoxication does not prevent an ACIS intervention including assessment.

Staff should familiarise themselves with drug and alcohol services in their local area to facilitate appropriate referral and collaborative interventions.

Consumers with an intellectual disability

People with an intellectual disability should be able to access all components of mental health services including an ACIS response. They should not be refused access to a service due to their intellectual disability.

It is important for those working in the 'front-end' of a mental health service to be aware of 'diagnostic overshadowing', which occurs when symptoms of mental ill-health are misattributed to intellectual disability rather than being recognised as part of a mental disorder.

The guide: accessible mental health services for people with an intellectual disability offers a framework for mental health professionals to improve accessibility and quality of mental health care for people with an intellectual disability. This guide is accessible at:
http://3dn.unsw.edu.au/the-guide