

Model of Care – Tuggeranong Medicare Mental Health Centre

Think Community Services (TCS)

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Think Mental Health acknowledge the Traditional custodians on the land on which we live and work, and of the many different nations across the wider regions from which we all come. In Canberra this is the Ngunnawal people. We pay our respects to the Elders past, present and emerging as the holders of the memories, the traditions, the culture and the spiritual wellbeing of the Aboriginal and Torres Strait Islander peoples across the nation.

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1.0 Overview

Tuggeranong Medicare Mental Health Centre (the Centre) commenced operations in July 2025. It operates as a satellite of the Canberra Medicare Mental Health Centre, extending the reach of high-quality, person-centred mental health care to consumers and carers in an accessible location on the south side of Canberra. In alignment with the National Safety and Quality Mental Health Service Standards, the Model of Care (MOC) describes how the Centre delivers culturally safe, trauma-informed, person-centred, evidence-based or evidence-informed, high quality, recovery-oriented health care across the full consumer journey.

The Model of Care for the Tuggeranong Centre has been tailored to the local context through consultation with key stakeholders and consumers across the region, ensuring the delivery of the right level of care, at the right time, for those in need. The MOC incorporates the four core service elements outlined in the National Service Model for Medicare Mental Health Centres (Department of Health, Disability and Ageing, Version 2.0, April 2025), supplemented by region-specific strategies to address local service gaps and improve people's experience of navigating the complex and often fragmented mental health sector. This process has ensured that the MOC is locally responsive while grounded in national best practice.

Designed to meet the needs of individuals with moderate to severe mental ill-health, the Centre aims to reduce unmet demand and improve access to care for those residing on the south side of the ACT. This document presents the MOC from the perspective of the consumer's journey describing core funded services, types of interventions offered, and the range of clinical and wellbeing supports available. This version includes the integration of the Centralised Tele-health Service, a national referral option for consumers needing psychology or psychiatry support who are unable to access it via the Centre directly. It also outlines the Centre's collaborative and integrated approach to care planning, ensuring high-quality outcomes for all consumers, families, carers, and support people.

2.0 Background

The Canberra Medicare Mental Health Centre was established in 2021 as one of eight national pilot Adult Mental Health Centres, following key recommendations from the Productivity Commission (PC) Inquiry into Mental Health (2020–21). Initially the only centre in the ACT, the Canberra Centre was developed as a significant Commonwealth initiative to improve access to adult mental health care. In response to growing demand, the Tuggeranong Centre has been established to expand service coverage and better meet the needs of ACT residents living on the south side of Canberra. Like its counterpart, the Tuggeranong Centre is a Commonwealth funded initiative commissioned by the Capital Health Network (CHN) and delivered by Think Mental Health (TMH).

The PC Report noted the complexity of the mental health system in Australia and that many consumers were unable to locate appropriate services to meet their needs. The Commonwealth has invested significant funds in the establishment of community-based adult mental health centres delivered by multidisciplinary teams who provide holistic, collaborative care. These centres play an important and unique role within the fragmented mental health service landscape, connecting people experiencing distress to services which best meet their particular needs — either through the centre, or through supporting pathways to appropriate care outside of the Centres.

The National Service Model for Medicare Mental Health Centres (Version 2.0, April 2025) outlines four key service elements that form the basis of this MOC:

- A highly visible entry point for people in distress including those at heightened risk of suicide where all feel safe and welcomed, providing support that may reduce the need for emergency department attendance.

- In-house assessment, including standardised Initial Assessment and Referral (IAR), information, and support to access appropriate services.
- A central point to connect people to other services in the region, including service navigation and warm referral pathways to ensure individuals, families, carers, and support people can access the right services.
- Evidence-based and evidence-informed immediate, and short to medium term episodes of care, including utilisation of digital mental health platforms.

These four elements form the basis of the Centre's MOC, ensuring a regional approach that fits within the broader national service model. One of the strengths of the Commonwealth approach has been the use of a National Model with the opportunity to regionalise ensuring each region can design a model to meet the needs of local consumers.

2.1 Consultation Undertaken

To ensure the model met local needs, TMH engaged in consultation with a broad range of key stakeholders, taking an iterative approach to designing the best MOC for the region. The consultation process included engagement via provision of information, surveys, and organised consultation meetings with the following representative groups:

- Capital Health Network
- Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS), Canberra Health Services
- Office of Mental Health and Wellbeing
- Mental Health Community Coalition of the ACT
- ACT Mental Health Consumer Network
- Carers ACT Mental Health Carers Voice
- Consumer Advisory Group (CAG), Canberra MMHC
- Meridian ACT
- A Gender Agenda
- Community Sector Mental Health providers — Marymead CatholicCare, Grand Pacific Health (headspace), and Woden Community Services
- Local South Side GP and psychiatry practices.

All feedback and information provided has been incorporated, where possible, into the MOC designed for the Centre.

3.0 Principles of Care

As detailed within the Quality, Safety and Clinical Governance Framework, the Centre is designed to provide access to safe, high-quality, evidence-based, and evidence-informed services that are inclusive and appropriate in their practices. The Centre does not endorse or condone coercive or restrictive practices in any manner. The Centre supports consumer choice and autonomy in all aspects of their care including worker allocation, intervention approach, goals, and planning. Where possible, the Centre will accommodate consumer preferences.

The following principles underpin all delivery of care within the Centre:

- Respecting the rights and responsibilities of people using the Centre's services
- Providing timely access to user-friendly services
- Being culturally safe and appropriate in all practices
- Being family, carer, and support person inclusive
- Being inclusive of all forms of diversity
- Providing gender affirming care
- Providing holistic, trauma-informed, integrated care
- Providing care for co-occurring issues
- Working in an integrated clinical system with a multidisciplinary team
- Using safe practices that comply with relevant regulations and legislation
- Using evidence-based and evidence-informed practices where these exist.

3.1 Family, Carer, and Support Person Inclusion

The Centre acknowledges and applies the Triangle of Care model (Worthington, Rooney & Hanna, 2013), recognising the value and ongoing role that family, carers, and other support persons play in the life of someone with mental ill-health. The Centre works to ensure ongoing and informed consent is in place, enabling the care team to be fully engaged in recovery planning throughout all stages of a consumer's engagement with the service.

3.2 Child Safety

As an adult mental health service, the Centre acknowledges, applies, and reviews the National Principles for Child Safe Organisations as relevant. Child safety and wellbeing are important to the service; young people are well-informed about their rights and actively involved in decisions affecting them. All clinicians working at the Centre are required to hold an ACT Working with Vulnerable Persons (WWVP) check and receive ongoing training on mandatory reporting requirements. Parents are also engaged in promoting child safety and wellbeing where necessary. The Centre's physical environments are designed to prioritise safety and reduce harm.

3.3 Gender Affirming and Culturally Safe Care

The Centre follows the ACT Government's Guidance to Support Gender Affirming Care for Mental Health. Gender affirming care is provided according to guiding principles from the National Mental Health Standards. Staffing, along with the Centre's Consumer Advisory Group (CAG), reflect community diversity and a commitment to respecting differences. The Centre has engaged Meridian, a community-controlled, peer-led organisation to deliver training to staff, ensuring the team is confident and competent in delivering safe care for all. Staff at all levels are encouraged to normalise asking for pronouns and show visible support to gender diverse communities by displaying symbolic iconography.

