MENTAL HEALTH CASE MANAGEMENT

DOCUMENT CONTROL

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File location:	*AC Performance Services ZenDesk*
Document type (& enforceability):	Guidelines (recommendations)
Responsible parties:	Psychologists; Player Development Managers; Doctors; Dietitians
Beneficiaries:	All players participating in matches and/or training as a part of an AC HP program
Applicable setting:	National and S/T HP environments

1. PURPOSE

1.1 These Guidelines establish a nationally consistent approach to care coordination ("case management") for players experiencing mental health concerns, ensuring that:

a) Clinical care is governed and delivered by appropriately credentialed professionals

b) Non-clinical roles provide support around care only

c) Clinical risk is appropriately identified, escalated, and managed through the clinical spine

d) Players receive coordinated, ethical, and player-centred care

1.2 This document must be read in conjunction with the Mental Health Clinical Governance Framework.

2. KEY PRINCIPLES (MANDATORY ALIGNMENT)

2.1 Clinical Authority

a) All clinical decision-making, risk assessment, diagnosis and treatment sits with:

(I) Psychologists

(II) Medical Practitioners

(III) (Where relevant) Dietitians

b) Clinical authority cannot be delegated to non-clinical roles

2.2 Support Around Care

a) Non-clinical staff (including PDMs) operate within "support around care" only, meaning they:

(I) Enable access to care

(II) Support engagement and logistics

(III) Coordinate operational elements of care

(IV) *Do not* assess, treat, interpret or manage clinical conditions or risk

2.3 Role Clarity

a) Care coordination does not equal clinical management

b) All roles must operate within defined scope of practice

2.4 Player-Centred Care means players retain:

a) Choice of provider

b) Input into care decisions

c) Control over consent (within safety limits)

2.5 Risk Escalation

a) All mental health concerns must be escalated according to the Clinical Governance Framework escalation pathway

b) High-risk cases are managed by a multidisciplinary clinical team

3. DEFINITIONS

For the purposes of these guidelines:

3.1 The **Case Manager** will, in most circumstances be the **Clinical Lead**. When this is not feasible, the Head of Performance Support / SSSM Manager will act as Case Manager, where they are a practitioner registered with a professional body.

3.2 The **Clinical Lead** is an AHPRA-registered (or DA-registered where appropriate) practitioner responsible for clinical oversight, including:

a) Risk assessment

b) Treatment planning

c) Clinical decision-making

3.3 The **Core Multidisciplinary Team** (**CMT**) will be pulled together for complex or high-risk presentations and may include:

a) Psychologist;

b) Medical Practitioner; and

c) Dietitian (for ED/DE presentations)

3.4 The **Clinical Spine** is the defined hierarchy of clinical authority and escalation, led by:

a) CA's Mental Health Manager

b) State/Territory clinical leads

3.5 Any non-clinical staff may be appointed as the **Care Coordinator**. This role will:

a) be appointed when the Clinical Lead does not have the capacity to coordinate logistics; and

b) be responsible for coordinating care logistics and supporting engagement with care, operating strictly within "support around care" principles (as outlined in *Schedule 15: Mental Health Clinical Governance Framework*).

This role *will not* hold clinical responsibility or risk and is often the PDM.

4. 4. ROLES AND RESPONSIBILITIES

4.1 A Clinical Lead is essential for all Level 3–5 presentations (as outlined in *Schedule 15: Mental Health Clinical Governance Framework*), and is responsible for:

a) Clinical assessment and diagnosis;

b) Risk assessment and management;

c) Determining treatment plans (including referral when a presentation is outside of the CMT's competence or training);

d) Leading the CMT (where applicable); and

e) Decision-making regarding:

(I) Return to play;

(II) Safety planning; and

(III) Escalation

4.2 The Care Coordinator may be any staff member, though will most commonly be the Clinical Lead or the PDM. If not a registered clinician, the responsibilities will include:

a) Facilitating access to services;

b) Coordinating appointments and logistics;

c) Maintaining appropriate communication flow (non-clinical);

d) Supporting engagement with care; and

e) Documenting role-appropriate interactions

If a non-clincian, the Care Coordinator is explicitly NOT responsible for:

f) Risk assessment;

g) Clinical decision-making;

h) Treatment planning; and

i) Interpreting clinical information

If not a clinician, the care coordinator must act under the supervision of a psychologist (of the CA or S/T program, or the ACA), and should have received education and training regarding escalation, professional boundaries, and "support around care" principles".

5. CARE LEVELS

Aligned to the Mental Health Clinical Governance Framework, the following table outlines the levels of care required regarding players' mental health.

Level	Presentation	Clinical Involvement	Clinical Lead Requirement	PDM	Key Actions
Level 0 **Preventative / Developmental**	No current mental health concerns	Not required	Not required	Support wellbeing environment only Proactive positive MH skill development	• Education and prevention • Build protective factors • Promote positive wellbeing culture
Level 1 **Psychosocial Strain**	Early distress (e.g., stress, adjustment challenges) No clear clinical symptoms	Optional / advisory only	Not required	Support and monitor within "support around care" principles	• Provide support and check-ins • Encourage help-seeking • Escalate if symptoms increase
Level 2 **Symptoms of Poor Mental Health**	Emerging or identifiable clinical symptoms	Required (Psychologist and/or Medical Practitioner)	Essential	Facilitate engagement with care	• Refer to clinician • Assign Clinical Lead • Support attendance and access to care
Level 3 **Complex / High-risk (incl Eds)**	Significant symptoms, impairment, or elevated risk ED suspected or diagnosed	Multidisciplinary (Psychologist, Medical, Dietitian where relevant)	Essential	Coordinate logistics and support engagement only	• Activate CMT as appropriate • Clinical Lead governs care • Notify relevant MH leadership as required
Level 4 **Acute Risk**	Active risk of harm and/or player unavailable for training/selection	Intensive external multidisciplinary clinical management	Essential	Support system coordination only	• Clinical Lead acts as main point of contact when player is ready to re-engage • Clinical Lead Initiates MH RTP process when appropriate • Ongoing clinical risk management once RTP has commenced

