Metro South Health | Better together

Research and Learning Resources

Metro South Addiction and Mental Health Services

Queensland Government

Contents

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Summary of capability levels

Summary of Capability Levels

Foundation level: this level incorporates awareness of MSAMHS service guidelines and the fundamentals for working with consumers and their carers. It involves a general awareness of other levels in the framework and as such is aware of a range of services offered within your team and how referrals can be actioned with support from more experienced staff. All entry-level staff who have completed online training will be at this level. Administration staff are encouraged to aim to be at this level across all Therapeutic Pillars.

Practice-informed level: this level incorporates basic understanding of the Therapeutic Pillar principles including how to provide basic interventions to enhance regular practice. Also included is how to assess and review outcomes as well as engage in supervision, self-reflective practice and further own understanding and education around the intervention. Practice in this area will always be accompanied by supervision and there is no requirement to provide “therapy” at this level. All clinical/peer/frontline staff are encouraged to aim to be at this level across all Therapeutic Pillars.

Practitioner level: at this level, staff will have good knowledge and experience in the principles, theory and application of the intervention specific to particular populations. Formal training in this intervention has been completed along with ongoing supervision of practice and engagement in supervision of less experienced staff. Staff at this level will have contributed to research or service development around this intervention.

Advanced Practitioner level: staff at this level will have a detailed and comprehensive knowledge of theory, contemporary interventions, skills, strategies and practice emerging from recent scientific research. Staff will provide consultation and leadership to MSAMHS for promotion of the intervention including contributing to development of protocols of supervision, staff training, research design and evaluation for the promotion of EBP.

General summary: descriptors for each capability level - please use full version during self reflection			
Foundation Practitioner	**Practice informed Practitioner**	**Practitioner**	**Advanced Practitioner**
The practitioner has a fundamental basis for understanding and working with mental health consumers and receives regular practice supervision The practitioner has a basic knowledge of § assessment § alliance building § diagnosis § formulation in the context building a therapeutic alliance The practitioner is able to appropriately link therapy principles to connectedness and recovery-oriented practice Awareness of best available evidence in relation to therapy practice and ACU models of care	The practitioner has a basic and general introductory knowledge of the therapy assessment and treatment modalities as well as appropriate clinical frameworks, models, and core practice skills The practitioner has received introductory training in the therapy and is able to appropriately combine therapeutic practice with connectedness and recovery oriented principles Therapy techniques are used as a limited range of interventions that can enhance current clinical practice and are applied safely as sub-skills of routine treatment Knowledge of best available evidence in relation to therapy practice	The practitioner has a sound overview of assessment and treatment for the therapy as well as appropriate clinical frameworks, processes and specific therapy techniques Certified core training in the specific therapy Applies recovery and social inclusion principles to enhance therapy in a mental health context The practitioner clinically applies the specific therapy in relation to the best available evidence and supports the skill development of others The practitioner provides supervision and training to less advanced practitioners Regular active participation in peer review, therapy evaluation and development	The practitioner has a contemporary and in-depth knowledge of the therapy assessments and interventions, therapy specific clinical frameworks, processes and specific technical skills The practitioner applies recovery and social inclusion practices in therapy and leads the effective evaluation of the effectiveness of therapy interventions The practitioner selects the therapy in relation to the best available evidence and tailors it appropriately The practitioner provides supervision and training to less proficient practitioners and leads service initiatives The practitioner contributes to the evidence base by driving evaluation or research

Our Metro South Community

Our Metro South Community

It is acknowledged that we work with individuals within our community who are marginalised, discriminated against and who have poorer life expectancy and physical health outcomes when compared with the general population. Within this community again are individuals who experience additional hardship including environmental and political circumstances that contribute to their overall picture of life challenges, recovery journey and resilience. Overarchingly, there is a need to further our cultural competence and sensitivity of practice when working with consumers.

Aboriginal and Torres Strait Islander Consumers: It is estimated that the life expectancy of Aboriginal and Torres Strait Islander people is lower than the general population by 10.6 years in males and 9.5 years in females. Non-communicable and preventable diseases account for an estimated 70% of this health gap. Some of these diseases include cardiovascular disease at 23%, diabetes at 12%, mental disorders at 12% and chronic respiratory disease at 9% (Markwick, Ansari, Sullivan, Parsons, & McNeil, 2014).

Added to recognition of health disparity between Aboriginal and Torres Strait Islander people and non-Aboriginal and Torres Strait Islander people, a sensitivity is needed along with an acknowledgement of the ongoing health inequalities that have resulted from the trauma experienced due to Australia's colonisation by Europeans (Atkinson, Nelson, Brooks, Atkinson & Ryan, 2019; Merritt, 2011). Further to the recognition of systemic discrimination is the concept of barriers to help seeking, as help seeking has been shown to be lower in Aboriginal and Torres Strait Islander people (Coates, Saleeba & Howe, 2018). When considering this, it becomes essential that services are aware of these barriers and seek to actively dismantle them in order to fully service all consumers equally. Barriers of note include experience of racism and discrimination, lack of trust in mainstream services, negative past experiences, low mental health and addiction literacy, holding mental health and addiction stigma and shame, and lack of culturally appropriate services (Coates et al., 2018).

Key considerations for MSAMHS are therefore:

- Acknowledgement of potential trauma and its impact on presentation
- Consideration of the local community the consumer comes from
- Whole person perspective including physical, mental and spiritual wellbeing (Parker & Milroy, 2019).
- Consideration of Aboriginal and Torres Strait Islander concepts of health and methods of health care that are mindful of diversity and identity
- Not limiting health care to diagnosis or limiting care with the perspective of 'personal responsibility" rather than seeing a broader contextual causation and maintenance of poor health and good health (Markwick et al., 2014).

- Referral to Aboriginal or Torres Strait Islander support staff
- Culturally aware staff who understand the impact of intergenerational trauma, the separation from culture, spirituality, language, and social injustice (Gilbert, 1995)
- Respond to barriers to help seeking.

Cultural Diversity: Cultural beliefs about what constitutes mental illness and how to respond to it affects how individuals from a culturally and linguistically diverse background seek help and whether they will choose to access mental health services (Cross & Bloomer, 2010). Although there are considerable research and data gaps in this area, evidence indicates that individuals from a culturally and linguistically diverse background have lower rates of mental health service utilisation when compared to the Australian-born population (Minas Kakuma, Too, Vayani, Oranpeleng, Prasad-Ildes, Turner, Procter, & Oehm, 2013; Colucci, Too, & Minas, 2017).

Some barriers for people in accessing mental health services include lack of knowledge about mental health services, language barriers, stigma of mental illness, concerns about confidentiality, cultural beliefs about mental health symptoms, negative experiences of using mental health services, concerns about not being understood or respected or cultural needs not being met (Minas, et al., 2013).

There are a range of factors contributing to an increased risk of mental health problems in people from culturally and linguistically diverse backgrounds, including: loss of family and social connections, discrimination, stresses of migration and adjusting to a new country, exposure to trauma before or during migration and a range of other social determinants (Baker, Procter, & Ferguson, 2016).

When working with people from culturally and linguistically diverse backgrounds it is important to address the barriers that prevent people from accessing mental health services and to identify the range of risk and protective factors that influence mental health and wellbeing. Mental health clinicians who work in culturally responsive ways seek to understand the illness experience of culturally and linguistically diverse consumers and work collaboratively with consumers and their family to respond to cultural needs (Cross & Bloomer, 2010).

Key considerations for MSAMHS are therefore:

- Respect for the cultural values and needs of the consumer and their family to support good therapeutic alliance and communication.
- Understanding what is culturally normative for the individual with respect to their cultural reference group and their own individual baseline.
- Understanding the challenges associated with using interpreters. Seek to offer interpreters even when an individual has a conversational level of English language proficiency. Ask about dialect and gender preferences.
- Explaining confidentiality and roles and responsibilities in a way that individuals can understand.
- Understanding an individual's cultural/ethnic/racial/spiritual/language identity (or identities).Understanding of the individual's level of acculturation with the host country.
- Understanding the cultural meanings of health and mental health and addiction and an individual's explanation of their illness or distress.
- Understanding the psychosocial environment and level of functioning with respect to cultural norms.
- Understanding of the unique circumstances of the individual and the impact and implications of these circumstances i.e. trauma, residency stress,

citizenship, and refugee status.

- Understanding that cultural differences between an individual and the clinician can influence communication, language, interpretation of responses and behaviours, relationship and rapport building.
- Facilitate referral to transcultural mental health services and other culturally appropriate treatment or psychosocial support services.

Diverse Sexuality and Gender: There are clear disparities in health outcomes within the Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and/or Asexual (LGBTQIA+) consumer community when compared with cisgender heterosexual community members. Members of this community are disproportionally affected by depression and anxiety in part due to experiences of gender and sexuality based discrimination (Briggs, Hayes, & Changaris, 2018).

Suicide attempt rates in the transgender population are worryingly high, around 11 times higher than in the general population, and LGBTQIA+ people aged 18-27 are five times more likely to attempt suicide in their lifetime (National LGBTI Health Alliance, n.d). As such, services need to be knowledgeable and inclusive of diverse gender and sexual identities. Some barriers to help seeking include overt and covert discrimination and a lack of LGBTIQA+ sensitive practice (Narang, Sarai, Aldrin, & Lippmann, 2019). This includes, but is not limited to, assumptions regarding gender, and not respecting name, dress, and pronouns when communicating with consumers. Additionally, the lack of acknowledgement of the impacts of familial and social rejection and exclusion, bullying and violence, historical social trauma and disrespecting identity can act as barriers to engagement (Klein & Golub, 2016).

Key considerations for MSAMHS are therefore:

- Tailoring interventions to meet the needs of LGBTQIA+ consumers.
- Linking consumers with peer groups and LGBTQIA+ services, whether face-to-face, online, or by telephone.
- Understanding the importance of safe spaces for the LGBTQIA+ community.
- Gaining a better understanding of contemporary research and standards of sensitive practice specific to LGBTQIA+ consumers.
- Understanding the challenges LGBTQIA+ consumers face with regards to social and familial relationships, including rejection.
- Understanding of how stigma, discrimination and marginalisation can impact on mental health, addiction, and physical health outcomes - including perceived or actual exclusion from support services.
- Understanding intersectionality in the context of LGBTQIA+ consumers.
- Understanding the impact of domestic and family violence on LGBTQIA+ consumers.
- Acknowledgement of struggles including prejudice, social stress, social exclusion, homophobia and transphobia, bullying, abuse and violence.

Therapies Capability Framework

Pease insert the relevant therapy in the '……" space provide (e.g. CBT, DBT, MI)

	Foundation Practitioner	Practice informed Practitioner	Practitioner	Advanced Practitioner
Domain 1 Therapy knowledge and practice skills	Basic core skills in building a therapeutic alliance including a shared *understanding, history taking, risk assessment and formulation in the context of the …… therapeutic framework Basic knowledge of treatment and referral options for ……. therapy Basic knowledge of …… principles and connection to recovery oriented and person-centred practice Able to deliver basic education and therapeutic support (including dual diagnosis context) for consumers * "understanding" refers to stepping into the person's world and conveying this back	General knowledge of ……..therapy concepts and how to incorporate these into current clinical practice Practice framework influenced by a general knowledge of the …… model/s and core practice skills Knowledge of …….. in relation to evidence-based practice Awareness of ……. therapy in the context of recovery-oriented and social inclusion practices Able to evaluate and modify care plan according to individual needs and …… principles	Sound knowledge of ……practice competencies for assessment and intervention Frequent independent application of a …….. practice framework and specific therapy techniques Comprehensive understanding of …… in relation to the best available evidence Application of recovery oriented and social inclusion practices to enhance therapy outcomes Ability to evaluate and refine ……. interventions to improve therapy outcomes with regular supervision	In-depth knowledge of ……. therapy knowledge and skills, contemporary techniques and practice competencies Able to provide consultation to service leaders on therapeutic frameworks for complex clinical practice Advanced knowledge of best available evidence for ……, including its strengths and limitations Leads application of recovery-oriented and social inclusion practices in the evaluation of ……. therapy Facilitates the evaluation and reporting of therapy program outcomes

	Foundation Practitioner	Practice informed Practitioner	Practitioner	Advanced Practitioner
Domain 2 Autonomy and Support (required and provided) in therapy ***(for supervision requirements see domain 4)***	Able to perform most clinical tasks in a safe manner with regular clinical and professional reflective practice supervision	Completes straightforward clinical tasks incorporating basic …….. skills supported by observation and reflective practice supervision Requires frequent support and advice from practice supervisor, multidisciplinary and professional teams	Independently completes most complex clinical tasks applying …… techniques confidently using own judgement Seeks and provides regular advice within the multidisciplinary and/or professional team Provides support and mentoring for ……. therapy skills to other members of the multi-disciplinary or professional team	Independently and holistically manages complex clinical scenarios in therapy for a multidisciplinary team or across clinical units Independently goes beyond basic standards, creating interpretations and learning tools for self and other clinicians across various clinical units and professions Provides support and mentoring for …… therapy skills within the multidisciplinary and professional teams across various clinical unit

	Foundation Practitioner	Practice informed Practitioner	Practitioner	Advanced Practitioner
Domain 3 Dealing with Complexity in Therapy	Able to deal with complex clinical situations with appropriate mental health interventions This is achieved using non-specific factors, and without the specific…...therapy modality or framework perspective	Able to identify opportunities and provide intervention in complex situations with only partial understanding of therapy frameworks and techniques …… therapy is used as a limited range of techniques that can enhance current clinical practice. These are applied safely as sub-skills of routine treatment.	Ability to manage complexity through purposeful analysis and reflection utilising supervision from a more proficient therapist on a regular basis. Sees overall picture and how own actions contribute to consumer outcomes as a result of engagement in therapy.	Deals with clinical situations considered by the treating team to be highly complex using ……. therapy Holistic grasp of complex situations, moves between intuitive and analytical approaches with ease Sees overall picture and alternative approaches; vision of possibilities in therapy.

	Foundation Practitioner	Practice informed Practitioner	Practitioner	Advanced Practitioner
Domain 4 Supervision Role and Credentials	Recipient of core clinical and professional practice supervision from senior clinician and/or relevant peer group process as per usual business Core clinical practice skills endorsed by performance coaching and appraisal process. Participates in the identification of own learning needs and development activities Professional registration and/or credentialing requirements met.	Frequent reflective supervision from a more capable practitioner with an emphasis on specific …….. skills and direct observation of practice Provides basic …... Education to less knowledgeable clinicians and foundation practitioners Completed introductory training in ..... therapy skills	Ongoing and routine reflective practice supervision with a more proficient …… therapist, utilising individual, peer supervision and/or direct observation Provides …... Practice supervision to Foundation and Practice-Informed Practitioners as well as other less proficient ..... therapists Certified core training in ,,,,,, therapy	Routine …... Therapy practice supervision with a more proficient therapist or peer group Provides therapy practice supervision for less proficient therapists Identifies ,,,,,, therapy development needs for others and delivers appropriate continuing professional development activities Certified advanced or intensive training in ..... therapy

	Foundation Practitioner	Practice informed Practitioner	Practitioner	Advanced Practitioner
Domain 5 Research and evidence-based practice (EBP) Role	Awareness of best available evidence in relation to …… therapy practice and ACU models of care	Consumer of literature and knowledge of best available evidence in relation to …… therapy practice Active participant in peer discussion in relation to …… therapy practice	Regular active participation in EBP activities including peer review and …… therapy evaluation and development	Leads EBP initiatives including facilitation of peer review Active participation by driving ……therapy evaluation and/or research and service initiatives

Metro South Health

Addiction and Mental Health Services

Therapy Capability Framework

Manual

We care about you

Queensland Government

Therapy Capability Framework

Welcome

Welcome to the Therapy Capability Framework. We hope this becomes a useful and valuable resource for your clinical skill development.