Consistent with the National Service Model and the Gayaa Dhuwi (Proud Spirit) Declaration (2015), the Centre ensures the Model of Care offers a culturally safe response to the needs of Aboriginal and Torres Strait Islander people, working towards the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.

4.0 Purpose and Scope

The Centre is designed to complement, not replace or duplicate, mental health services already provided within the region. The model is not designed to offer long-term, multi-year care, but is based on an episode of care model delivering packages of evidence-based or evidence-informed care and support to consumers, families, carers, and support people to meet short to medium term needs.

The Centre provides accessible, responsive services that collaboratively assess consumer needs and provide timely resources, referrals, and services to meet identified needs. Services may be provided internally within the Centre or via service navigation and warm referral to existing services, best matched to meet consumer needs.

The Centre operates as a safe and inclusive service for all those who live, work, or play within the ACT. Services do not require a particular severity or mental health diagnosis; they are freely available to all in need. The Centre welcomes those from diverse backgrounds, including First Nations peoples, people from culturally and linguistically diverse (CALD) backgrounds, and members of LGBTIQ+ communities. The Centre also welcomes those who may face challenges with complex and/or co-occurring needs, including alcohol, drug, or dual disability needs.

The Centre delivers a range of evidence-based and evidence-informed, person-centred, recovery-oriented, and cost-effective mental health services to the community. Services provided are aligned with a stepped care approach, designed to fill gaps in existing service provision and evolve over time within an iterative approach to service delivery.

The Centre openly shares knowledge and expertise in a manner conducive to capacity building and collaboration across the mental health care sector including supporting GPs and other health professionals to make appropriate referrals to the Centre, or to access referral networks and knowledge developed by the Centre, ensuring people are referred to the right place, for the right care, at the right time.

The Centre ensures efficiency and effectiveness of practice, being cognisant of cost-effectiveness and timeliness in the development and implementation of service delivery and referral pathways including the appropriate use of existing and emerging digital technologies that facilitate improved consumer access and outcomes. An innovative and evaluative approach is taken, ensuring a continual cycle of quality improvement to optimise services available to consumers.

4.1 Services Provided In-House, In-Reach, or by Referral

Consistent with the National Service Model, the following services are available to people who present to the Centre, either on an in-house, in-reach, or referral basis.

Most of these services are provided under the clinical governance of the Centre, particularly where founded on an in-reach or in-house basis:

- Intake, assessment, and service navigation
- Psychological assessment and evidence-informed psychological interventions
- Psychiatric assessment and medication management, where available
- Care coordination and multidisciplinary care planning
- Peer support and family support services
- Group programs and psychoeducation
- Suicide prevention and distress support services
- Alcohol and Other Drug (AOD) support for co-occurring conditions
- Vocational, psychosocial, housing, financial, and social support through integrated care or referral
- Outreach and flexible service delivery where appropriate
- Culturally safe and inclusive care for priority populations.

4.2 Services Provided by Referral

Where it is not possible to provide services in-house or through using the Centre as a platform, the following services are provided on referral:

- General practitioners and primary care providers
- Private and publicly funded psychology and psychiatry services
- Specialist state and territory mental health services
- Acute mental health and emergency services
- Alcohol and Other Drug (AOD) services
- Disability supports, including the National Disability Insurance Scheme (NDIS)
- Child, youth, family, and perinatal mental health services
- Housing, employment, legal, financial, and community support services
- Veteran services and other specialist programs
- Other services commissioned by the Primary Health Network or government agencies.

4.3 Services Out of Scope

Consistent with the National Service Model, and to ensure demand management and capacity for new people to present, the Centre does not generally provide longer-term or ongoing mental health care or support services. The Centre is not funded to provide:

- Services for people who cannot be managed safely within the Centre
- Acute reception of police or ambulance referrals
- Pathology, radiology, or pharmacy services
- Ongoing, long-term psychosocial support services
- Recreational services
- Direct financial support
- Residential or bed-based services, including short-stay services
- Services targeting children and young people which could be more appropriately provided by headspace or other specialised children's or youth mental health services
- Disability support services provided through the NDIS
- Other services provided by other agencies in the area.

5.0 Intended Outcomes and Evaluation

The key measures of success of the Centre's implementation, as defined by the Commonwealth Department of Health, Disability and Ageing (National Service Model, Evaluating the Service Model), are:

- The Centre will be recognised as an accessible entry point to the mental health sector.
- People will be able to access, or be connected to, the particular mental health and related services they are assessed as needing.
- People will receive immediate advice and care which reduces their level of mental and emotional distress, resulting in a reduction in non-acute presentations to local hospital emergency departments.

Individuals experiencing high levels of psychological distress or in crisis receive the care they need from the Centre, supporting a reduction in non-urgent presentations to local hospital emergency departments.

5.1 Planned Monitoring, Evaluation, and Improvement Activities

In addition to national reporting obligations, the Centre undertakes the following planned activities to monitor, evaluate, and continuously improve service delivery:

- Regular review of consumer outcome and experience data, clinical outcome measures, consumer-reported outcomes, and consumer experience surveys to identify trends and opportunities for improvement.
- Periodic review of referral and partnership arrangements with local services to identify any duplication, fragmentation, or emerging service gaps.
- Collection and review of service user feedback, including from the post-discharge user experience survey, used to inform service improvements and raised with the Quality Improvement Committee (QIC).
- Review of complaints, compliments, and suggestions received, consistent with the Consumer Participation and Feedback Policy.
- Clinical case review and supervision processes to support quality and consistency of assessment, treatment, and risk management practice.

Findings from these activities are reported through the Quality, Safety and Clinical Governance Framework and the Quality Improvement and Assurance Framework, ensuring service user feedback and operational data actively inform the ongoing development of the Centre.

6.0 Cohort

All people 18 years and over who live, work, or play in the ACT and require support to manage their mental health are eligible to access the Centre for information, assessment, and connection to services that meet their needs. This broad cohort is

supported to access the right level of service within the community through the Centre or through other lower or higher intensity services.

The Centre recognises the need for flexibility to meet the needs of those seeking mental health services. Where applicable, services are offered to independent help-seekers aged 16 years and over particularly those with severe or complex needs who are unable to access other services. Young people aged 12–25 are given information about care and support available from youth-specific services, such as headspace, where this is the most appropriate way to meet their needs.

Priority is given to consumers with moderate to severe mental health needs, as assessed using the Initial Assessment and Referral (IAR) tool, for access to intervention services delivered within the Centre.

Priority is also given to addressing service gaps for those in underserved or hard-to-reach populations including those for whom there is no existing local service, and those at risk of disengagement from services.

The service prioritises those identified as vulnerable persons, including: First Nations peoples, culturally and linguistically diverse peoples, sexual or gender diverse peoples, men over 50 years of age, and Veteran populations.