5.1 Players presenting with concerns from Level 2-4 may prefer to engage psychology support via the ACA's Wellbeing Network (a network of registered psychologists and psychiatrists). In these instances, a player, the PDM are encouraged to contact the ACA Wellbeing Lead to initiate engagement with the Wellbeing Network. Other staff are asked to encourage players to engage with this network if they are reluctant to engage with their team staff.

6. ESCALATION

6.1 Any AC staff member identifying a MH concern must escalate to either the program's medical officer or psychologist (or if a DE/ED concern, to the dietitian), or to the ACA Wellbeing Lead (when a player wishes to keep their MH concern separate from their cricket environments).

6.2 Care Coordinators:

a) Must not act as a buffer to escalation

b) Must escalate early and conservatively

6.3 High-risk cases must be:

a) Managed via the clinical spine

b) Notified to CA Mental Health Manager or the ACA Wellbeing Lead in a confidential manner

7. 7. INFORMATION SHARING & DOCUMENTATION

7.1 Clinical Information should be:

a) held by clinicians in secure systems only, as per Australian Cricket's HP Data Governance Framework; and

b) shared only with consent **or** under duty of care obligations

7.2 Care Coordinator documentation should be limited to:

a) Engagement and logistics; and

b) Observations (non-clinical)

7.3 Care Coordinator documentation should not:

a) Record clinical interpretations; or

b) Store sensitive clinical details

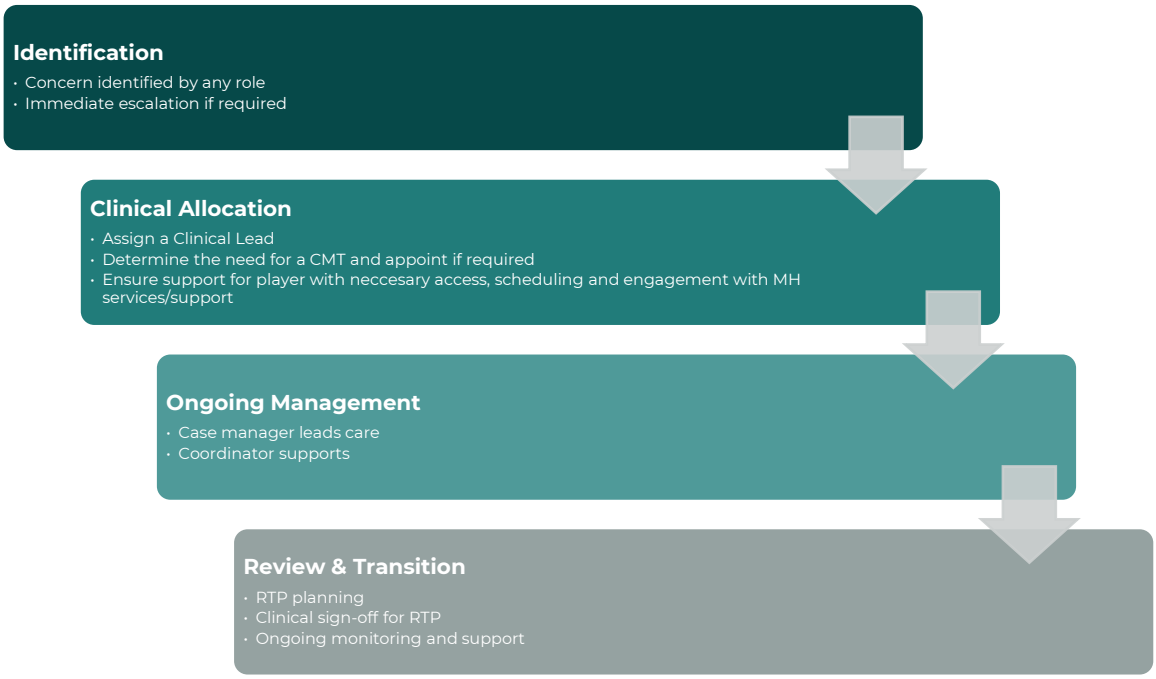
7.4 Communication principles regarding MH issues include:

a) Document only minimum necessary information;

b) Keep communication to role-appropriate sharing only; and

c) Clinicians determine what is shared clinically

8. CASE MANAGEMENT PROCESS



9. SAFEGUARDS

9.1 To prevent role drift, non-clinical staff must:

a) Have mandatory supervision as per the MH Clinical Governance Framework;

b) Understand and have received professional development regarding clear escalation triggers; and

c) Have clearly defined scope boundaries as outlined in their position's roles and responsibilities.

9.2 Regular audits of escalation timeliness and role compliance are recommended on an annual basis.

RELATED DOCUMENTS

Document Name	Location
Mental Health Clinical Governance Framework	*ZenDesk*
AC Wellbeing Strategy	*ZenDesk*