All clinicians will use this framework during supervision as a continuing professional development tool. *It is not intended for and should not be used for performance management purposes.*

The framework creates a platform for continual improvement at both clinician and organisation levels.

Its structure mirrors the *Dreyfus* Model of Skill Acquisition (1980)*. Therefore, it is in nature an easy to use tool providing guidance for measuring capability in the context of therapies.

** Dreyfus, Stuart E.; Dreyfus, Hubert L. (February 1980). A Five-Stage Model of the Mental Activities Involved in Directed Skill Acquisition, Washington, DC: Storming Media. Retrieved June 13, 2010.*

Our Mission
To support practitioners to share common goals and objectives that contribute to the consumers' recovery journey, to which the strengths of each member of the team contribute in a coordinated manner, in accordance with his/her clinical capabilities, whilst respecting those of others.

(Adapted from "Health manpower requirements for the achievement of health for all by the year 2000 through primary health care", WHO Technical Report Series, No 717 (p. 89))

What does the Framework aim to achieve?

The Therapy Capability Framework was created under the premise that clinical practice improvement will improve outcomes for the consumer (and carer).

In developing the Therapy Capability Framework we aim to identify:

a) Current therapy skills and developmental needs that guide clinical practice
b) Future supervision and continuing professional development opportunities

The goals of the framework are to strengthen:

- *Consistent access to therapeutic practice informed by the best available evidence for all mental health consumers*
- *Clinical capability requirements for therapies in each of the Divisions*
- *Individual learning and development pathways to the clinical capabilities required across all services*
- *Staff recognition and reward based on clinical expertise*
- *Clinical and professional leadership in the delivery of therapeutic services for consumers*
- *Decision making for learning, development and practice supervision priorities for each Academic Clinical Unit*

When is the framework used?

The Therapy Capability Framework is used when:

- *a new clinician commences within the MSAMHS*
- *a clinician transfers between Divisions*
- *the Professional Appraisal and Development (PAD) tool is reviewed*

However, don't feel restricted by this. The Therapy Capability Framework can be used at any time to guide clinical improvement in therapies.

How is capability different to competency?

Capability is:

- The practitioner's capacity to apply values, knowledge and skills to overcome a variety of challenges, some of which may be unusual from normal

Competency is:

- The appraisal of a practitioner's ability to successfully undertake set tasks/techniques within specific contexts

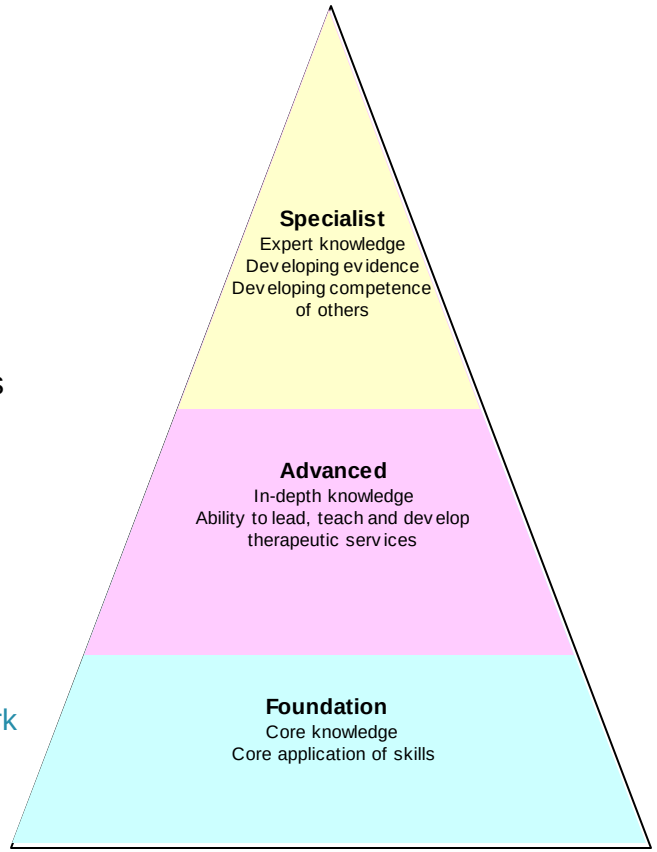
What is a 'Clinical Capability Framework'?

A Clinical Framework refers to a:

- Well-structured and systematic approach to learning and development

Therefore, a Clinical Framework captures:

- Layered hierarchical core values, clinical knowledge and skills
- Central aspects for clinical practice in all fields at its foundation
- Additional knowledge and skills specific to individual levels and domains built on top of these foundations



Basic clinical capability framework

Therapeutic pillars

It is important to note that the Pillars do not denote all areas of intervention, practice and therapy being offered at MSAMHS, but rather highlights areas of practice that will be emphasised through education and training, as well as through supervision, research and service development.

While these pillars have been separated into separate domains to provide detailed guidance and support for practice, it is intended that they be used together for a robust, broad formulation that informs the direction of care and services. As such, these pillars are interrelated and will have features of overlap and correspondence, e.g. working with a consumer who has experienced trauma will require consideration of their broader context including lived experience, family relations and supports, their physical health and possible substance use, as well as maladaptive cognitions and behaviours, thus incorporating all pillars when working with consumers and carers.

Consumer, Carer and Family Engagement

Active engagement of consumers, families and carers in their therapeutic process over the duration of care.

Physical Health Care

Whole-of-person care focusing on mental and physical quality of life and wellbeing.

Cognitive and Behavioural Therapies

Understanding and addressing thought process that govern behaviour and emotions.

Trauma Informed Care

Sensitivity and consideration to the impact of trauma and the importance of considering trauma when understanding a consumer's or carer's presentation.

Lived Experience

Acknowledging and learning from the experiences of people with a lived experience of mental illness and the therapeutic benefits of a peer lived experience workforce.

Trauma-Informed Care and Practice for Aboriginal and Torres Strait Islander Peoples
A guide to working well with Aboriginal and Torres Strait Island Peoples

How will the framework assist me?

The Therapy Capability Framework can help clinicians to:

- **Self-assess** against a number of key criterion for clinical development
- **Identify strengths** for maintaining improvement
- **Recognise key barriers** for improvement, relating to specific contexts (e.g. Academic Clinical Unit or profession)
- **Plan** for sustainability of improvement efforts (e.g. training, education, mentoring and support needs)
- **Monitor** progress over time

How do I use the Therapy Capability Framework?

Prioritisation of therapies for the application of this framework will be guided by:

1. Professional scope of practice and credentials
2. Clinical Division Service Plans (created by best available evidence)
3. PCS content

Step 1 Identify priority therapies

a) Clinician nominates a specific therapy in consultation with team leader and clinical practice supervisor (e.g. cognitive behaviour therapy (CBT) for depression, acceptance and commitment therapy (ACT), etc.)
b) If using one of the pillars, the Clinician nominates a specific framework in consultation with team leader and clinical practice supervisor .

Pillars

- Consumer, Carer and Family Engagement
- Physical Health Care
- Trauma Informed Care
- Cognitive and Behavioural Therapies
- Lived Experience

How will the framework assist me cont...

Step 2 determine capability levels for each clinician

- In collaboration with the clinical practice supervisor, use each domain to reflect on the clinician's "best fit" capability level for that specific therapy.
- Reflecting on each domain will ensure that the capability level is not only determined by knowledge and skills but also elements of autonomy, leadership and dealing with complexity in practice.

The capability level 2 was designed to demonstrate the difference between a trained, supervised and skilled Practitioner versus a clinical practitioner influenced or informed by a specific therapy. The framework also outlines the leadership roles expected of higher level Practitioners within the MSAMHS. The 'best fit' capability level for each of the five domains is determined during supervision.

- Determine the capability level (1 to 4) for each domain which will guide the clinician's overall capability and practice level for that therapy/pillar.
- Consultation between clinician, clinical practice supervisor and team leader is essential.

- Capability Level 1 - Foundation Practitioner
- Capability Level 2 - Practice Informed Practitioner
- Capability Level 3 - Practitioner
- Capability Level 4 - Advanced Practitioner.

General summaries of each capability level are provided in the appendix.

Important: Please use the full version of the Therapy Capability Framework during self-reflection and supervision.

Step 3 Data collection and analysis

- The overall capability level for the specific therapy is documented in the clinician's PAD and monitored by the team leader and the clinical practice supervisor.
- The team leader and professional leaders will also utilise this information for workforce development and support strategies. This workforce capability map represents capability levels for various therapies for every case manager across the work unit.
- The data regarding the capability levels of case managers for a range of therapies, can be examined and used to identify current workforce gaps and future priorities for the team.

What happens if agreement on capability levels cannot be achieved?

Should the clinician, practice supervisor and team leader disagree with the rating and a resolution is not achieved, the decision is referred to the relevant division leadership group and, if required, an expert therapy reference group for final review. The clinical practice supervisor and team leader are to guide the practitioner through this process.

Appendix

General Summary: Descriptors for each capability level

1. Foundation Practitioner	2. Practice-informed Practitioner	3. Practitioner	4. Advanced Practitioner
The practitioner has a fundamental basis for understanding and working with mental health consumers and receives regular practice supervision The practitioner has a basic knowledge of ▪ assessment ▪ alliance building ▪ diagnosis ▪ formulation in the context building a therapeutic alliance The practitioner is able to appropriately link therapy principles to connectedness and recovery-oriented practice Awareness of best available evidence in relation to therapy practice and DIVISIONS models of care	The practitioner has a basic and general introductory knowledge of the therapy assessment and treatment modalities as well as appropriate clinical frameworks, models, and core practice skills The practitioner has received introductory training in the therapy and is able to appropriately combine therapeutic practice with connectedness and recovery-oriented principles Therapy techniques are used as a limited range of interventions that can enhance current clinical practice and are applied safely as sub-skills of routine treatment Knowledge of best available evidence in relation to therapy practice	The practitioner has a sound overview of assessment and treatment for the therapy as well as appropriate clinical frameworks, processes and specific therapy techniques Certified core training in the specific therapy Applies recovery and social inclusion principles to enhance therapy in a mental health context The practitioner clinically applies the specific therapy in relation to the best available evidence and supports the skill development of others The practitioner provides supervision and training to less advanced practitioners Regular active participation in peer review, therapy evaluation and development	The practitioner has a contemporary and in-depth knowledge of the therapy assessments and interventions, therapy specific clinical frameworks, processes and specific technical skills The practitioner applies recovery and social inclusion practices in therapy and leads the effective evaluation of the effectiveness of therapy interventions The practitioner selects the therapy in relation to the best available evidence and tailors it appropriately The practitioner provides supervision and training to less proficient practitioners and leads service initiatives The practitioner contributes to the evidence base by driving evaluation or research

Useful link: http://en.wikipedia.org/wiki/Dreyfus_model_of_skill_acquisition

Produced by Metro South Addiction and Mental Health Services.

How to use the therapies capability framework

	Prioritisation of therapies for the application of this framework will be guided by:
	1. Professional scope of practice and credentials
	2. Clinical Division Service Plans
	3. PCS content
Step 1	clinician nominates a specific therapy in consultation with team leader and clinical practise supervisor e.g. cognitive behaviour therapy (CBT) for depression, acceptance and commitment therapy
Step 2	apply the Therapy Capability and Practice Framework to the specific therapeutic approach
Step 3	• In collaboration with the clinical practice supervisor, use each domain to reflect on the clinician's "best fit" capability level for that specific therapy. • Reflecting on each domain will ensure that the capability level is not only determined by knowledge and skills but also elements of autonomy, leadership and dealing with complexity in practice. The capability levels 2 and 3 were designed to demonstrate the difference between a trained, supervised and skilled therapist versus a clinical practitioner influenced or informed by a specific therapy. The framework also outlines the leadership roles expected of higher-level therapists within the MSAMHS.
	- Capability Level 1 - Foundation Practitioner - Capability Level 2 - Practice Informed Practitioner - Capability Level 3 - Practitioner - Capability Level 4 - Advanced Practitioner.
	General summaries of each level are provided via link
Step 4	• Determine the capability level (1 to 4) for each domain which will guide the clinician's overall capability and practice level for that therapy. • Consultation between clinician, clinical practice supervisor and team leader is essential.
Step 5	• The overall capability level for the specific therapy is documented in the clinician's PAD and monitored by the team leader and the clinical practice supervisor. • The team leader and professional leaders will also utilise this information for workforce development and support strategies.

Using the capability framework

In collaboration with his/her clinical supervisor, the five capability domains are used as a tool for self-reflection by each clinician for each priority therapy indicated by the clinical unit (e.g. CBT). The "best fit" capability level for each of the five domains is determined during supervision. Reflecting on every
domain will prompt the supervisor and supervisee to recognise that overall capability is not just determined by knowledge and skills, but other parallel elements including autonomy and leadership.

Table 1: TCF capability domains and therapy capability levels matrix case scenario

	Therapy Capability Levels			
Capability Domains	Foundation Practitioner	Practice-Informed Practitioner	Therapist	Advanced Therapist
Therapy knowledge and practice skills		✓		
Autonomy and support required and provided in therapy	✓			
Dealing with complexity in therapy		✓		
Supervision role and credentials		✓		
Research and evidence-based practice roles	✓			

Case scenario

For example, a nurse may consider his/her capability level for CBT for domain 1 (knowledge and skill) to be at a Therapist level (level 3) due to completion of advanced CBT training. However, during the course of discussion with their professional practice supervisor, they realise that CBT only influences their practise, and they do not strictly adhere to CBT techniques nor participate in CBT supervision. This would indicate an overall capability level of a Practice-Informed Practitioner (level 2).