7.0 Multidisciplinary Workforce

The Centre is staffed by a multidisciplinary workforce to ensure the best outcomes for service users.

Table 1 – Multidisciplinary workforce by team and services

Team	Services Provided	Qualifications / Profession
Clinical Services	Support for people in distress; completion of intake (IAR); service navigation; comprehensive assessments; care coordination; individual psychological therapy; individual Dialectical Behaviour Therapy (DBT) for those engaged in the comprehensive DBT program at CMMHC; group programs; specialist services	Registered/accredited health professionals: social worker, psychologist, clinical psychologist, occupational therapist, counsellor, nurse, psychiatrist
Wellbeing Services	Peer social group; mindfulness and relaxation group; individual peer support	Peer Worker — lived experience of mental ill-health and completion (or working towards) of Certificate IV in Peer Work Social and Emotional Wellbeing (SEWB) Worker — emotional and social wellbeing case worker with appropriate qualifications

and/or relevant experience
(Aboriginal identified role)

8.0 Consumer Journey Overview

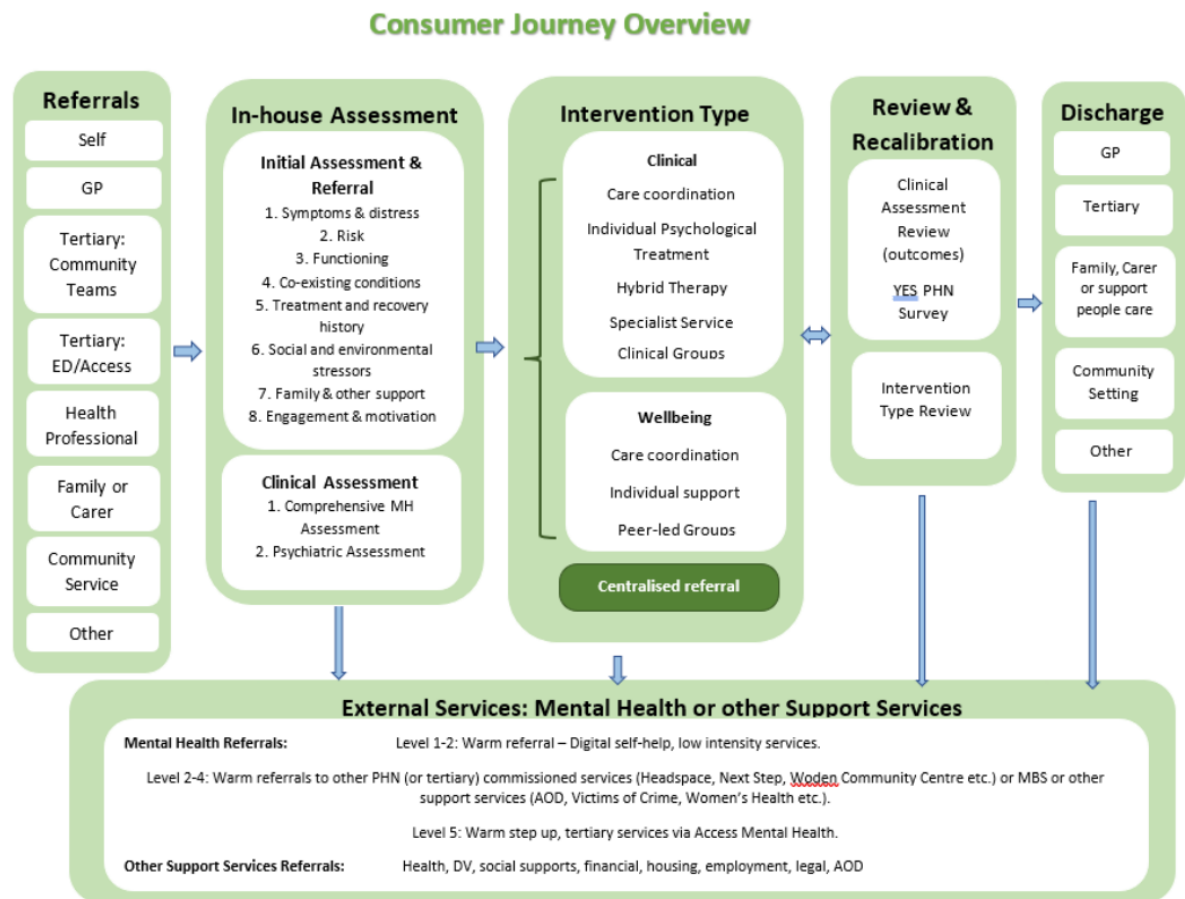


Figure 1 – Consumer's Journey through Medicare Mental Health Centre

Table 2 – Consumer Journey across service streams

Stage	Information for Self/Others	Mental Health Service Needs (Non-Crisis)	Crisis Services (Alternative to ED)
Initial contact and intake	By phone, online, walk-in, or referral from other services (e.g. GP, hospital, state/territory service)	Same	Same
Initial brief assessment	Identify need is for information only	IAR completed; GP advised consumer is receiving services	Immediate support to de-escalate in-house support, supported transfer to home/carers, or warm

			transfer to acute services
Immediate support	Connect with information and services; support and advice for families, friends, and carers	Initial support provided per IAR outcome	Full assessment following stabilisation, as per non-crisis pathway
Short to medium term care	Support to access digital information and treatment resources	Episode of care per assessed need: clinical or wellbeing services	Short-term targeted therapeutic care while connecting to longer-term support; regular contact and follow-up for those at heightened risk of suicide
Service navigation and referral	Referral to relevant services	Warm referral and 24–48 hour and 7–10-day follow-up	Warm referral to relevant services; referral to Way Back or other suicide prevention follow-up services
Review	N/A	Follow-up and review	Follow-up and review

9.0 Key Services

In line with the National Service Model, the Centre provides four core key services:

- Accessible service and support for those in distress
- Assessment
- Service navigation
- Interventions divided into Clinical Services and Wellbeing Services.

Day-to-day operations are managed efficiently to allow timely support to consumers and minimise disruption, providing continuity of care as appropriate for those engaging across all key services. Where changes or interruptions are unavoidable, alternative arrangements are negotiated with the relevant consumers.

9.1 Accessible Service Providing Support for Those in Distress

The Centre is located in Tuggeranong, accessible via public transport and personal vehicle, with on-street parking available nearby. The Centre has been designed to provide a warm and welcoming environment including a bright and open reception and waiting space, an accessible quiet (Welcome) room off the reception area with various seating options, a hot/cold water point, and various snack options. There are five consulting rooms and a group/meeting room, in addition to staff workspaces.

The Centre opens 9:00am–5:30pm Monday to Friday, though group programs are expected to be offered after hours. Opening hours are flexible and responsive to service demand and consumer feedback. Online information and call-back requests available 24/7.

People can walk in to seek support at times of distress. Whilst the service does not provide crisis management, the Centre provides support in times of need and, where necessary or appropriate, provides warm hand-over to acute services for crisis management. The Centre works closely with Safe Haven in Belconnen, who provide after-hours support for those in crisis and/or distress enabling the Centre to focus on addressing gaps and avoid duplicating available services.

The Centre aims to reduce risk and demand for acute services by providing person-centred, non-judgemental, and timely support for those experiencing situational or emotional distress. This service is provided by the Clinical Team as part of their core business, with an onsite peer worker available to support those who would prefer to engage with someone with lived experience. Staff engage with consumers, their carers, families, and support people. All staff are trained to recognise and respond to early signs of deterioration, crisis, or distress. Wellbeing staff escalate matters of risk to an appropriate clinician as necessary, in line with the Clinical Risk Management Guidelines. Anyone seeking to use the service is entitled to an interpreter, if a new consumer requests one, staff use the phone-based interpreter service TIS National, and the IAR proceeds with their assistance.

9.2 Assessment

The Centre provides two distinct types of assessments, each with a different purpose and provided by the appropriate team.

9.2.1 Initial Assessment and Referral (IAR)

Standardised initial assessments are offered to all consumers who wish to go through the process of assessment and referral. It is the Centre's standard intake process, available in-person. The IAR is a needs assessment developed by the Commonwealth that assists in developing a thorough understanding of consumers' needs and circumstances, guiding decision-making about the most appropriate next steps aligned to the required level of care: Level 1 (self-management), Level 2 (low intensity interventions), Level 3 (moderate intensity interventions), Level 4 (high intensity interventions), and Level 5 (acute and specialist mental health services).

All new IARs are presented and reviewed at the daily Triage meeting, facilitating clinical review and best-practice decision-making for appropriate resources and referrals. All consumers are followed up within 24–48 hours of their IAR to discuss the outcome of the initial assessment, resources, and referral options including review of the level of care and resources recommended, to ensure services are person-centred and meet consumer expectations. These details are discussed verbally (via telephone or in person), then followed up in writing (email or text). A final 7–10-day check-in is scheduled post-IAR to ensure consumers have found resources useful and fit for purpose. Should resources not be useful or suitable, the case returns to Triage for review and further consideration of next steps.

9.2.2 Comprehensive Mental Health Assessments (MHA)

Provided to consumers identified as presenting with complex needs during the review and triage meeting, requiring more comprehensive clinical assessment to

clarify diagnosis and inform treatment planning. It may also be offered at the discretion of the clinical worker upon a consumer's initial presentation.

A comprehensive MHA is undertaken by a mental health professional, and all assessments are presented for clinical review with a senior clinician. MHAs are semi-structured biopsychosocial assessments used to clarify clinical presentation, diagnosis, formulation, and inform appropriate recovery planning. The outcome of the MHA may, in some circumstances, be referral to other higher or lower intensity services external to the Centre, rather than providing the episode of care within the Centre. This service is provided by Clinical team members.

9.3 Service Navigation

People can call or walk in to receive information about services available within the region. The Centre is open to providing information to members of the public, family, carers, support people, other health professionals, and service providers. For specialised information about the best-matched services to meet consumer need, people need to have completed the intake process (IAR) so the Centre is fully aware of individual circumstances and is best placed to match referrals to need. All consumers who complete an IAR receive carefully matched resources and referrals, including clarity on wait times and any potential barriers to engagement.

The team provides warm referrals and, with consumer consent, ensures their information goes with them to the referred service, minimising the need to re-tell their story and providing smooth pathways into services. All consumers who have been through the intake process receive follow-up at 24–48 hours and again at 7–10 days, to ensure resources and referrals have been suitable, engaged with, and met their needs.

Service navigation typically ends when information and warm referrals are provided to the consumer at the 24–48 hour call. Service navigation is a critical component of the Centre's MOC and is provided by intake staff as a standardised process after all IARs. At times, consumers with particularly complex needs and barriers to engaging with referrals will be stepped up to receive care coordination within the Centre.

All resources recommended must be evidence-based, accessible, affordable or free to use, culturally and linguistically sensitive, and personalised to meet the identified needs and recovery goals of the consumer. Referrals are holistic addressing the full range of a consumer's needs, not mental health needs alone and may include non-mental-health services such as housing, financial counselling, legal assistance, or family support, where these are necessary to meet the consumer's overall wellbeing. A resource database is maintained and regularly reviewed to ensure currency, including consultation and liaison with community services.

9.3.1 Key Referral Categories

Warm referrals are made across the following categories of service, selected according to the consumer's assessed needs and preferences:

- CHN-commissioned services including other Medicare Mental Health Centres, Headspace, and other PHN-commissioned psychological and AOD services

- ACT Government-funded mental health services including ACT Acute Mental Health Services and other Canberra Health Services programs
- Private services including private psychiatry, psychology, and other allied health providers, on a fee-for-service basis where this is the most appropriate option to meet the consumer's needs
- Non-mental-health services necessary to meet broader needs including housing, financial, legal, family, and social support services
- Medicare Mental Health Check-In is a free national digital mental health service providing evidence-based self-guided online tools and low-intensity CBT support (via telehealth) for people aged 16 and over experiencing mild mental health challenges. Accessible via medicarementalhealth.gov.au or by calling 1800 595 212. Appropriate for consumers assessed at Level 1–2 who have access to digital devices and internet.

9.3.2 Components of a Warm Referral

A warm referral is the standard referral practice of the Medicare Mental Health Centre and consists of the following components:

- Centre staff contact the receiving service on behalf of the consumer, with the consumer's consent, rather than simply providing contact details for the consumer to action themselves.
- The Centre continues to support the consumer throughout the referral process and while they are awaiting contact, assessment, or acceptance by the receiving service.
- The referral addresses the consumer's needs holistically covering mental health, AOD, and other relevant psychosocial needs, rather than a single issue in isolation.
- The referral process is trauma-informed and preserves the consumer's choice and agency. The consumer is not referred to a service against their preference, and alternatives are discussed where the first option is not acceptable to them.
- With consumer consent, relevant assessment information (including the completed IAR outcome) is shared with the receiving service and travels with the consumer to their point of referral minimising the need for the consumer to retell their story or undergo unnecessary re-assessment.
- Where appropriate and practicable, a direct clinical handover occurs between Centre staff and the receiving service using the ISBAR framework (Identity, Situation, Background, Assessment, Recommendation) to ensure a structured, consistent, and complete transfer of information regarding the consumer's needs, goals, risks, supports, and recommended care pathways.

9.3.2.1 Digital Solutions for Secure Information Transfer

Where available, the Centre uses digital solutions to support timely, accurate, and coordinated transfer of consumer information between services. Digital information sharing reduces reliance on verbal handover alone, minimises the risk of information loss, and supports continuity of care across the consumer's service journey.

Where appropriate and with consumer consent, digital transfer may include:

- Referral information
- Intake and psychosocial assessment outcomes
- Mental state examination findings
- Suicide and safety risk assessments
- Risk management and safety plans
- Clinical recommendations
- Consent documentation
- Other information necessary to support safe and coordinated care.