Level Descriptors

General summary: descriptors for each capability level - please use full version during self reflection			
Foundation Practitioner	**Practice informed Practitioner**	**Practitioner**	**Advanced Practitioner**
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Continuing Professional Development Diary		
	Staff member name:	
	Profession:	
	Commencement date:	
	Annual PDA entitlement:	
	Annual PDL entitlement:	

Date	**Learning activity**	**Provider of activity**	**Learning outcomes**	**Type of leave used**	**Cost**	**Line manager signature**

Feedback from focus group participants –

Two focus groups

Group 1 - PL = Practitioner level (clinicians assessed at Foundation or Practice-Informed Practitioner capability levels for all therapies)

Group 2 - ThL = Therapist level (clinicians assessed at Therapist or Advanced Therapist capability levels for any therapy)

Most participants in both groups believed that the TCF could influence changes to the case management model and support clinicians to become proficient and at least practice informed, in the provision of psychosocial therapies. A PL participant stated, *'this therapy capability framework is showing us that the case management model has to change to accommodate (therapies).'*

Both focus groups' participants also believed that the TCF could be beneficial in supporting a clinician's professional development pathway, specifically for therapy capabilities, as well as developing a strategic service-wide workforce planning profile: *'The capability framework allows some of that to be teased out, because you identify whether you're practice-informed or whether you're a therapist or whatever and so, down the track, maybe it allows some room for those skills to be further identified.'* (PL)

ThL participants articulated how the TCF Process had extended meaningful discussions regarding evidence-informed therapies to the rest of the multi-disciplinary team to promote relevant team-based professional development planning: *'It was a tool to see where you sit and map against for different therapies, and we, as a team, had added some extra things and we're using it as a tool across therapies [development].'*

Majority of participants from both groups understood the differences between the various TCF levels and described how the terminology of the Practitioner Level criteria was an accurate description of core therapy capabilities for all clinicians: "*I really like the beginning, the framework. My understanding is it wants to get everyone to be at least [practice-informed] enough to provide a level of therapeutic input"* (ThL).

The capability framework will give you an overview of who's trained in [therapy], to what level, what level supervision they are getting, …then you would know how many people you need to train, how many people you need to get from this level to the other level and how many people you need to be at the higher levels in order to implement this [therapy]. Then the framework will be well connected to the service provision

How and why the TCF has changed:

Findings from the original study highlighted a need to align the TCF and TCF Process with structured service-level governance strategies. A key message that emerged is the need to strengthen engagement between staff, line mangers and leaders across the organisation for psychosocial therapy strategic planning prior to the TCF mapping process.

A strategic model for person-centred psychosocial therapies has since been established at MSAMHS. This model promoted shared participation, distributed leadership, and led to the evolution and collaborative development of the TCF tailored to four different areas. These specific capability frameworks were developed by therapy leaders and case managers across the organisation and include (a) Consumer, Carer and Family Engagement, (b) Trauma-informed Care, (c) Physical Health Care, and (d) Cognitive and Behavioural Therapy versions of the TCF. It is imperative that the implementation of these bespoke TCFs strengthen collaboration and emphasise leadership across all roles in the organisation to enhance the provision of evidence-informed care.

Therapy Capability Framework worksheet

Please insert the relevant therapy in the "….." space provided (e.g. CBT, DBT, MI)

Domain 1	Foundation Practitioner	Practice-Informed Practitioner	Practitioner	Advanced Practitioner
Therapy Knowledge and Practice Skills	Basic core skills in building a therapeutic alliance including a shared *****understanding, history taking, risk assessment and formulation in the context of the …… therapeutic framework Basic knowledge of treatment and referral options for ……. therapy Basic knowledge of …… principles and connection to recovery-oriented and person-centred practice Able to deliver basic education and therapeutic support (including dual diagnosis context) for consumers ***** "understanding" refers to stepping into the person's world and conveying this back	General knowledge of ……. therapy concepts and how to incorporate these into current clinical practice Practice framework influenced by a general knowledge of the …… model/s and core practice skills Knowledge of …….. in relation to evidence-based practice Awareness of ……. therapy in the context of recovery-oriented and social inclusion practices Able to evaluate and modify care plan according to individual needs and …… principles	Sound knowledge of ……. practice competencies for assessment intervention Frequent independent application of a practice framework and specific therapy techniques Comprehensive understanding of …… in relation to the best available Application of recovery-oriented and social inclusion practices to enhance therapy outcomes Ability to evaluate and refine ……. interventions to improve therapy outcomes with regular	In-depth knowledge of …… therapy knowledge and skills, contemporary techniques and practice competencies Able to provide consultation to service leaders on therapeutic frameworks for complex clinical practice Advanced knowledge of best available evidence for ……, including its strengths and limitations Leads application of recovery-oriented and social inclusion practices in the evaluation of ……. therapy Facilitates the evaluation and reporting of therapy program outcomes

Domain 2	Foundation Practitioner	Practice-Informed Practitioner	Practitioner	Advanced Practitioner
Autonomy and Support (required and provided) in Therapy **(For supervision requirements see Domain 4)**	Able to perform most clinical tasks in a safe manner with regular clinical and professional reflective practice supervision	Completes straightforward clinical tasks incorporating basic ……. skills supported by observation and reflective practice supervision Requires frequent support and advice from practice supervisor, multidisciplinary and professional teams	Independently completes most complex clinical tasks applying ……. techniques confidently using own judgement Seeks and provides regular advice within the multidisciplinary and/or professional team Provides support and mentoring for ……. therapy skills to other members of the multi-disciplinary or professional team	Independently and holistically manages complex clinical scenarios in therapy for a multi-disciplinary team or across clinical units Independently goes beyond basic standards, creating interpretations and learning tools for self and other clinicians across various clinical units and professions Provides support and mentoring for ……. therapy skills within the multidisciplinary and professional teams across various clinical units

Domain 3	Foundation Practitioner	Practice-Informed Practitioner	Practitioner	Advanced Practitioner
Dealing with Complexity in Therapy	Able to deal with complex clinical situations with appropriate mental health interventions This is achieved using non-specific factors, and	Able to identify opportunities and provide intervention in complex situations with only partial understanding of therapy frameworks and techniques …… therapy is used as a	Ability to manage complexity through purposeful analysis and reflection utilising supervision from a more proficient Practitioner on a regular basis	Deals with clinical situations considered by the treating team to be highly complex using ……. therapy Holistic grasp of complex situations, moves between intuitive and analytical

	without the specific …….. therapy modality or framework perspective	limited range of techniques that can enhance current clinical practice These are applied safely as sub-skills of routine treatment	 Sees overall picture and how own actions contribute to consumer outcomes as a result of engagement in therapy	approaches with ease Sees overall picture and alternative approaches; vision of possibilities in therapy

Domain 4	Foundation Practitioner	Practice-Informed Practitioner	Practitioner	Advanced Practitioner
Supervision Role and Credentials	Recipient of core clinical and professional practice supervision from senior clinician and/or relevant peer group process as per usual business Core clinical practice skills endorsed by performance coaching and appraisal process Participates in the identification of own learning needs and development activities Professional registration and/or credentialing requirements met	Frequent reflective practice supervision from a more capable practitioner with an emphasis on specific …….. skills and direct observation of practice Provides basic ……. education to less knowledgeable clinicians and foundation practitioners Completed introductory training in …… therapy skills	Ongoing and routine reflective practice supervision with a more proficient …… Practitioner, utilising individual, peer supervision and/or direct observation Provides ……. practice supervision to Foundation and Practice-Informed Practitioners as well as other less proficient …… Practitioners Certified core training in …… therapy	Routine …… therapy practice supervision with a more proficient Practitioner or peer group Provides therapy practice supervision for less proficient Practitioners Identifies …… therapy development needs for others and delivers appropriate continuing professional development activities Certified advanced or intensive training in ……. therapy

Domain 5	Foundation Practitioner	Practice-Informed Practitioner	Practitioner	Advanced Practitioner
Research and Evidence-Based Practice (EBP) Role	Awareness of best available evidence in relation to …… therapy practice and ACU models of care	Consumer of literature and knowledge of best available evidence in relation to …… therapy practice Active participant in peer discussion in relation to …… therapy practice	Regular active participation in EBP activities including peer review and …… therapy evaluation and development	Leads EBP initiatives including facilitation of peer review Active participation by driving ……therapy evaluation and/or research and service initiatives

Continuing Professional Development Diary	Staff Member Name:	
	Profession:	
	Commencement date: (i.e. commencement of PDA/PDL entitlements)	
	Annual PDA entitlement:	
	Annual PDL entitlement:	

Date	Learning activity	Provider of activity	Learning outcomes (related to PAD)	Type of leave used (e.g. Conference leave, PDL, special leave)	Cost (Please indicate proportion of funding- i.e. PDA, Hospital and Health Service funded)	Line Manager signatures

Reference: Metro South Health, Allied Health - Guidelines for Health Practitioners, Professional Development Allowance (PDA) and Professional Development Leave (PDL)

Single Session Therapy (SST) Practice Development Matrix for Access Services

To achieve SST Foundation Practitioner

Practice: Clinicians will have SST knowledge

Attainment: Staff who have completed the LEAP SST online module only

Aim: To develop an induction schedule to identify and engage learning in SST

Clincian Actions:

Complete SST LEAP Online module within 3 months of commencement of service

Undertake Active Learning:

- Familiarity, peer discussion of SST in team meeting & case review.

- Observe practice under a SST Practice Informed Practitioner.

Relevant & timely: Feedback to SST leads of the online module at the end of the module.

Team Leader Actions:

- Identify clinicians who have not completed the LEAP SST on line module

- Provide time for SST LEAP online completion for all existing & new clinicians

- Facilitate SST discussion in team meetings & case review

Service Actions:

Supportive working environment:

- Integrate SST into the induction to clinical services

- Leaders to articulate training expectations

- Compile annual report on SST online training for tracking and action

- Acknowledge service achievements in online learning

PROGRESSION: Move clinicians to Practice Informed Practitioners

To achieve SST Practice Informed Practitioner

Practice: Clinicians will be developing their practice

Attainment: Staff who have completed the SST Training: Module & Workshop

Aim: To build confidence in individual practice and integrate SST within team processes

Clincian Actions:

Complete SST Workshop within 3 months of completing the online module

Active learning:

- Engage with a more experienced SST practitioner in a joint SST session within 1 month of SST Workshop.

-Complete SST on line Refresher within 12 months

Draw on practice examples:

- Incorporate SST into individual practice or in pairs

- Share learning with peers, at supervison & case review

- Reflect directly after session with co-facilitator, SST Practitioner or clinical lead at supervision 'on the run'

Relevant & timely:

- Identify SST learning needs in PCS goals.

- Feedback learning needs to SST leads through the online refresher

Team Leader Actions:

Build on existing learning:

- Identify clincians who have achieved Foundation Practitioner

- Direct clinicians to complete SST Workshop

- Incorporate SST discussion in team meetings & case review

Enable Reflective Practice:

- Direct and facilitate clinicians to access SST supervision

- Ensure SST is part of PCS conversation

Service Actions:

Supportive work environment:

- Leaders acknowledge achievements of face-to-face SST learning

- Leaders to support a culture of peer learning through SST co-facilitation and supervision processes

- Compile annual report on SST workshop training for tracking and action

- Provide permission for SST to be a validpractice approach with acute care settings

PROGRESSION: Move clinicians to Practitioner

To achieve SST Practitioner

Practice: Clinicians will be practicing and mentoring others

Attainment: Clinicians report on practice

Aim: To Consolidate individual & team practice and expand team & interprofessional practice in SST

Clincian Actions:

Active Learning

- To practice with the objective of incorporating SST into daily practice

-Expand brief therapy knowledge & practice with aditional training; linked to PCS

Draw on practice examples

- Interprofessional and collaborative practice with peers; ad hoc and routinely in case review

- Provide leadership in SST through supervision and peer practice

- Lead SST discussion at case review and team meetings

Team Leader Actions:

Build on existing learning:

- Identify SST Practitioners to be clinical site leads

-Facilitate SST clinical site leads to assist in advancing colleagues practice through peer practice, supervision and case reviews

Service Actions:

Supprtive work environment:

- Promote SST Practitioner roles as leaders

Relevant & timely:

Endorse SST as best practice within acute services

Engage in quality review:

- Invite SST practitioners to contribute to formal evaluation and to confirm SST processes in service planning

- Compile annual report on SST provision of service for tracking and action

PROGRESSSION: Clinician may decide to advance practice

Developed using OTCEP Quick Reference Guide: Using principles of best practice in education within health learning environments, March 2019, MSAMHS Therapy Capability and Practice Framework, and Lau, G., Meredith, P., Bennett, S., Crompton, D., & Dark, F. (2017). A capability framework to develop leadership for evidence-informed therapies in publicly-funded mental health services. *International Journal of Public Leadership*, 13(3), 151-165. doi:10.1108/ijpl-08-2016-0030.

Metro South Health

Therapies Capability Framework

Physical Health Care

Nursing case studies

We care about you

Queensland Government

So what is a *Therapies Capability Framework* anyway?

Therapies Capability Framework: "…used as a reflective tool by individual practitioners and supervisors, helping to direct further capability development for provision of evidence-informed therapies, and to identify therapy leaders amongst the workforce"

Competency

Capability

*Knowledge based
*Technical skills
*Easily assessed (e.g. pass/fail)
*Controlled environment

*Higher level understanding
*Dealing with complexity
*Performing under challenges (e.g. time pressure)

Can we use the *Therapies Capability Frameworks* to assess competency or for performance management?

Please don't…. The TCF should empower staff to develop their own portfolios collaboratively with supervisors, support learning pathways directly linked to best practice, and foster leadership and autonomy aligned with consumer and service priorities.

Domains

	Foundation	Practice Informed	Therapist
Knowledge & Skills	*Core competency	*Developing capability	*High capability
Autonomy & Supervision	*Receives mentoring *Follows EBP guidelines	*Provides mentorship; receives supervision *Developing autonomy	*Provides supervision; participates in group mentoring *Recognised leader
Evidence-based Practice & Research	*Informs consumers *Participates in QI	*Contributes to guideline, research and QI development	*Takes a leading role

Developing capability

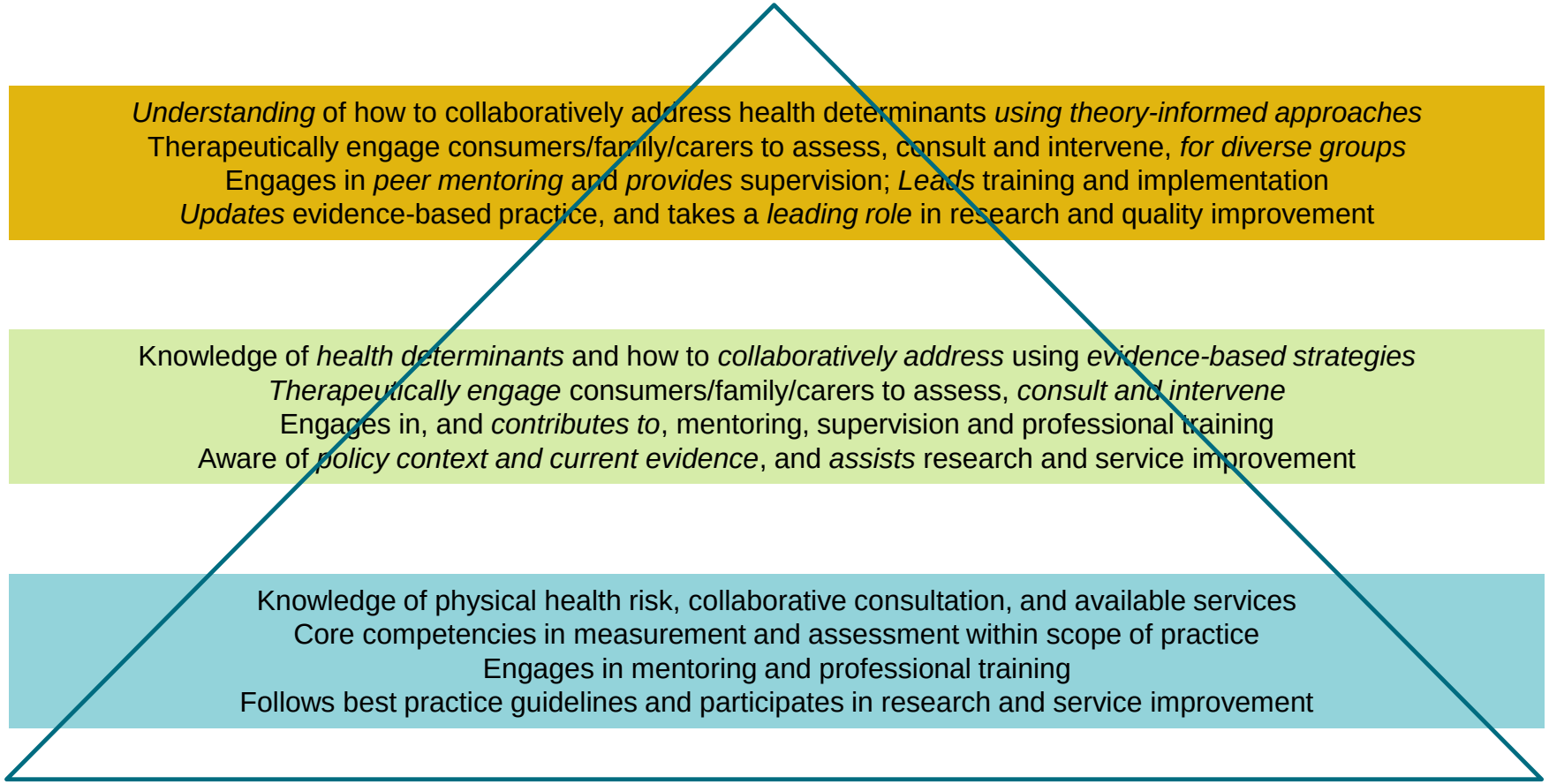
*Efficiency
*Trauma-informed, person-centred, family/carer engagement
*During busy clinic times
*Even when consumers don't seem to value their own health

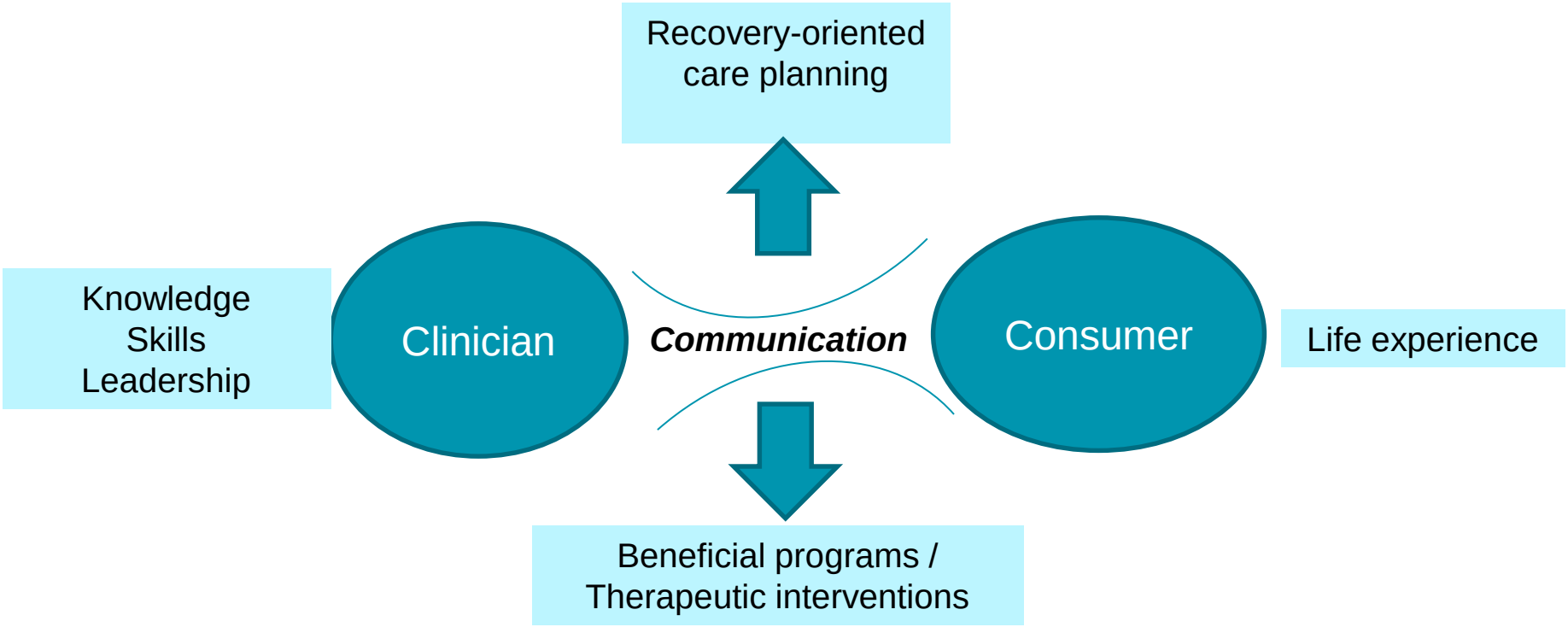
*Effective
*Trauma-informed, person-centred, family/carer engagement
*Confidence
*Consumers with complex presentations

Developing capability

Domains

Knowledge & Skills	**Determinants of health:* biopsychosocial, lifestyle and environmental – assessment and monitoring; explaining meaning and implications; suggesting management strategies. **Care planning:* Recovery-oriented and integrated with relevant services within and outside MSAMHS, taking into consideration medical concerns and history, and values and preferences of consumers/families/carers **Behaviour change*: theory-based and adapted to individual, family and cultural expectations, in individual or group settings
Autonomy & Supervision	**Mentorship and supervision* **Training – Participating* to *Developing* **Tasks – Competencies* to *Quality Improvement*
Evidence-based Practice & Research	**Follows* guidelines, to *Updates* guidelines **Assists* with research and QI, to *Leads* research and QI


Understanding of how to collaboratively address health determinants *using theory-informed approaches*
Therapeutically engage consumers/family/carers to assess, consult and intervene, *for diverse groups*
Engages in *peer mentoring* and *provides* supervision; *Leads* training and implementation
Updates evidence-based practice, and takes a *leading role* in research and quality improvement
Knowledge of *health determinants* and how to *collaboratively address* using *evidence-based strategies*
Therapeutically engage consumers/family/carers to assess, *consult and intervene*
Engages in, and *contributes to*, mentoring, supervision and professional training
Aware of *policy context and current evidence*, and *assists* research and service improvement
Knowledge of physical health risk, collaborative consultation, and available services
Core competencies in measurement and assessment within scope of practice
Engages in mentoring and professional training
Follows best practice guidelines and participates in research and service improvement



Therapist: *Distils expertise into therapeutic communication to collaboratively improve life experiences*

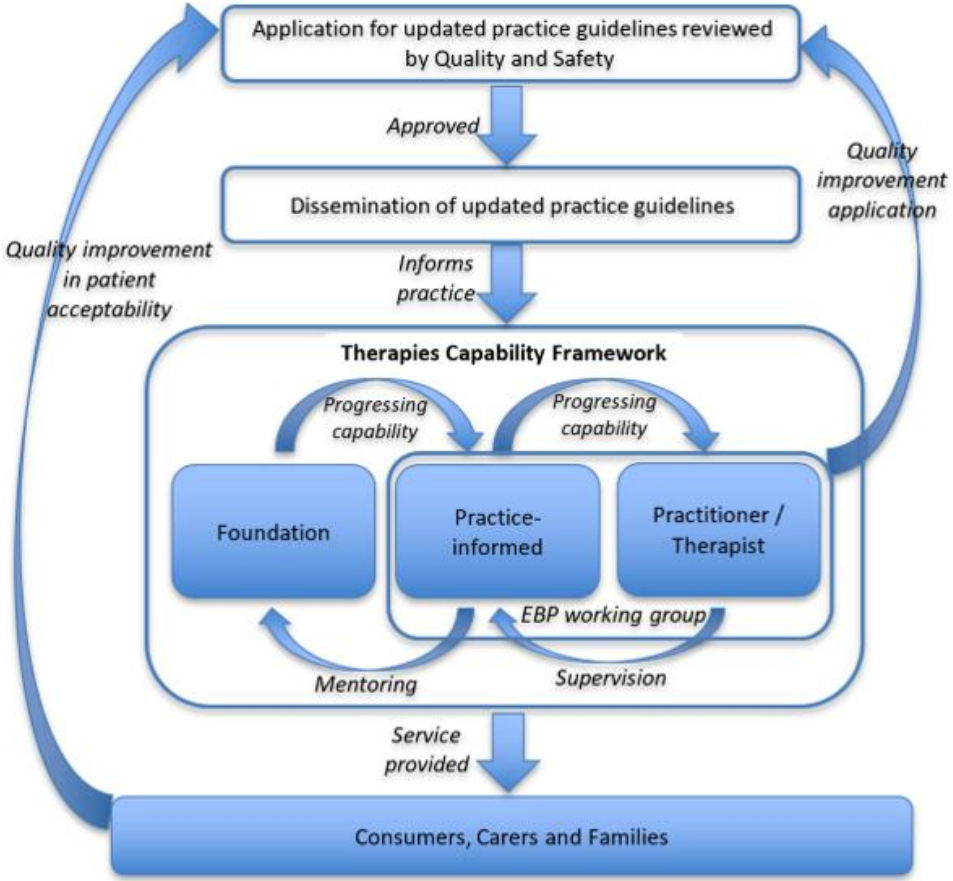
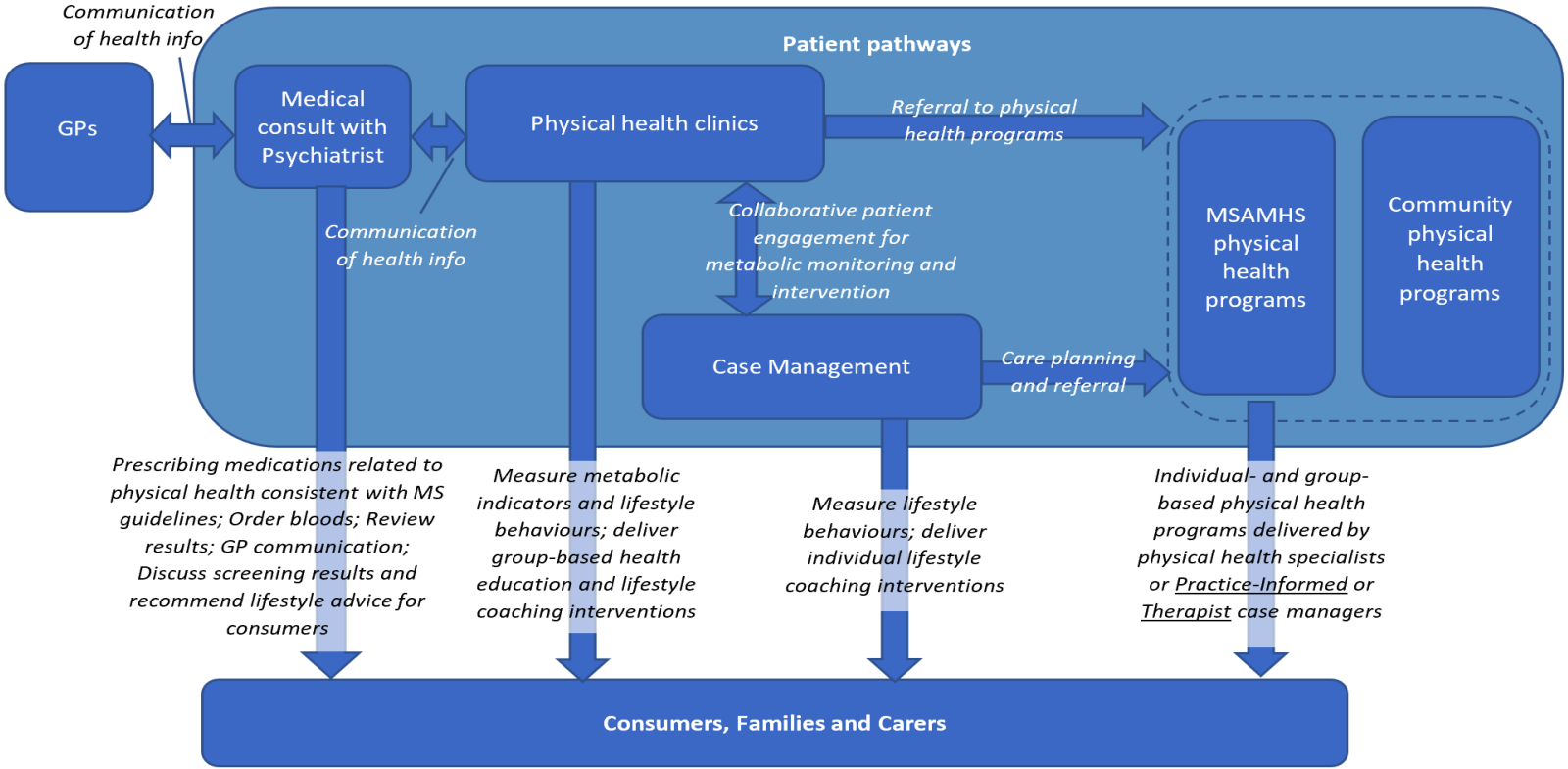


Figure 2: Therapies Capability Framework as an embedding mechanism for continual quality improvement and evidence-based practice (EBP).

Metro South Health | Model for Person Centred Therapeutic Approaches

(i) Involves nurse-led physical health monitoring and intervention, (ii) multidisciplinary intervention (Allied Health and peer; e.g. exercise, lifestyle intervention), (iii) site-based rather than team based, (iv) implemented in collaboration with external organisations (PCYC and BIG in the current trial sites), (v) group-based rather than individual



What can be done from here?

- Formalise *capability development pathways* for nursing, including Foundation expectations (and other staff who have therapeutic contact with consumers).
- Protect time for involvement in physical health clinics and service-wide EBP working groups.
- Formalise mentoring and supervision arrangements, and embed TCF into mentoring and supervision.
- Formalise physical health interventions and programs (e.g. health literacy etc)

Metro South Health

Quality healthcare every day

Metro South Addiction and Mental Health Services QPS and QAS Co-responder program evaluation

ICARE² values

Queensland Government

This evaluation was conducted by Dr Marianne Wyder, Senior Research Fellow, Research and Learning Network, Metro South Addiction and Mental Health Services (MSAMHS).