Information is shared using secure communication methods that comply with relevant Commonwealth and State/Territory legislation, ensuring that only authorised providers can access consumer information. Digital transfer is used where available for referrals to external services, to the ACT Medicare Mental Health Phone Service, and to the Centralised Tele-health Service for consumers referred for tele-psychology or tele-psychiatry. Where digital transfer is not available, the Centre uses alternative secure communication methods, including encrypted email or direct clinician-to-clinician handover using the ISBAR framework, supported by documented referral information to ensure continuity of care.

The Centre actively monitors and adopts emerging digital solutions that improve interoperability between providers. Opportunities may include integration with national digital health infrastructure, secure messaging networks, shared electronic health records, electronic referral platforms, and other technologies that enhance coordinated care while maintaining consumer privacy and information security.

The effectiveness of digital information transfer processes is monitored through quality improvement activities, including:

- Referral completion and acceptance rates
- Timeliness of information transfer
- Incidents relating to information sharing
- Consumer and provider feedback
- Privacy and security audits
- Continuous review of emerging digital health initiatives.

9.4 Interventions

The Centre provides a range of short- and medium-term intervention services depending on consumer need. These include care coordination, individual psychological treatments, hybrid therapy, specialist services, individual peer support, social and emotional wellbeing support, and a range of group programs. The particular mix of services depends on assessed need and the recovery plan for each individual.

For example, some people with complex needs may receive a short-term, stabilisation-focused intervention while waiting to access a longer-term community service that better meets their needs. Others may receive a substantial episode of

care, including access to groups, care coordination, and individual psychological treatment.

The Centre recognises that mental health and personal circumstances can change over time. Processes are in place to ensure the primary care team is promptly informed when critical information or risks related to a consumer's care emerge or change. Consumers, their families, carers, and support people are also supported to share important updates or concerns with the care team, to ensure safe, responsive care. Where needed, agreed collaborative pathways are established to escalate supports in response to changes in a consumer's needs or risk profile, with appropriate partner services for example, Safe Haven, Access Mental Health, and the Way Back Service.

At times, a consumer may require a change in care needs due to deterioration in mental health, this may involve adjusting care provided or referring the consumer to an external service with more appropriate expertise. Whilst the Centre is focused on providing short to medium term episodes of care and is not a crisis service, both clinical and wellbeing staff are equipped to respond during periods of increased need and will, when appropriate, coordinate a smooth transition to acute services.

9.4.1 Clinical Services

Care Coordination

Care coordination is designed to provide enhanced support to consumers who experience complex needs or barriers that interfere with their ability to access and engage with the most appropriate services. One allocated staff member works collaboratively with the consumer to arrange and facilitate engagement with relevant services that meet their recovery needs and goals. Care coordination is particularly useful for those with complex care needs, helping people integrate their care across providers, improve health outcomes, and promote autonomy and self-agency.

A core function of care coordination is the organisation and integration of care across multiple service providers, including the Centralised Tele-health Service for psychology and psychiatry sessions. The care coordinator maintains clinical accountability for ensuring safe, appropriate, and coordinated care including developing, monitoring, and modifying all care or wellbeing plans, determining the suitability of the consumer for telehealth services, and ensuring all providers involved (telehealth or local) receive timely, clear information regarding the consumer's needs, progress, and risk status.

For consumers engaged in care coordination to support access to individual psychological treatment via the Centralised Tele-health Service, care coordination should be provided by a clinician, clear delineation between the role of the clinician providing care coordination and the clinician at the Centralised Tele-health Service providing individual psychological treatment is required.

From a biopsychosocial perspective, care coordination recognises that complexity arises from a combination of social, environmental, financial, cultural, psychological,

and clinical factors. The care coordination pathway ensures consistency and integration of care through clear communication, collaborative planning, and coordinated service linkages tailored to the consumer's unique needs.

In relation to safety, the care coordinator is responsible for risk communication and any necessary escalation including urgent responses or transitions to acute or higher-level services. The care coordinator supports a safe and seamless transition ensuring continuity of care, minimising service disruption, and maintaining a clear, collaborative approach across all involved providers.

Hybrid Therapy

An innovative program delivered via the Centre, a hybrid of individual counselling and digital mental health treatment programs. Digital mental health programs have a growing evidence base and provide structured, discreet, convenient, and effective treatments; however, uptake and completion can sometimes be problematic.

The hybrid therapy program aims to reduce drop-out and improve completion rates. The digital programs prescribed are evidence-based internet-delivered Cognitive Behavioural Therapy (iCBT), delivered in collaboration with This Way Up (TWU) a trusted Australian provider with a secure online platform, sponsored by the Australian Government and supported by the Clinical Research Unit for Anxiety and Depression at St Vincent's Hospital, Sydney, and the University of New South Wales Faculty of Medicine.

All referrals to this program come via triage and are allocated by the Clinical Team Leader. Following referral, an initial in-person session is scheduled to identify the presenting problem, outline the hybrid program, identify the best program for the consumer's needs, and review potential barriers to successful completion. Consumers may complete online modules at home on their own device, or at the Centre on one of its devices within a specifically designed E-therapy space providing free access to computers, high-speed internet, and support to navigate the online platform. This program alternates in-person counselling sessions with completion of online modules, at a negotiated pace and structure to meet the consumer's circumstances.

Individual Psychological Treatment

Individualised psychological treatment interventions are provided for consumers identified with moderate to severe mental health needs who cannot be better serviced by existing external services. These services are provided by Mental Health Clinicians from the Clinical Team or may be provided by the Centralised Tele-health Service if this is deemed the most appropriate source of intervention. A collaborative, person-centred episode of care model is provided, with all consumers receiving evidence-based or evidence-informed individual interventions.

The duration of interventions depends on consumer need and is typically delivered in blocks of 6 sessions (6/12/18) with in-built review. These interventions follow the comprehensive MHA and clinical review including case formulation and treatment

planning and may be supported by care coordination, including recovery-oriented collaborative shared care planning to link clinical needs to broader services.

Interventions provided depend on individual case formulations and the evidence base, and are likely to include:

- Cognitive Behaviour Therapy (CBT)
- Acceptance and Commitment Therapy (ACT)
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Dialectical Behaviour Therapy (DBT)

South side consumers may be provided with individual DBT onsite if assessed as suitable for the comprehensive DBT program delivered at the Canberra MMHC. Where a consumer is receiving individual DBT treatment, their episode of care length is substantially longer (33 sessions), as required for participation in the full DBT program.

Specialist Services

The Centre offers specialist psychiatry services through a part-time psychiatrist available periodically (once per month), with follow-up available either at the Canberra Centre or via telehealth onsite in Tuggeranong. The specialist provides direct clinical services to adults presenting with complex mental health issues including clinical assessment, diagnosis, review, and interventions, delivered within an episode of care model for those who require psychiatric input but are unable to access appropriate care elsewhere. Referrals may occur through the Centre's standard intake process, internal referral from the clinical team, or referral from the team at the Canberra Centre. Psychiatric care is short-term, and all consumers are connected to an appropriate GP as their primary carer and for ongoing care. The psychiatrist does not directly provide medications, though may provide a prescription for the consumer to have filled and subsequently managed by their GP.

All consumers engaged with specialist psychiatry services receive a letter (via mail or preferred method of correspondence) outlining appointment details, what to expect, and crisis contact numbers should support be needed prior to their appointment. Where clinically indicated, consumers may also receive care coordination.