We would like to thank the following people:
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Paul Bedward	Gladys Tams	Michelle McKay
		Utopia Edwards

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Sergeant Megan Ward, Mental Health Intervention Coordinator & Co Responder, Domestic, Family violence & Vulnerable Persons Unit, Logan District.
Detective Senior Sergeant Paul Fletcher, Domestic, Family Violence & Vulnerable Persons Unit, Logan District.
A/Inspector Bernie Quinlan, Performance, Engagement and Governance. South Brisbane District.

QAS:
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Dr Emma Bosley, Director Information Support, Research & Evaluation, QAS.
Christopher Rendall, Officer in Charge, Beenleigh Station, Metro South Region Queensland Ambulance Service.

MSAMHS:
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SUGGESTED CITATION

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MODEL OF CARE AND KEY OBJECTIVES

Mental health presentations to the emergency department (ED) have steadily increased over the past years. Emergency departments are often the initial contact point for people experiencing a mental health crisis.

According to the Australian Institute of Health and Welfare over 300 000 presentations for mental health were recorded in 2022, accounting for 3.5 percent of all presentations.

There is now mounting evidence that the ED is not always the most appropriate nor effective place to respond to people experiencing a mental health crisis. For many, such crises are best managed in the community.

> ED is not always the most appropriate nor effective place to respond to people experiencing a mental health crisis.

Queensland Ambulance Service (QAS) or Queensland Police Service (QPS) are frequently the first services to attend incidents involving individuals who are experiencing a mental health crisis. It has been recognised that a specialised response is required.

For QPS and QAS to perform their 'mental health' role there is a need for clear protocols as well as increased collaboration between the key agencies such as mental health services.

Over the past years Mental Health Co-Responder programs have been introduced to improve the management of people who experience a mental health crisis. These initiatives involve the employment of mental health staff to work alongside police and ambulance services during the assessment and management of individuals who are experiencing a mental health crisis.

In this model, QAS or QPS officers and mental health clinicians work together to address the crisis in the community.

The West Moreton Mental Health Co-Responder Project (WM MH CORE) commenced in March 2017 through collaboration with Queensland Police Service.

The Metro South Addiction and Mental Health Services Co-responder program (MSAMHS MH CORE) expanded this model to include a QAS crew. It was implemented in 2019.

The QAS or QPS officers and mental health clinicians work together to provide on-site interventions based on the theory that a joint response better serves consumers, carers and the Services involved.

OPERATION OF MSAMHS MH CORE

A team of experienced mental health clinicians who can be integrated either into a QPS or QAS first responder unit attending a mental health crisis/incident in the community. The team is in operation 7 days a week for 10 hours a day.

MSAMHS MH CORE Clinicians are autonomous and are responsible to consider, assess and determine the best response to the mental health crisis.

The MSHMHS MH CORE is intended to be:

- A secondary response unit for QPS. This response unit can also be used a first responder unit for QPS when required. QPS have two co-responder crews.
- A first responder unit for QAS. QAS have one co-responder crew.

MSHMHS MH CORE Clinicians operate alongside front-end services such as the Acute Care Team, MHCALL Teletriage and Emergency Departments.

Referrals are made through the 000 system and are triaged to either the QAS Operations Centre or the QPS Communication Centre. Police referrals can also be made via direct requests from police crews at the scene and Policelink. Appropriate referrals can also be identified by the QPS co-responder crews.

MSAMHS MH CORE AIMS

OVERALL PROGRAM AIMS

The co-responder model was established to:

- Provide timely and appropriate mental health care to people who present to QAS or QPS with a mental health crisis
- Provide assessment, treatment and care which is tailored to the needs of the person in crisis
- Reduce the number of people experiencing a mental health crisis transported to the emergency department
- Develop and increase QAS and QPS officers' knowledge and capability to respond to people experiencing a mental health crisis.

CLIENTS TARGETED BY CO-RESPONDER MODEL

The co-responder model aims to support people who are in distress and showing one or more of the following signs:

- Suicidal ideation and self-harm
- Bizarre or unusual behaviours
- Anxiety or depression

EVALUATION FRAMEWORK

EVALUATION OBJECTIVES

The objectives of this evaluation were to:

- Identify and describe the demographic and clinical characteristics of people accessing MSAMHS MH CORE Services
- Identify and describe service and representation patterns of people accessing MSAMHS MH CORE Services
- Explore the experiences of clinicians, QAS and QPS officers working within the MSAMHS MH CORE Services.

EVALUATION DESIGN

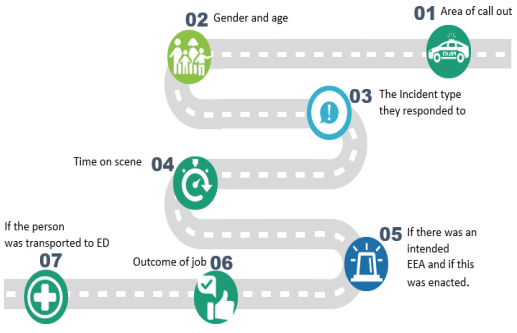
The study employed a mixed method approach using service data, semi-structured individual interviews with QPS Officers and MSAMHS mental health staff and a survey for QAS Officers. The QAS survey had an option for open ended responses. These responses were included in the qualitative analysis.

QPS data was collected during the period of March 2019 and February 2021. The QAS data was collected between July 2019 and June 2021.

QUANTITATIVE DATA COLLECTED

Routinely collected service data was used for the quantitative component of this study. At the end of each call out, MH CORE Clinicians recorded the following data on a data collection sheet:

- Area of call out
- Gender and Age
- Incident type responded to
- Time on scene
- Intended and enacted Emergency Examination Authority
- Outcome of the job
- Person transported to the ED



The incidents were categorised as following:

- Behavioural disturbance
- Bizarre or unusual behaviour
- Substance misuse
- Suicidal behaviours (ideation, plan, intent, or self-harm)
- Providing information/advice (CORE not attending).

The contacts were divided into direct or indirect contact. The incidents where the co-responders provided phone advice or were on scene for less than 10 minutes were coded as an indirect contact.

Presentations to the ED within 14 days of contact with the MSAMHS MH CORE were also recorded. For this analysis we focused on those that had presented to the MSAMHS CORE program up to three times.

Chi-square tests were used to determine significant differences in nominal data. To determine significant difference between variables and average time on scene the data was first tested for normality. The data was non normally distributed and as such, the Kruskal Wallis Test was used to determine statistical significance. The significance level was set at .05. The means and medians were very similar and for ease of interpretation only the means are reported in this report. The statistics reported are rounded to nearest whole number. Because of this the percentages may not add up to a 100.

QUALITATIVE DATA COLLECTED

To capture the experiences of the co-responder staff, all MSAMHS Clinicians and managers as well as 22 purposefully selected police personnel in the co responder program, were interviewed about their experiences of delivering the co-responder model. In June 2020, a survey of the QAS MHCORE paramedics who were involved in the pilot was conducted. This anonymous, online survey posed Liker Scales and a free text question to obtain feedback from the practitioners about their experiences in delivering the survey. The results were reported in the interim QAS Mental Health Co-responder evaluation report[1].

These interviews were conducted by a person external to the team. Participation in the interviews was voluntary and all interviews were taped and transcribed verbatim.

The interviews were analysed qualitatively using a general inductive approach. Common themes were identified, and the data was regrouped into these general overarching themes. The data was managed in the qualitative software analysis program Atlas TI.

Direct quotations from the transcripts are used in this report. The quotes have been de-identified to ensure participant anonymity. Some open-ended responses from the MSAMHS MH CORE paramedics surveys are also included in the current report.

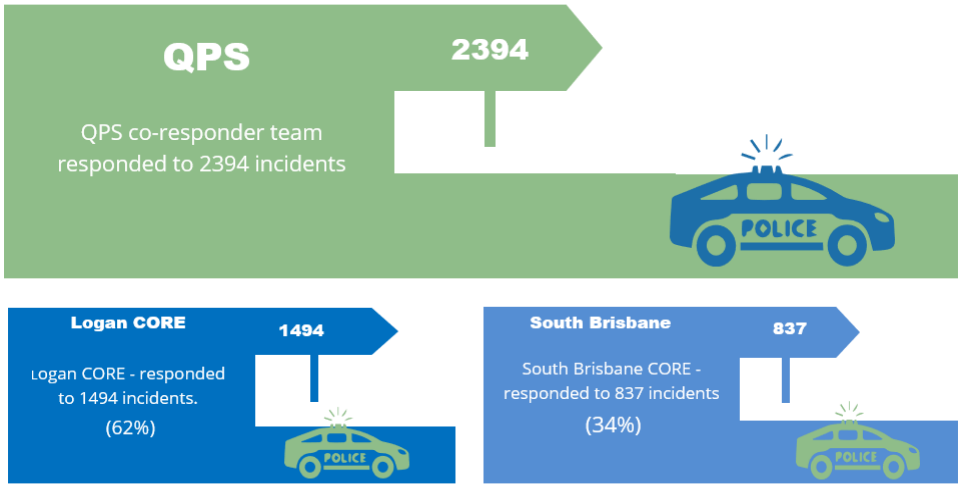
[1] Queensland Ambulance Service (2020). Mental Health Co-Responder Evaluation Report.

QPS QUANTITATIVE DATA

OVERALL NUMBERS

NUMBER OF INCIDENTS

Between March 2019 and February 2021, the QPS co-responder team responded to 2394 incidents. The MSAMHS MH CORE in the Logan Beaudesert Region (Logan CORE) responded to 1494 (62%) incidents. The MSAMHS MH CORE in the Brisbane South Region (South Brisbane CORE) responded to 837 incidents (35%). For 56 percent (n=1335) of the incidents MSAMHS MH CORE attended, the QPS first responder team had been on scene. For 44 percent of the incidents, the co-responder team was the first responder unit.



There was missing information about the region for 63 (4%) incidents.

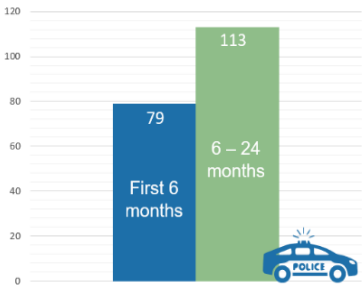
DIRECT AND INDIRECT CONTACTS

Eighty-one percent of provisions of service were classified as direct face to face contacts. The remainder were classified as indirect contacts.

There were no differences in age and gender distribution between direct and indirect contacts.

PATTERNS OF USE

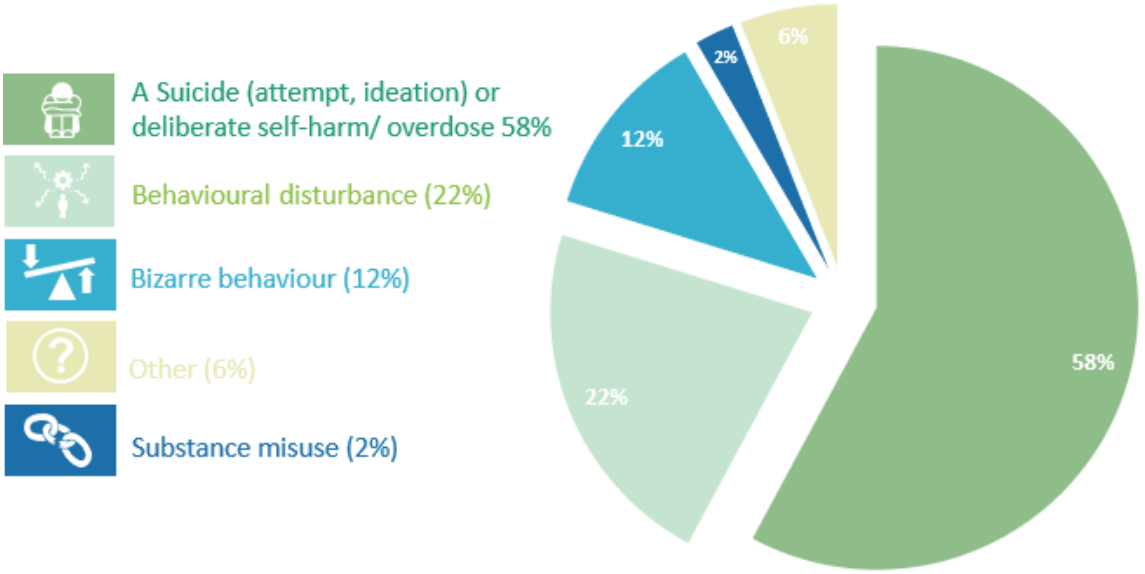
Over time there has been an increase in the number of incidents the MSAMHS MH CORE team attended. During the first six months the co-responder team responded to an average of 79 incidents per month. This almost doubled to 113 incidents per month throughout the remaining 18 months of operation of the program.



REASON FOR CALL OUTS

DIRECT CONTACTS

Based on the information provided by the attending mental health clinicians, over half of all the reasons where QPS MSAMHS MH CORE had direct contact were suicidal behaviours (ideation/plan/intent or deliberate self-harm) (n=1091; 58%). This was followed by behavioural disturbance (n=414; 22%); bizarre or unusual behaviour (n=225; 12%) or substance misuse (n=44; 2%). Hundred and thirteen (6%) of the direct contact incidents were classified as other. The main reasons noted for the category "other" were: hoax calls; depression and anxiety, follow up and medical issues. There was missing information for 37 incidents about the type of contacts.



INDIRECT CONTACTS

The main reasons for the indirect contact were:

- Provision of information/advice
- Stood down prior to arrival
- Not being able to find the person
- QAS MSAMHS MH CORE attending or medical concerns.

OUTCOME OF JOB

Two thirds of the incidents that MSAMHS MH CORE had direct contact with were managed in the community. For 45 percent (n=1083) no referral was made as the crisis was resolved. The remaining were either referred to primary care or a Non-Government Organisation (NGO) (n=394; 17%,) or mental health services (n=289; 12%). Thirty-five incidents (2%) were classified as taken into custody. Twenty four percent (n=581) of the incidents were transported to the ED. There was missing information for 12 incidents about the outcome of the job.

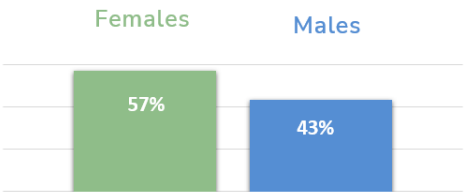
DEMOGRAPHIC CHARACTERISTICS

CURRENT MENTAL HEALTH CONSUMERS

The majority of incidents attended by the QPS MSAMHS MH CORE (1560; 65%) involved persons who were not current MH consumers.

GENDER

The incidents MSAMHS MH CORE attended involved more females than males (n= 1342; 57% VS n= 1043;43%). There was missing information for 9 incidents.



AGE

There were significant differences in the age patterns between the Logan MH CORE and the South Brisbane MH CORE. Over one third of all the people seen by the co-responder team were under 25. While for both areas the 25 to 34 age group represented the highest numbers of incident attended to in the Logan area, this age group represented a third of all presentations. In the South Brisbane area this group represented a fifth of all presentations. The South Brisbane area had a higher representation in the higher age groups.

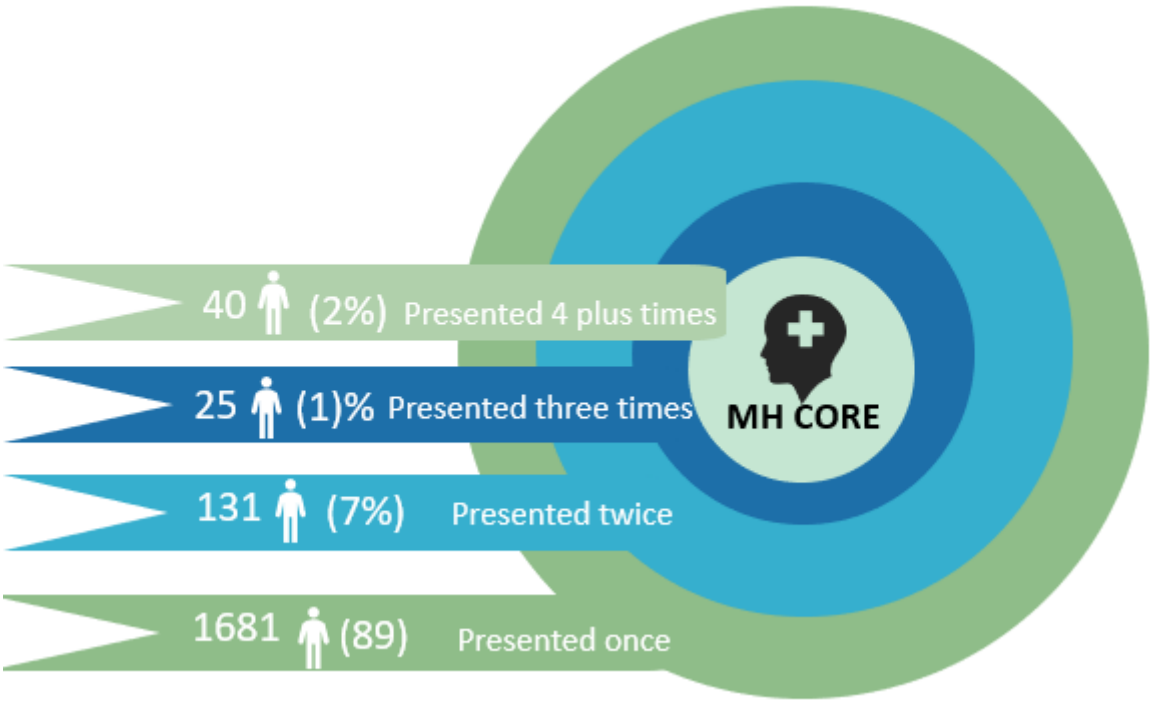
Age	Logan	PAH	Total
0 to 14	95 (6%)	42 (5%)	137 (6%)
15 to 19	172 (11%)	103 (12%)	275 (12%)
20 to 24	164 (11%)	83 (10%)	247 (11%)
25 to 34	**519 (35%)**	**183 (22%)**	**702 (30%)**
35 to 44	257 (17%)	165 (20%)	422 (18%)
45 to 54	150 (10%)	116 (14%)	266 (11%)
55 to 64	61 (4%)	59 (7%)	120 (6%)
65 to 74	17 (1%)	24 (3%)	41 (2%)
75 plus	**59 (4%)**	**62 (7%)**	**121 (5%)**
Total	1494	837	2331

There was missing information for 63 incidents.

REPEAT PRESENTATIONS

There were a total of 2394 incidents relating to 1877 individuals.

- One thousand, six hundred and eighty-one (89%) individuals presented once to MH CORE.
- One hundred and thirty-one individuals (7%) were seen by the MH CORE twice.
- Twenty-five (1%) individuals presented three times.
- Forty individuals had needed support from MH CORE more than 4 times. This represented 309 incidents (12% of total incidents). Of note, within the Logan area, two individuals made up 63 percent (n=193) of the more than 4 incidents category in this area.



TIME ON SCENE

ALL CONTACT

The average time on scene for all contacts was 41 minutes.

DIRECT CONTACT

The average time on scene for direct contacts was 50 minutes.

INDIRECT CONTACTS/PROVISION OF ADVICE

The average time on scene for phone contacts was 7 minutes.

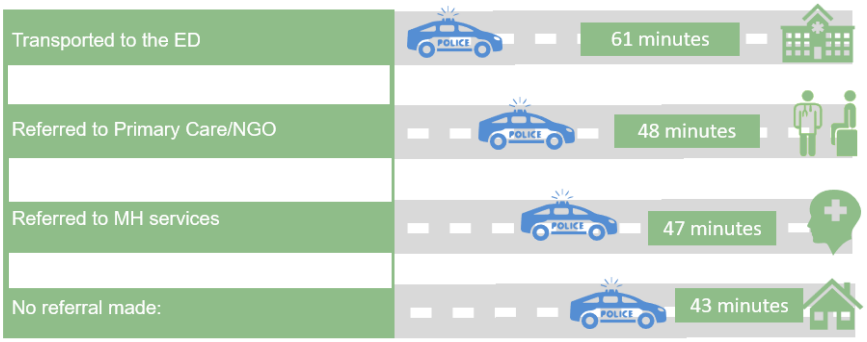
TIME ON SCENE BY INCIDENT

There were significant time differences between the different types of incidents the QPS MH CORE responded to. The average times on scene for the different types of incidents are listed below:

- Behavioural disturbance - 47 minutes
- Suicidal behaviours (ideation/plan/intent or self-harm) - 47 minutes
- Substance misuse - 54 minutes
- Bizarre or unusual behaviour - 66 minutes.

TIME ON SCENE AND OUTCOME OF JOB

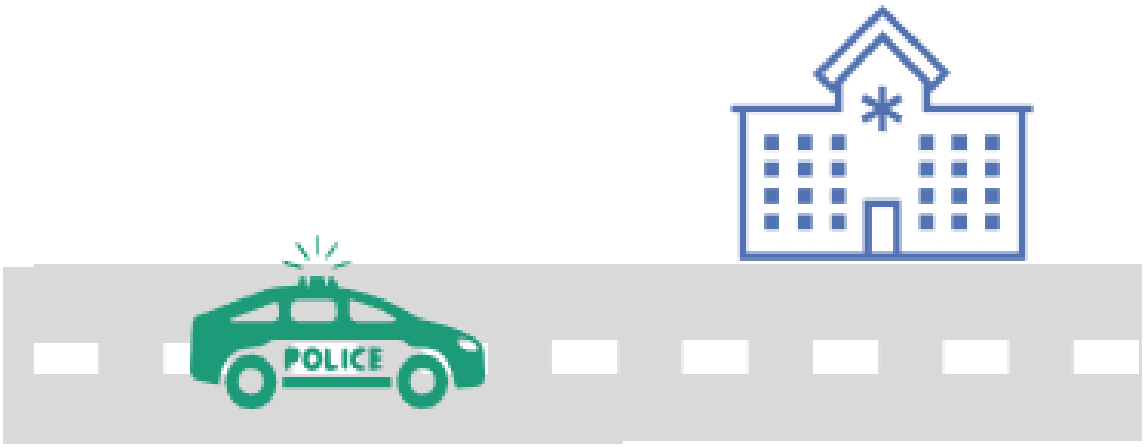
The time on scene varied significantly by outcome of the job. The average time on scene for those that were transported to the ED was 61 minutes compared to 48 minutes for those referred to primary care/NGO and 47 minutes for those referred to MH services. The average time for those where no referral was made was 43 minutes. The average time for incidents where an Emergency Examination Authority (EEA) was enacted was 10 minutes longer compared to the incidences where there was no EEA (60 minutes compared to 46 minutes). The presence of the first responder unit did not impact on the time on scene.



INTENDED AND AVERTED EEA

- One thousand two hundred and ninety-seven (54%) incidents were classified as intended EEA and flagged for possible transfer to the ED.
- Of these incidents, 386 (30%) were confirmed by MH CORE as requiring an EEA. Overall, confirmed EEAs represented 16% of the work undertaken by MH CORE.
- Only one percent (n=29) of the incidents that were not flagged as a possible EEA were transported to the ED under an EEA.

Over 70% of intended EEA were averted



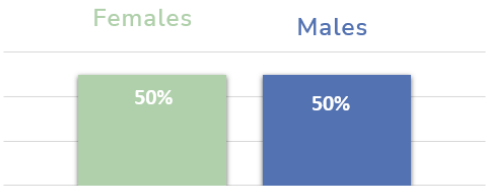
PRESENTATIONS TO THE ED WITHIN 14 DAYS OF CONTACT

TIMING AND TYPE OF CONTACT

- Hundred and sixty-eight people (8%) presented to the ED within 14 days of their contact with the MSAMHS MH CORE program. This number does not include the presentations of the frequent presenters (four or more presentations).
- The average time between the contact with MSAMHS MH CORE program and the presentation to the ED was 3.4 days. Seven people (4%) presented the same day.
- For over one third (36%) of this group, the contact with the QPS MSAMHS MH CORE program had been indirect.

AGE AND GENDER DISTRIBUTION

An equal proportion of males (n=83; 50%) and females (n=85; 50%) presented to the ED subsequent to their contact with QPS MH CORE. The age group that represented to the ED most frequently were the 25- to 34-years old.



Age	Total
0 to 14	4 (2%)
15 to 19	20 (12%)
20 to 24	17 (10%)
25 to 34	**39 (23%)**
35 to 44	35 (20%)
45 to 54	33 (21%)
55 to 64	16 (10%)
65 to 74	1 (1%)
75 plus	3 (2%)

REASONS FOR INITIAL CALL OUT

The main reasons for the call out are listed below:

- suicidal behaviours (ideation/plan/intent or deliberate self-harm) (n=60; 36%)
- Provision of advice/CORE not attending (n=32; 19%)
- Behavioural disturbance (n=29; 17%)
- Bizarre or unusual behaviours (n=19; 11%).

The remainder were classified as other (n=19; 11%), substance misuse (n=5; 3%) and unknown (n=4; 3%).

OUTCOME OF THE JOB

Among those who presented to the ED subsequent to the MH CORE attendance the outcomes of the initial contact with the MSAMHS MH CORE program were:

- No referral made (n=114; 68%)
- Referral to Mental Health Services (n=27; 16%)
- Referred to primary care (n=21; 13%)
- Taken to the emergency department (n=3; 2%)
- Taken into custody (n=3; 2%).

MAIN PRESENTING PROBLEM IN THE ED

The main presenting problems as coded in the MSAMHS ED Journey board, in descending order were:

- Suicidal Ideation (n=72; 43%)
- Schizophrenia, schizotypal and delusional disorders (n=28; 17%)
- Suicide attempt (n=10; 6%)
- Depression and Anxiety Disorders (n=15; 9%)
- Mental and behavioural disorders due to use of alcohol and drug (n=13; 8%)
- Other or unknown (n=30; 18%).

DISCHARGE DESTINATION

Most people that presented to the ED department were either:

- Discharged home (n=85; 51%)
- Discharged to a Community Team (n=11; 6%)
- Discharged to the Acute Care Team (n=26; 15%).

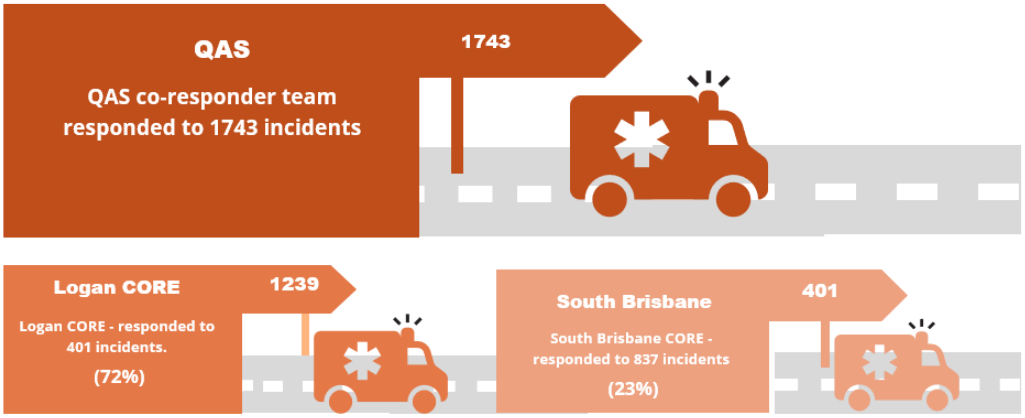
Twenty seven percent (n=46) required an inpatient admission.

QAS QUANTITATIVE DATA

OVERALL NUMBERS

NUMBER OF INCIDENTS

Between July 2019 and June 2021, the MSAMHS MH CORE QAS team responded to 1743 incidents. The MH CORE in the Logan Beaudesert Region (Logan CORE) responded to 1239 (71%) incidents. The MH CORE in the Brisbane South Region (South Brisbane CORE) responded to 401 incidents (23%). There was missing information on the location for 103 incidents.

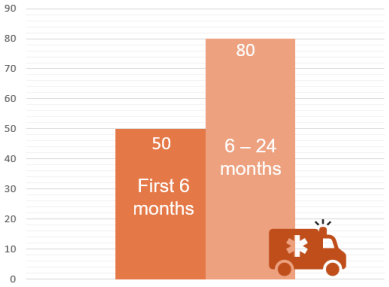


DIRECT AND INDIRECT CONTACTS

Eighty seven percent of provisions of service (n=1525) were classified as direct contacts. The remainder were indirect contacts. There were no differences in age and gender distribution between direct and indirect contacts.

PATTERNS OF USE

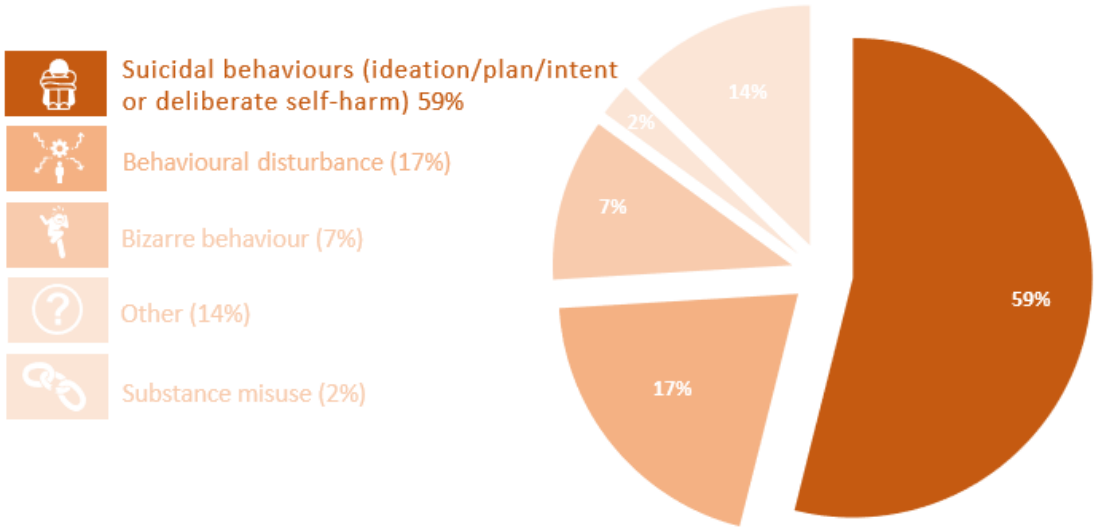
Over time there has been an increase in the number of incidents the CORE team have attended. During the first six months the co-responder team responded to an average of 50 incidents a month. This increased to an average of 80 incidents a month throughout the remainder of the operation of the program.