The specialist provides appropriate information to consumers, family, and/or support people to assist informed choice when considering medications potential side effects are explained, with appropriate follow-up provided either onsite (time-limited) or via the consumer's GP.

Tele-psychiatry is also available as part of the Centralised Tele-health Service. This service is only available to those deemed eligible and appropriate for telehealth, this decision is made after the IAR and in consultation with a senior clinician. Consumers who receive tele-psychiatry are also allocated to care coordination at the Centre with a clinical staff member, who maintains clinical accountability for ensuring safe, appropriate, and coordinated care.

The Centre ensures that staff involved in prescribing medicines operate within their defined scope of practice to maintain high standards of consumer care. No psychotropic medications are stored onsite, nor dispensed by any Centre staff member, as this falls outside the Centre's scope of practice. Processes are in place to confirm that medicine-related information, including allergies and adverse drug reactions, are thoroughly documented in the consumer's care record. This involves proactively screening for potential medicine allergies and adverse reactions by directly inquiring with the consumer. Information gathered during these interactions are documented in clinical notes, ensuring comprehensive and accurate records are maintained, including any input from psychiatrists to support safe and informed decision-making in medicine management. The service provider ensures that suspected Adverse Drug Reactions (ADRs) experienced by consumers during service delivery are appropriately documented in the consumer care record and relayed to those with shared responsibility of care including relevant healthcare providers such as the consumers GP and those prescribing the medication.

Robust processes of action when a suspected medicines-related problem is identified are determined by actions plans created by the psychiatrist prescribing the medication. Any concerns regarding the medication can be relayed to the psychiatrist via reception, whilst urgent requests are directed towards Access Mental Health or the consumers GP.

Detailed accounts of any suspected ADR, including symptoms, timing, and possible contributing factors, are recorded in the clinical notes providing a comprehensive view. The consumer's file is also updated to include information about the ADR, ensuring that it is readily accessible for future reference and continuity of care. Any suspected ADR can be reported through an organisation-wide incident reporting system and to the Therapeutic Goods Administration (TGA) as necessary.

9.4.2 Wellbeing Services

Individual Wellbeing Support

Individual support can be provided by Wellbeing staff including a Peer Worker (PW) and/or a Social and Emotional Wellbeing (SEWB) Worker (Aboriginal identified position). These staff are companions who support and guide consumers on their recovery journey, bringing personal experience and offering emotional support rather than clinical treatment. Consumers can elect to work with a wellbeing staff member rather than a clinician for individual support.

The Centre is committed to embedding those with lived experience of mental ill-health into the service model as part of the service delivery team. This role ensures the Model of Care offers a culturally safe response to the needs of Aboriginal and Torres Strait Islander people, in line with the principles of the Gayaa Dhuwi (Proud Spirit) Declaration.

A collaborative, person-centred episode of care model is provided, with all consumers receiving evidence-based or evidence-informed interventions. Typically, to receive individual wellbeing intervention, consumers need to be able to keep themselves (and others) safe and not be in frequent crisis or experiencing an acute

mental health episode (e.g. psychosis or mania), to fully engage with and benefit from wellbeing support. The duration of interventions depends on consumer need and typically begins with a block of 6 sessions with built-in review. All wellbeing sessions are provided within a recovery-oriented approach.

9.4.3 Group Programs

The range of group programs offered is dependent on consumer need and is regularly reviewed to address identified service gaps. As the Model of Care is iterative, program offerings are expected to evolve over time in response to changing consumer priorities and service developments. The Centre offers both clinical and wellbeing groups, with most groups co-facilitated by a mix of clinical and wellbeing staff. Groups are delivered on a rotational needs' basis, meaning not all groups are delivered every term. Groups are available onsite at the Centre, accessed via the standard intake process (IAR), and available to any consumer engaging with the service.

Consumers identified as suitable for group participation may be referred to the Canberra Centre for group programs not currently offered at the Tuggeranong Centre, coordination between centres ensures consumers have access to a broader range of therapeutic and support groups.

The following groups are currently available:

- Healthy Coping Workshop
- Men's Resilience Group
- Peer Social Group (focused on building social connections)
- Mindfulness and Relaxation Group (skills development focused)

Peer Social and Mindfulness and Relaxation are Wellbeing groups, delivered by lived-experience staff.

10.0 Collaborative Shared Care and Recovery Planning

Facilitating joined-up, integrated care is central to the Centre's Model of Care. When a consumer requires the support of multiple services, the care team comes together with those parties including family, carer or other support persons, health workers, GPs, and other support services to establish agreed working practices and develop a Collaborative Shared Care (Recovery) Plan. All consumers engaged in individual psychology services complete a Collaborative Recovery Plan at the start of treatment; this is shared with the treatment team and regularly reviewed. Where a consumer has an Advance Care Plan in place, this is used to inform the recovery plan as appropriate.

For all consumers identified as benefiting from monitoring and/or safety planning, this is undertaken collaboratively including development and documentation of a Self-Management Plan identifying early warning signs, positive coping strategies, and agreed pathways for escalating care if needed. This plan is shared (with consent) with the consumer's care team, including family, support persons, and other relevant external services. The plan is a two-way mechanism any member of

the care team can raise concerns and request escalation of care in response to a consumer's deterioration.

There are two ways in which the Centre facilitates collaborative shared care arrangements:

- Internal partnerships between multidisciplinary clinicians or other providers who work at the Centre and collaborate on the recovery care plan for individuals.
- External partnerships and shared care arrangements with other individuals or services providing support needed to achieve the best outcomes for consumers with complex needs.

For external partnerships, a Collaborative Shared Care Plan promotes shared understanding of the consumer and their recovery goals, promotes consistency in practice, avoids duplication of care, reduces stress, and ensures all care team parties are working towards the consumer's identified goals. Ongoing and informed consent, confidentiality, and appropriate information sharing are central to a recovery-oriented collaborative shared care plan.

Collaborative safety plans are developed and documented for consumers presenting with risk of suicide and shared with all care team members when clinically indicated.

A whole-of-person approach is taken, ensuring physical health needs are managed in concert with mental health and broader social and/or vocational needs. The team works with consumers to facilitate links back to their GP, and where a consumer does not have a regular GP, works with them to establish one.

Clear communication with the referrer and the consumer's care team, including their GP, is paramount including provision of regular feedback, treatment reports as necessary, and formal care team meetings with all members at a frequency matched to consumer need. Formal care team meetings may occur face-to-face or via telehealth/videoconferencing, generally coordinated by Centre staff.