REASONS FOR CALL OUTS

DIRECT CONTACTS

Based on the information provided by the attending mental health clinicians, over half of all the reasons where QAS MH CORE had direct contact were suicidal behaviours (ideation/plan/intent or deliberate self-harm) (n=894; 59%). This was followed by behavioural disturbance (n=262; 17 %); bizarre or unusual behaviour (n=113; 7%) or substance misuse (n=35; 2%). Two hundred and ten of the direct contact incidents were classified as other (14%). The main reasons noted for others were hoax calls, depression and anxiety, follow up and medical issue. There was missing information for 11 incidents about the type of contacts.



INDIRECT CONTACT S

Twenty percent of the indirect contacts were recorded as providing information/advice. The main reasons for the indirect contact noted were:

- Stood down prior to arrival
- Not able to find the person
- QPS CORE attending or medical concerns.

OUTCOME OF JOB

Over 70 % of incidents that MSAMHS MH CORE attended were managed in the community. For 38 percent (n=575) no referral was made as the crisis was resolved. The remaining were either referred to primary care or an NGO (19%, n=285) or mental health services (12%, n=181). Six of the incidents (0.4%) were classified as taken into custody. Thirty one percent (n=466) of the incidents were transported to the ED.

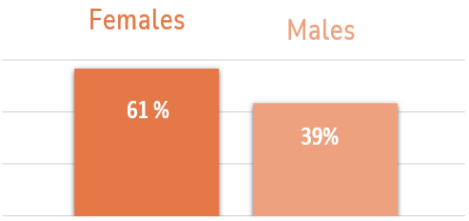
DEMOGRAPHIC CHARACTERISTICS

CURRENT MENTAL HEALTH CONSUMERS

The majority of the incidents attended to by the QAS MH CORE were not current mental health consumers (n=1125, 65%).

GENDER

The incidents MSAMHS MH CORE attended involved more females than males (n=1055; 61% females compared to n= 665; 39% of males). There was missing information for 23 incidents.



AGE

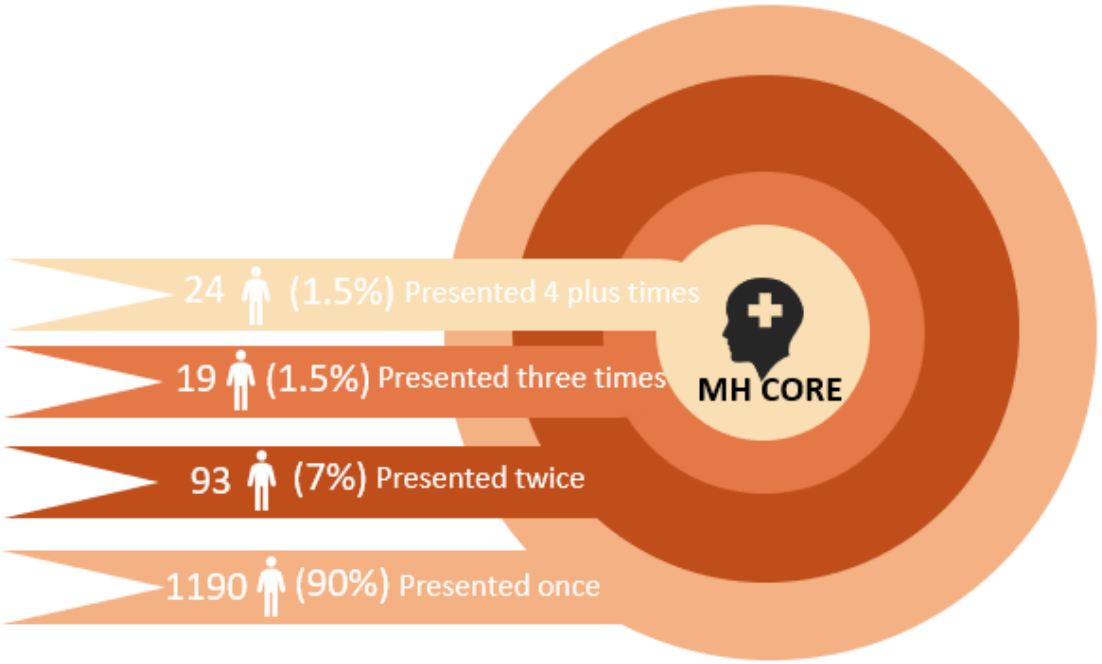
The age group most frequently attended by QAS co-responders were those aged 25-34 years (33 percent in the Logan area and 20 percent in the PAH area). There were no differences in the mean age (32 years) between the Logan and PAH areas.

Age	Logan	PAH	Total
0 to 14	58 (5%)	24 (6%)	82 (5%)
15 to 19	136 (11%)	54 (14%)	190 (12%)
20 to 24	176 (14%)	55 (14%)	231 (14%)
25 to 34	**403 (33%)**	**80 (20%)**	**483 (30%)**
35 to 44	204 (17%)	71 (18%)	275 (17%)
45 to 54	133 (11%)	60 (15%)	193 (12%)
55 to 64	77 (6%)	35 (9%)	112 (7%)
65 to 74	28 (2%)	17 (4%)	45 (3%)
75 plus	14 (1%)	2 (.5%)	16 (1%)
Total	1229	398	1627

There was missing information for 116 incidents.

REPEAT PRESENTATIONS

There were a total of 1743 incidents relating to 1326 individuals. The majority of the individuals only had one presentation (n=1190; 90%). 93 (7%) individuals presented twice and 19 individuals (1.5%) presented three times. Twenty-four (1.5%) individuals presented more than 4 times. This group presented a total of 310 incidents. Of note is that 72 percent of these repeat presentations were from six people, with one person accounting for over a hundred presentations.



TIME ON SCENE

ALL CONTACT

The average time on scene for all contacts was 41 minutes.

DIRECT CONTACTS

The average time on scene for direct contacts was 56 minutes.

PHONE CONTACTS

The average time on scene for phone contacts was seven minutes.

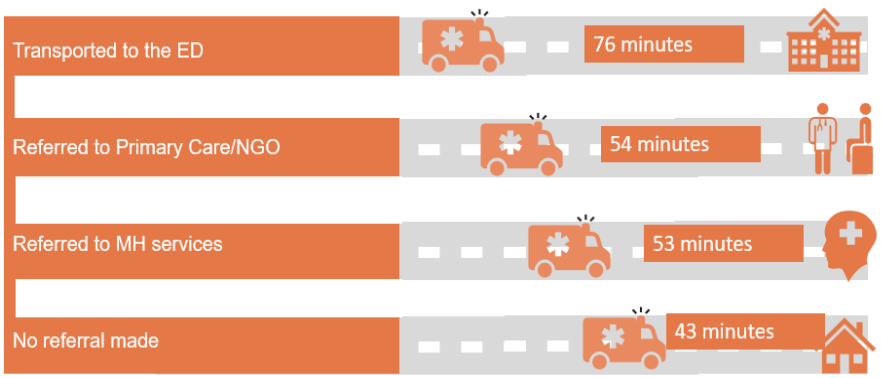
TIME ON SCENE BY INCIDENT

Time on scene also varied significantly by incident. The average times on scene for the different types of incidents are listed below:

- Bizarre or unusual behaviour – 76 minutes
- Behavioural disturbance – 57 minutes
- Suicidal behaviour – 56 minutes
- Substance misuse – 50 minutes.

TIME ON SCENE AND OUTCOME OF JOB

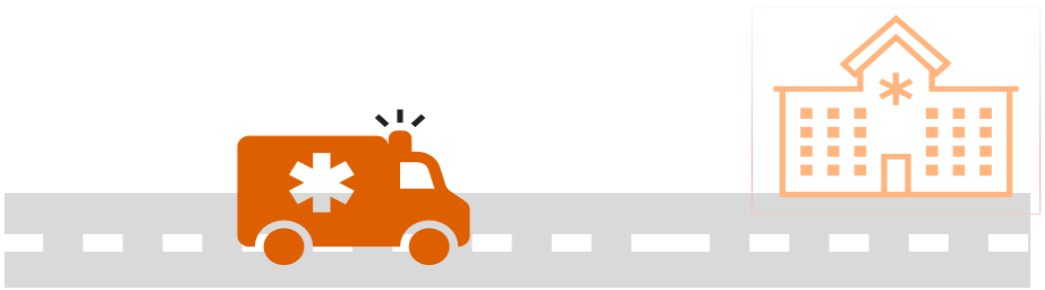
Time on scene also varied significantly by outcome of the job. The average time on scene for those that were transported to the ED was 76 minutes compared to 54 minutes for those referred to the primary care/NGO and 53 minutes to mental health services. The average time on scene when there was no referral made was 43 minutes. The average time for incidents where an EEA was enacted was 25 minutes longer compared to the incidences where there was no EEA (51 minutes compared to 76 minutes).



INTENDED AND AVERTED EEA

- Seven hundred and eighty-seven (45%) of all incidents were classified as intended EEA and flagged as possible transfer to the ED.
- The EEA was enacted in 225 (28%) of these incidents.
- Only 7 percent of the incidents that were not flagged as possible EEA were transported to the ED under an EEA.

Over 72% of intended EEA were averted



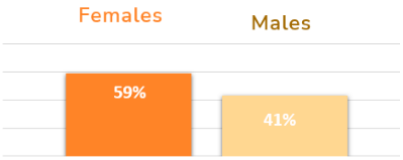
PRESENTATIONS TO THE ED WITHIN 14 DAYS OF CONTACT

TIMING AND TYPE OF CONTACT

- One hundred and sixty-one people (11%) presented to the ED within 14 days of their contact with the MSAMHS MH CORE program. This number does not include the presentations of the frequent presenters (four or more presentations).
- The average time between the contact with MSAMHS MH CORE program and the presentation to the ED was 3.5 days. Seven people (4%) presented the same day.
- For over one fifth (n=36; 22%) of this group, their contact with the QAS MSAMHS MH CORE program had been indirect.

AGE AND GENDER DISTRIBUTION

A higher proportion of females (n=96; 59% compared to n= 65; 41%) presented to the ED subsequent to their contact with QAS MH CORE. The age group who most frequently presented to ED were those aged 25-34 years.



Age	Total
0 to 14	9 (5)
15 to 19	21 (13%)
20 to 24	30 (19%)
25 to 34	**39 (24%)**
35 to 44	29 (18%)
45 to 54	17 (10%)
55 to 64	11 (7%)
65 to 74	4 (3%)
75 plus	1 (1%)
Total	161

REASONS FOR INITIAL CALL OUT

The main reasons for the initial call out are listed below:

- Suicidal behaviours (n=66; 41%)
- Behavioural disturbances (n=22; 14%)
- Bizarre and unusual behaviours (n=20; 12%).
- Provision of advice/CORE not attending (n=10; 6%)

The remainder were classified as other (n=38; 24%), substance misuse (n=3; 2%) and unknown (n=2; 3%).

OUTCOME OF THE JOB

Among those who presented to ED subsequent to a QAS MH CORE attendance, the outcomes of the initial contact with the MSAMHS MH CORE program were:

- No referral made (n=90; 56%)
- Referral to Mental Health Services (n=30; 19%)
- Referred to primary care (n=25; 16%)
- Taken to the emergency department (13; 8%).
- Other (n=2; 1%).

MAIN PRESENTING PROBLEM IN THE ED

Among those who presented to the ED following a QAS MH CORE attendance, the main presenting problem as coded in the MSAMHS ED Journey board, in descending order were:

- Suicidal Ideation (n=57; 35%)
- Schizophrenia, schizotypal and delusional disorders (n=26; 16%)
- Suicide attempt (n=9; 6%)
- Depression and Anxiety Disorders (n=22; 13%)
- Mental and behavioural disorders due to use of alcohol and drug (n=9; 6%)
- Other (n=29; 18%)
- Unknown (n=9; 6%).

DISCHARGE DESTINATION

Most people that presented to the ED department were either:

- Discharged home (n=81; 50%)
- Discharged to a community mental health service (n=4; 3%) or Acute Care Team (n=29; 18%).

Twenty nine percent of the presentations (n=47) required an inpatient admission.

QAS AND QPS COMPARISON

SIMILARITIES

When comparing the people that were seen by QPS and QAS CORE Teams there were no statistically significant differences in:

- Age distribution
- Proportion of consumers known to the to the mental health services
- Proportion of diverted EEA
- Outcome of the job
- Proportion of transportation to the ED.

DIFFERENCES

There were statistically significant differences in the proportion of incidents involving males and intended EEAs. The QPS MSAMHS MH CORE had a higher proportion of:

- Male consumers (43% compared to 39%; p<.0001)
- Intended Emergency Examination Authorities (54% compared to 45%; p<.0001)

QUALITATIVE DATA

MODEL OF SERVICE

The MSAMHS MH CORE program has one team of Mental Health Clinicians who can either be rostered on the QPS or QAS co-responder team. The clinicians are co-located with QPS or QAS. The clinicians noted that the work was very similar.

> *There are very few differences between the QPS and QAS co-responders. There is some interpersonal stuff, but apart from that the work does not differ much. The only big difference is with QAS we are the first response team whereas with QPS we are the second response team." (MSAMHS Clinician).*

MODEL ADDRESSES A COMMUNITY NEED

Both MSAMHS Clinicians and QPS Officers noted that there was a real need for the MSAMHS MH CORE. QPS is currently the front-line response to a mental health crisis and the demand for services is very high. While this is the case many of the officers interviewed described how police has limited training and knowledge as to how to deal with complexities of these crises. They also described how responding to a mental health crisis could be time consuming. Prior to the MSAMHS MH CORE program, the QPS default response to many mental health crises was the enactment of an EEA. QPS officers would either ring QAS or take the person to the emergency department themselves. Both MSAMHS Clinicians and QPS Police Officers described the aims of the service as changing the default of taking the consumer to the emergency department to addressing the crisis in the community. The service was described as early intervention and preventative.