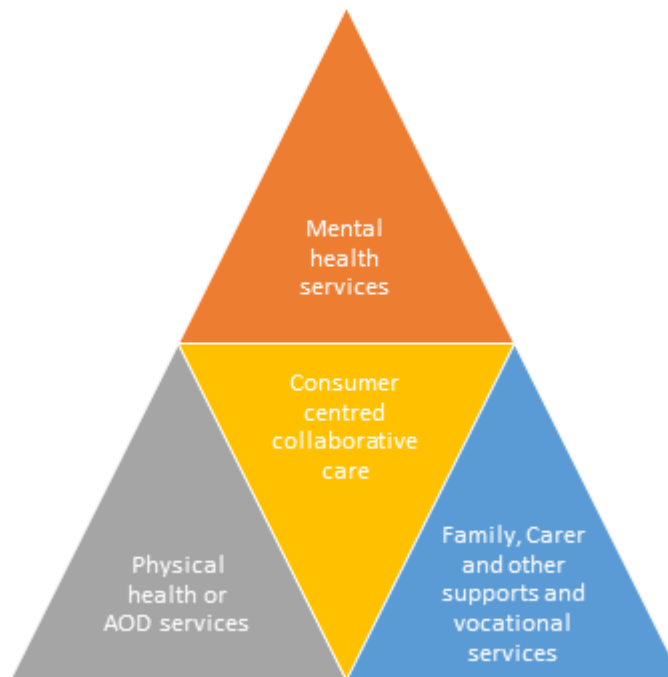


Figure 2 – Partnerships for Consumer Centred Collaborative Care

11.0 Service Exit / Discharge

The Centre operates within an episode of care model, meaning discharge and recovery planning is considered from the beginning of engagement with services including the capacity to step up or step-down care for those whose needs change during their involvement with the Centre.

The Centre provides a range of services with variable duration. Regardless of the duration of involvement, planning for discharge is always considered and conducted in conjunction with the care team particularly important for a service that does not provide multi-year care, where consumers are often discharged back into the care of family, carers, and other supports.

At times, the service provided will be a short-term intervention focused on attainable goals and/or stabilisation, while consumers wait to engage with an external service provider who better meets their longer-term needs, discharge occurs once the consumer has engaged with the new service. At other times, a lengthy service is provided internally, and no further service is required at discharge in these cases, a clear relapse prevention plan forms part of discharge planning, ensuring consumers know when and how to re-engage if circumstances change.

At service discharge, all care team members are involved in or informed of the completion of care, and a summary of the rationale and ongoing arrangements is provided to appropriate third parties. All consumers receive a user experience survey link at completion of their episode of care, forming part of the Centre's continual review process and quality improvement cycle.

12.0 Community and Service User Engagement

There was a considerable period of engagement across the mental health sector as part of localising the service model for the Centre, ensuring it meets the needs of local service users. This is expected to be an iterative process, the Centre continues to engage with key stakeholders both through the Consumer Advisory Group (CAG) and more broadly with people with lived experience, ensuring ongoing input into service design, implementation, delivery, and evaluation. Continued community and service user engagement supports good awareness of the Centre and what it offers the community, while building collaboration and partnerships across the sector.

The Centre values community and consumer partnerships and is working to embed a feedback loop including a consumer, family, carer, and other support person reference group for those who have had direct service delivery experience with the Centre.

The Centre's overarching Quality, Safety and Clinical Governance Framework acknowledges the importance of consumer, family, carer, and other support person participation across the continuous quality improvement cycle at a service level and commits to engaging consumers as partners in their care at an individual level. The framework has four key elements addressing different types and levels of engagement:

Table 3 – Consumer, Family and Career Participation across the Service

Element	How This Is Achieved	Policy / Framework
Consumers, families, carers, and other support persons as partners in care	Input to care planning; informed consent; promoting opportunities for self-care; peer support	Consent and Confidentiality Policy; Centre Model of Care
Input to service design and implementation	Consultation with people with lived experience in designing models of care; consumer advisory structures	Quality, Safety and Clinical Governance Framework
Input to monitoring and review	Engagement of consumers through the continuous improvement cycle via regular surveys, focus groups, and advisory structures	Quality, Safety and Clinical Governance Framework
Ongoing feedback on the safety and quality of care	Opportunity for complaints, compliments, and suggestions	Consumer Participation and Feedback Policy

13.0 Quality, Safety and Risk

The Centre operates under a comprehensive Quality, Safety and Clinical Governance Framework, which facilitates effective clinical governance ensuring the Centre meets its legal and ethical responsibilities for the provision of safe, quality

programs and services by staff and subcontractors. This framework sets out the Centre's commitment to implementing safety and quality systems, including developing policies and procedures, identifying risk, monitoring performance, analysing clinical incidents, implementing quality improvement processes, and reporting to the Primary Health Network and Commonwealth on the performance of these systems and outcomes of care.

The Framework allows the Centre to be clear about how it defines, delivers, and reviews quality care in partnership with consumers, their carers, and support systems. Clinical governance, as outlined in the Framework, seeks the following outcomes:

- Consumers and carers — confident they are receiving quality care, provided by competent staff working within a learning culture, with continuous monitoring and review of standards of practice.
- Staff — understand their roles and responsibilities, are supported to provide quality care, and are engaged in a system designed for continuous monitoring and improvement.
- Members of governing bodies — understand their roles and responsibilities, demonstrate effective leadership, monitor and respond to performance, and ensure risk is identified and managed.
- Partnering organisations — understand each other's roles and responsibilities and can demonstrate accountability for ensuring evidence-based care is delivered safely, efficiently, and appropriately in accessible locations.

The Framework has been developed in line with the National Model Clinical Governance Framework published by the Australian Commission on Safety and Quality in Health Care and is consistent with the National Safety and Quality Health Service (NSQHS) Standards in particular the Clinical Governance Standard and the Partnering with Consumers Standard. It is informed by the National Service Model for Medicare Mental Health Centres (Department of Health, Disability and Ageing, Version 2.0, April 2025).

13.1 Safety Protocols and Escalation

The Centre's safety and quality protocols including clinical governance and credentialling, cultural safety, carer support consistent with the Carer Recognition Act 2010 (ACT), and privacy compliance under the Privacy Act 1988 (Cth) and the Australian Privacy Principles, operate under the Quality, Safety and Clinical Governance Framework and apply uniformly across all TCS programs. The following arrangements are specific to the Centre:

- Protocols with the relevant Local Hospital Network equivalent and emergency departments ensure that offering alternative services does not delay urgent care or risk consumer safety and wellbeing.
- After-hours arrangements ensure staff and clients are not at risk, and are equipped to discretely manage the care of individuals who are intoxicated or exhibiting anti-social behaviour associated with drug use.

13.2 Consent to Treatment and to Share Information

Clinicians must obtain informed consent from a consumer and/or their legal guardian before any service is provided and must ensure consent is obtained and documented in accordance with the Territory Records Act 2002 (ACT), the Health Records (Privacy and Access) Act 1997 (ACT), and the Human Rights Act 2004 (ACT). The consent process is undertaken at the commencement of the consumer's engagement with the Centre and includes the following options:

- Consent to receive service and share service delivery information
- Consent to seek/share information and data from relevant care providers, including the consumer's GP and other treating practitioners
- Consent to sharing of de-identified data with relevant reporting, research, and evaluation agencies
- Consent to receiving surveys regarding feedback
- Consent to be contacted via various means (e.g. email, phone, mail).

Clinicians confirm the type of consent provided at intake and review this where a consumer's circumstances or preferences change, consistent with the Consent and Confidentiality Policy.

13.2.1 Substitute Decision-Makers

Where a clinician identifies that a consumer may lack capacity to make decisions about their own care, for example, due to acute cognitive impairment, delirium, severe intoxication, or a guardianship order already in place, the clinician asks whether someone already holds a legal decision-making role for the consumer (e.g. an enduring guardian, attorney, or appointed decision-maker under the ACT Guardianship and Management of Property Act 1991) and, where one is identified and contactable, seeks their involvement in decision-making about next steps.

Where no substitute decision-maker is identified or able to be reached and the consumer's safety requires an immediate decision, the clinician acts in the consumer's best interests consistent with the Clinical Risk Management Guidelines, including escalation to ACT Acute Mental Health Services where appropriate. The basis for any capacity concern and the steps taken are documented in the consumer's file.

13.3 Additional Clinical Considerations

13.3.1 Language Barriers – Interpreter Services

Where a consumer has limited English proficiency or requests language assistance, accredited interpreter services, such as the Translating and Interpreting Service (TIS National), are used to facilitate effective communication. Family members or friends are not routinely used as interpreters, except when requested by the consumer and appropriate in the circumstances. The use of interpreters supports informed consent, accurate assessment, effective communication, and equitable access to services.

13.3.2 Screening for Cognitive Impairment

Where there is any indication or concern of cognitive impairment or delirium, appropriate screening is undertaken prior to proceeding with assessment or treatment including, where appropriate, administering the Mini Mental State

Examination, and/or referral to the consumer's GP or an Aged Care Assessment Team. Where a consumer is known to have a cognitive impairment, appropriate adjustments are made to the assessment and treatment process, with family/carer involvement sought with consent.

13.3.3 Deaf and Hearing-Impaired Consumers

Where a consumer is deaf or hearing-impaired, a service such as the Video Remote Interpreting Service (VRI) is considered, enabling communication using Australian sign language (Auslan).

13.3.4 Engaging Children and Adolescents

Where services are provided to a young person aged 16 or 17, the Centre takes a child-centred and family-focused approach, considering the young person's needs in the context of their family and building on their strengths. Clinicians engage directly with the young person wherever possible and invite the involvement of a parent or carer for collateral information and informed consent but do not decline to provide information, support, or referral to a young person who attends without parental involvement.

13.4 Re-Entry and Re-Engagement

Given the changing and evolving nature of mental health needs, a consumer may seek support from the Centre on more than one occasion following a prior discharge. The approach to re-engagement depends on the time elapsed since the consumer's last episode of care:

- 0–3 months — the clinician takes a review approach, understanding any change in circumstances, mental state (including risk), or need since the previous episode, and explores whether the consumer engaged with previous recommendations.
- 3 months or more — a repeat comprehensive assessment is generally undertaken; clinicians minimise the need for the consumer to retell their story by summarising what was previously documented and exploring what has changed.

The Centre does not create barriers to re-engagement but seeks to understand the consumer's current need to ensure the right services are provided.

14.0 Definitions

Term	Definition
Care Team	The consumer, family, carer, or support persons, and all health workers involved in collaborative shared-care plan development to address the health and other support needs of the consumer. Includes mental health professionals, other clinical staff such as AOD workers, peer workers, GPs, emotional and wellbeing support workers, housing workers, and other social and occupational support services, including family.
Catchment	The PHN regional area outlined in the service contract.

Clinical Governance	The system by which the governing body, managers, clinicians, and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care. Includes workforce credentialling and scope of practice determinations.
Episode of Care	The package of care and evidence-based treatment provided for individuals with a specific mental health need, delivered by a multidisciplinary team over a set period. The period between formal entry to and exit from the service, during which treatment for the presenting concern(s) is provided usually including multiple occasions of care. Formal exit includes formal discharge from the service's electronic patient management system; the episode remains open until this process is finalised.
Model of Care (MOC)	This document, as updated from time to time by the service provider in consultation with the CHN.
IAR	The Initial Assessment and Referral Tool — the initial intake assessment used to gather information from the consumer about needs and guide decision-making about the most appropriate next steps, aligned to the required level of care: Level 1 (self-management), Level 2 (low intensity), Level 3 (moderate intensity), Level 4 (high intensity), Level 5 (acute and specialist mental health services).
Step Down Care	The process and procedures required to facilitate transition to other mental health services of lower intensity, in consultation with a consumer, carer, and care team, as clinically appropriate.
Step Up Care	The process and procedures required to facilitate transition to other mental health services of higher intensity, in consultation with a consumer, carer, and care team, as clinically appropriate.
Stepped Care	An evidence-based, staged system of care comprising a range of help and support options of varying intensity, matched to the level of need and complexity of the conditions experienced by any given consumer. Once assessment is complete, the most appropriate, cost-effective level of care is provided and continually recalibrated to the consumer's changing needs.
Warm Transfer / Warm Referral	The process where the Centre actively communicates with the service to which the individual is connected, to provide essential information about their needs before transferring them. Support is maintained for the individual by Centre staff until they are received by the new service.

15.0 Reference Documents

15.1 Internal Policies, Procedures, and Guidelines

- Code of Conduct Policy
- Consumer Participation and Feedback Policy
- Consent and Confidentiality Policy
- Credentialling and Scope of Practice Policy
- Data Governance and Records Management Policy
- Records Management Guidelines
- Incident Management Policy and Procedure
- Infection Control Policy
- Open Disclosure Policy
- Risk Management Policy

- Clinical Risk Management Guidelines
- Supervision and Professional Development Policy
- Quality, Safety and Clinical Governance Framework
- Intake Operational Guidelines
- Clinical Operational Guidelines
- Wellbeing Operational Guidelines.

15.2 External Policies, Guidelines, Standards, and Legislation

- National Service Model for Medicare Mental Health Centres (Department of Health, Disability and Ageing, Version 2.0, April 2025)
- National Safety and Quality Mental Health Standards for Community Managed Organisations (NSQMHC MO)
- National Standards for Mental Health Services 2010
- Australian Council on Healthcare Standards — all relevant standards
- Practitioner profession-specific practice and competency standards
- Privacy Act 1988 (Cth) and Australian Privacy Principles
- Health Records (Privacy and Access) Act 1997 (ACT)
- Mental Health Act 2015 (ACT)
- National Framework for Recovery-Oriented Mental Health Services 2013
- National Principles for Child Safe Organisations 2019
- Guidance to Support Gender Affirming Care for Mental Health 2021
- Carer Recognition Act 2010 (ACT) and Carers Engagement Policy
- Children and Young People Act 2008 (ACT)
- Fifth National Mental Health and Suicide Prevention Plan, 2020
- ACT Joint Regional Mental Health and Suicide Prevention Plan
- Allied Health Credentialing, Competency and Capability Framework 2014
- Work Health and Safety Act 2011 (Cth)
- Mandatory reporting legislation
- Working with Vulnerable People (Background Checking) Act 2011 (ACT)
- Gayaa Dhuwi (Proud Spirit) Declaration, 2015
- Other PHN policies and procedures relevant to Program Services, as advised.