> *The main aim is alternative to hospitalisation and alternative to presentations to ED. I think it is also preventative as well." (MSAMHS Clinician).*

> *Generally, the only options for someone who is experiencing a mental health crisis is to either take no action or complete an EEA. Generally, the QPS first responders are risk averse, so an EEA will be the preferred option." (Police Officer).*

> *Without CORE there are few alternatives. In QPS we don't have the experience to be comfortable with the risk of leaving someone at a place of safety other than the ED." (Police Officer).*

PERCEIVED STRENGTHS OF THE PROGRAM

ABILITY TO DIVERT FROM THE EMERGENCY DEPARTMENT

Both police officers and MSAMHS clinicians perceived the MSAMHS MH CORE model to be an effective way of diverting people from the emergency department. The major strength of the model was the ability to deal with a person's crisis in their own home, where people felt more comfortable talking. However, for this to be effective clinicians spoke about the need to have access to a strong referral network (Public Mental Health Services, Non-Government Organisations as well as private providers). The QAS Survey results also indicated that there was total agreement to the question: "QAS MHCORE is an effective and efficient first response to mental health cases"

> *We try to keep people out of hospital if we can." (MSAMHS Clinician).*

> *They get probably better service from [CORE] than being taken to the hospital. The reason they're in crisis is cause no one's listening to them. [CORE] is just there to listen to what they have to say, so they can say it in a safe spot. They feel more comfortable at home than they would sort of being frog marched out to the hospital." (Police Officer).*

> *We have a good network of good community organisations and networks. We do a lot of referrals to the community and not just the GP but the NGO sector." (MSAMHS Clinician).*

> *It enhances the consumers' experiences. From a practical point of view, they are not being carted off on an EEA to ED to wait 4 hours to be discharged. The fact that they are in their own home, I personally can get more out of them than I can in ED setting." (MSAMHS Clinician).*

> *This service is essential. Patients, in my experience, are generally treated successfully. Follow up also shows that they are engaging with the community services that have been put in place for them by the Mental Health clinician.*
>
> *Furthermore, we generally do not have repeat calls for those who engage with the Co-responder team." (Paramedic).*

CONSUMERS ARE MORE LIKELY TO OPEN UP

From the perspectives of both MSAMHS clinicians and QPS officers, the model was effective. Both clinicians and police officers noted that there was less of a power imbalance as clinicians did not wear a uniform and were able to talk to the person on the same level. Clinicians also believed that, not having a time limit imposed allowed the consumers to tell their concerns and gave clinicians the space to listen. The model also allows for clinicians to get collateral information from the families and, when necessary, address some of their concerns and provide them with support options. Having access to information about the patients prior to arriving on scene through the QLD Statewide Clinical Information System (CIMHA) was also valuable as they were able to gain an understanding of what may have been happening previously. The QAS survey results also noted that that there was unanimous agreement by all the paramedics to the questions: "People attended by QAS MHCORE responded positively to the service" and "QAS MHCORE delivers appropriate and effective care to people in a mental health crisis."

> *There are differences in how we interact compared to how the police are taught to interact. They are taught to be assertive, to be to the point that they can come across a bit blunt. I can understand why they are like that.*
>
> *When we interact with somebody, we are gentler, a lot more curious. For example, I will sit down on the furniture, get on their level and talk to them softly. A general duties officer will not sit down. They all stand up. I guess that is from a safety perspective, they are mindful of other things. We come across as more gentle, whereas for police it is inherent in their work to have authority. They can't change that." (MSAMHS Clinician)*

> *Depending on the person, not everyone likes to see a police officer turn up. They don't typically open up to the police for fear that they're going to get themselves into trouble. When a co-responder turns up, obviously they're not wearing a uniform, they have a conversation That sort of lowers the barriers for that person to open up and have a conversation. So, in that respect a person is more likely to disclose what's affecting them to the co-responder rather than a police officer." (Police Officer)*

> *I strongly support this service and personally believe it is achieving some fantastic results for some of our most vulnerable patients." (Paramedic).*

ALTERNATIVE TO ENACTING A "DEFAULT" EMERGENCY EXAMINATION AUTHORITY

From the perspective of the QPS officers, the model was effective as they had an alternative option to enacting an EEA by default. They also believed that the MSAMHS MH CORE were faster and allowed for first responder crews to be released quicker and attend other incidents.

> *What's appealing for officers is being able to hand over jobs to a mental health clinician rather than being tied up waiting for an ambulance to transport for potentially hours, and then waiting to hand over at a hospital. This frees up resources much quicker." (Police Officer).*

> *The strength of the program is its ability to divert people from ED, freeing up crews." (Police Officer).*

> *I think [the CORE clinicians] are qualified and respected enough to be able to raise those issues with family and friends. And if an assessment can be done in the home that's obviously a heck of a lot quicker than QPS waiting for QAS or transporting them ourselves and having to waiting while the hospital completes the documentation. It is way, way quicker and more effective." (Police Officer).*

BETTER WAY TO MANAGE PEOPLE WHO PRESENT MULTIPLE TIMES

Both MSAMHS Clinicians and QPS Officers described how the MH CORE program was a more effective way to respond to people who called the service multiple times.

> *We have our regular people that make contact with police or QAS in this area who have ongoing behavioural or mental health issues. So, we're seeing those on a regular basis. But I think, again, because we've got the same people attending, those frequent presenters can be dealt with appropriately with a combined agency approach. Because we're sharing that information now and we're seeing them time and time again with the same people, so we can give the correct advice." (Police Officer).*

STRONG COLLABORATIONS AND WORKING RELATIONSHIPS

Another perceived strength of the model was the strong working relationships with QAS and QPS. The QAS Survey also noted a that all paramedics agreed with the question: "A good working relationship exists within MHCORE Teams". Both MSAMHS Clinicians and QPS Officers spoke about the importance of the co-location, to have very defined roles and a clear understanding of the different roles and responsibilities. It was also critical that the services were able to share information about different consumers.

In order to develop these strong working relationships, MSAMHS Clinicians and QPS Officers spoke about the importance of role clarification and awareness of each others' working environments. It was noted that the documentation requirements for the clinicians was much higher than that of QPS and QAS and that particularly in the early stages, this had become an issue. Furthermore, as the clinicians are part of MSAMHS, they can understand the processes within the ED and have developed strong relationships and pathways for those clients that do require an ED admission. This meant that if the person had to be taken to the ED, most of the time, the hand over with the ED was more streamlined.

> *I think we're all working for a common goal as opposed to us and them. We can take care of the person in crisis." (Police Officer).*

> *The working relationship between us, QAS and QPS is very effective. It has just evolved. We have learnt the parameters of their roles as have they learnt the parameters of our roles, we've grown together." (MSAMHS Clinician).*

> *It is all about relationships, building relationships between health care clinicians and emergency services, because if you don't have good relationships it is going to fall apart. It is not going to work. We have built very good relationships between us and QPS and QAS and that is just why it works so well." (MSAMHS Clinician).*

AUTONOMOUS AND EXPERIENCED PERSONNEL

Both MSAMHS Clinicians as well as QPS Officers noted the importance of having the right people selected for the program. From a health perspective it was critical to have experienced senior clinicians who were autonomous and are able to make decisions while on the road. From the police perspective it was critical to have people that were willing to work with people experiencing mental health crises.

> *You have to have the right staff; you absolutely have to have the right people who understand the overall objective of the co-responder and what it actually takes. They must be senior clinicians and must be autonomous." (MSAMHS Manager).*

> *We're very selective with the people that we are in a partnership with. We're a team and you have to spend the whole day with each other, you work together. You can also have your say. […] I can just talk from the Logan one that we have to have the right people, that we've got a really good team of police officers and clinicians. People genuinely love coming to work and working on program." (Police Officer)*

STRONG SUPPORT FROM MANAGEMENT

Furthermore, support at all levels of the organisation was required. In Queensland Health, all clinicians unanimously described how they felt supported by management and that they had been responsive to their concerns and needs and tried to find solutions to address their issues. They felt they had back up from the management team and were provided with regular supervision.

> *I know that we have the support of our organisation (MSAMHS) so that takes some of that stress off. They understand what is required of us and the fact that they have made a change in our shift shows us how supportive of us they are. The reduction in our stress levels was really noticeable [after they changed the shifts]." (MSAMHS Clinician).*

> *These guys [MSAMHS management] are amazing, in Metro South, the whole service has been unbelievably supportive." (MSAMHS Clinician).*

EDUCATIONAL COMPONENT

In addition to ED diversion, both the MSAMHS and QPS staff described the educational component of the co-responder model as a major strength of the program. QPS officers spoke about how they generally did not have much training or confidence in dealing with mental health crises and that depending on the circumstances they may not have the time to deal with what is happening.

> *Police aren't very well trained in dealing with people in different types of mental health crisis […]. We also don't have a lot of resources to help in these situations, so our go to move is calling QAS for an EEA." (Police Officer).*

INCREASED POLICE OFFICERS' KNOWLEDGE IN MANAGING MENTAL HEALTH CRISIS

Both MSAMHS Clinicians, QPS and QAS officers noted that having clinicians integrated into a co-responder team enhanced their knowledge and confidence in managing mental health crises. Clinicians spoke about the importance of modelling and talking with the ambulance and police officers around why they have made certain decisions. Clinicians are also involved in more formal training and by attending forums and training sessions. Police also noted that it was beneficial for the clinicians to gain an understanding about the issues they face and educate their QLD health colleagues on these.

> *Watching and listening to the clinicians has only broadened my knowledge of mental health issues, services available and ways to communicate." (Police Officer).*

> *The police and ambos are telling us all the time that they feel more confident in approaching these jobs." (MSAMHS Clinician)*

> *I think that for them [MH Clinicians] there's benefit and insight into the way that consumers sometimes present to police as opposed to how they may present in a clinical setting within a hospital. It gives them, I guess, a good understanding of what we face. They can take that back to help educate their own colleagues." (Police Officer).*

> *I learnt a lot with regards to [working with] these patients. (Paramedic)*

JOB SATISFACTION

Of note, all MSAMHS clinicians described high levels of job satisfaction. In fact, all staff described their role as one of the best jobs they have had in their careers. They particularly valued the autonomy they had, the variety of presentations and the fact that they did not know what was going to happen during each shift.

> *I love the job. There is a great feel- good factor to be able to stand down emergency crews. Clients love it, which is also nice. I can give them my time in their own environment, their own home." (MSAMHS Clinician).*

> *It is not for the faint hearted. It is seat of the pants stuff. It's like bouncing across the goal waiting for the ball to come. It's incredibly. You have a huge amount of autonomy but that comes with an equal amount of responsibility. So you need to be really confident in your skills and decision making and so you have to be fairly A type to do this job. It's exciting, really exciting. It is exciting not knowing what is coming." (MSAMHS Clinician).*

AREAS FOR IMPROVEMENT

EXPANSION OF SERVICE AND HOURS OF OPERATION

When asked if there were any improvements that could be made to the service, the overwhelming response from MSAMHS clinicians, QPS and QAS officers was the need to expand the hours of operation. It was also noted that it was critical to educate QPS and QAS dispatch and officers about the aim of the service as to avoid referrals that may not be appropriate for the MSAMHS MH CORE team.

> *We need more coverage. Unfortunately, people in mental health crisis don't exactly only operate between 2 and 10, in the afternoons. So, to have coverage of a clinician and an officer 24/7 is probably the ultimate goal. But then in saying that we need the support [to do this]." (Police Officer).*

> *I can't think of any improvements apart from make it 24 hours because they are useful." (Police Officer).*

> *To improve coverage, a MH co-responder operating out of [different area] would be beneficial. (Paramedic).*

HAVING ADEQUATE RESOURCES AND BACKFILL

QPS officers noted that while there is real value to the co-responder program there are resource implications. One senior police officer raised concerns that they had to take resources from other areas to deliver the program. It was noted that it was important to have dedicated resources to support the program. Furthermore, having a pool of clinicians that could be called on for backfill was also critical to the operations.

> *Crews on the road love it and the people that are involved in volunteering regularly, love it too. I think from a management level, we see its value and therefore we're willing to support it as much as we can. But it's quite difficult because we rotate staff through the model. So, it's a commitment that's spread across the district." (Police Officer).*

> *The other thing that isn't working well is that we don't have the resources to be able to service all the calls. This means that officers are disappointed because they'll call for us to attend [and we are unable to do so]. One of the things that isn't working well is the fact that we've only got one car for the entire South Brisbane district." (Police Officer).*

LESSONS LEARNT

QUANTITATIVE EVALUATION

The quantitative evaluation provided an overview of the demographic and clinical characteristics of people accessing MSAMHS MH Core program and identified services and representation patterns of people accessing MSAMHS MH Core Services. Over the two years both Services have been in operation, the QPS MSAMHS MH CORE responded to 2394 incidents and the QAS MSAMHS MH CORE responded to 1743 incidents.

There were very little differences between the two services in terms of age distribution, whether people were known to mental health services, the outcome of the job, percentage of averted EEAs or if people were transported to the Emergency Department. The QPS MSAMHS MH CORE program saw slightly more males and had more intended EEA.

Below we highlight the main findings:

- The age group most frequently attended by MH CORE were those aged 25-34 years. Over one third of the incidents were people aged under the age of 25.
- The majority of the people accessing the MSAMHS MH CORE program were not known to mental health services.
- Over 85 percent of the consumers have accessed the service only once.
- Over half of the reasons identified for a direct contact were for suicidal behaviours (ideation/plan/intent or deliberate self-harm). This was followed by behavioural disturbance; bizarre or unusual behaviour, or substance misuse.
- Over 70 percent of MH CORE contacts resulted in the individual remaining at home and did not require assessment in the ED. Only a quarter of the incidents resulted in the consumer being taken to the Emergency Department.
- Over 70% of the intended EEA were managed in the community.
- Only a small proportion of people (between 8 and 11%) represented to the ED within a 14-day timeframe.

QUALITATIVE EVALUATION

The qualitative interviews indicated that the MSAMHS MH CORE model was viewed as successful and that it addressed an important gap in service provision. The co-responder model was viewed as being able to divert people from the Emergency Department. Furthermore, both police and clinicians believed that it was beneficial for consumers to be assessed in their own homes. The co-responder model was viewed as an effective way to deal with mental health crisis. The perceived strengths of the model include the ability to divert from the Emergency Departments and an alternative to enacting the default EEA.

The working relationship between QPS and MSAMHS services was described as strong where the roles were clearly defined. Police also noted that Police Officers' confidence and understanding of mental health related concerns had increased since the co-responder program was implemented. Almost unanimously participants in this study noted that it was important to expand the hours of operation of the co-responder program.

Below we highlight some of the important lessons learnt from this evaluation:

- Importance of role clarification and strong working relations.
- Importance of clarifying the type of referral that would benefit from a co-responder unit.
- Importance of allocated QPS, QAS and MH resources to support the operations.
- Need for autonomy and support for MSAMHS Clinicians.
- Need for administration time and administrative days for the MSAMHS Clinicians.
- Need for technology and information sharing between different agencies.

CONCLUSIONS

This evaluation indicates that:

The MSAMHS MH CORE Team was able to provide timely and appropriate mental health care to people who present to QAS or QPS with a mental health crisis.

The program builds the capacity of QPS and QAS personnel to manage a mental health crisis confidently and effectively when co-responder clinicians are not available.