Insights

neami national Improving Mental Health and Wellbeing

Urgent Mental Health Care Centre and system reform

Insights from the first five years of operation

May 2026

‘I felt heard and genuinely cared for by everybody who I spoke with. They took time to ask me about myself and my feelings and gave me ways to move forward. They were also very clear that I could attend at any time when I am in need, giving me a safe space.’

Executive summary

The Urgent Mental Health Care Centre (UMHCC) in Adelaide represents a significant innovation in Australia’s mental health crisis response. Established in March 2021, it provides a free, 24/7, walk-in alternative to hospital emergency departments for people experiencing distress, including suicidal ideation.

Funded by the Commonwealth and SA Health, the UMHCC approach was developed by the South Australian Office of the Chief Psychiatrist, with co-design facilitated by the Lived Experience Leadership and Advocacy Network (LELAN) and The Australian Centre for Social Innovation (TACSI). Neami also drew on RI International as a thought partner for its expertise in recovery-oriented crisis alternatives.

The resulting Philosophy of Care places lived experience, relational practice and trauma-informed design at the centre of crisis care.

Since opening, the UMHCC has become a critical component of South Australia’s mental health crisis system. Over five years, it has supported more than 10,000 people and delivered more than 25,000 episodes of care. Following steady growth in its first three years, demand has stabilised, with the service now responding to an average of 500–600 referrals per month.

Across this period, presentations have become more complex and acute. Despite this, hospital transfer rates have remained low and stable, demonstrating that people experiencing significant psychological distress—including suicidal crisis—can be safely stabilised in the community.

The UMHCC also delivers broader system benefits by reducing pressure on emergency departments, enabling ambulance and police to return to duty more quickly, and supporting people before distress escalates to acute crisis.

Importantly, the UMHCC highlights that *how* services are delivered is as important as what is delivered. Community-managed models are well positioned to provide person-centred, relational alternatives to hospital-based crisis care, particularly where Lived Experience leadership and peer workforce integration are embedded.

This paper reflects on five years of delivery and implementation, sharing key lessons to inform the continued development of crisis care in Australia.

Key insights

1 An integrated peer and clinical model strengthens safety, engagement and accountability

A core element of the UMHCC's co-designed Philosophy of Care is that the direct service delivery workforce comprises equal parts peer workers with lived experience and clinicians. A 'peer-first, peer-last' approach ensures guests are supported by peer workers from arrival through to exit, drawing on lived expertise to build trust, support de-escalation and foster hope.

Peer workers collaborate with nurses and allied health practitioners in an integrated model that combines lived and clinical expertise. Clinical staff provide crisis-focused mental health assessment, brief intervention, basic physical health screening during welcome, and medication support where clinically appropriate. Senior medical staff and nurse practitioners review exit plans before guests leave, while psychiatric input supports consultation, training, supervision and clinical governance.

Governance structures reinforce this model by embedding Lived Experience leadership, including through co-chairing the governance committee.

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The UMHCC shows that safe and effective crisis care is strengthened when peer-informed practice, clinical capability and Lived Experience leadership work together. This builds trust, supports engagement and de-escalation, and embeds peer expertise in culture, practice and accountability.

2 High-acuity mental health crises can be safely supported outside hospital settings

The UMHCC responds to significant and varied psychological distress. Service data shows guests most commonly present with suicidal ideation, anxiety and panic, depression, self-harm and trauma-related distress. These presentations demonstrate the UMHCC's capacity to respond to escalating distress and acute crisis with timely, person-centred and trauma-informed support that reduces the risk of further deterioration.

This evidence challenges the assumption that emergency departments are the only appropriate setting for high-acuity mental health crises.

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The UMHCC provides evidence that people experiencing significant psychological distress, including suicidal crisis, can be safely supported in a community-based setting when the right workforce, governance and psychologically safe environment are in place. This supports de-escalation and stabilisation in ways that are difficult to achieve in emergency departments.

3 UMHCC is changing help-seeking behaviour and creating an accessible pathway to care

Guest-reported data indicates that the UMHCC is both diverting people from emergency departments and creating a pathway to support for those who may not otherwise have sought help.

Since July 2023, 5,196 guest presentations, around 30% of all UMHCC presentations, indicated they would otherwise have presented to an emergency department or were brought to the service by SA Ambulance Service (SAAS) or South Australia Police (SAPOL).

A further 4,828 guests (28.4%), reported they would not have sought support at all if the UMHCC had not been available.

This suggests the service is reaching people who may otherwise delay, avoid or miss out on care, creating opportunities for timely support before distress escalates.

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The UMHCC is not only diverting people from emergency departments; it is creating an accessible pathway for those who may otherwise delay, avoid or miss out on support.

4 The UMHCC reduces pressure on emergency and ambulance systems

The UMHCC maintains formal partnerships with SAAS, SAPOL and local emergency departments, enabling paramedics and police to transfer people experiencing mental health crisis directly to the service where appropriate. Guests arriving with SAAS or SAPOL are seen immediately; transfer times vary based on presentation, acuity and readiness to engage. This includes time to explain the service, support guest choice and confirm the UMHCC as the safest and most appropriate response.

In 2025, SAAS and SAPOL drop-offs averaged just over 12 minutes, well within SA Health's ambulance ramping threshold, enabling responders to return to duty quickly while guests received timely community-based crisis support.

The UMHCC helps keep urgent mental health presentations out of emergency departments, reducing pressure on ambulance, police and hospital systems.

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The UMHCC improves emergency system flow by providing ambulance, police and emergency departments with a safe, community-based pathway for appropriate mental health crisis presentations. This enables rapid transfer, quicker return to duty and timely support in a setting designed for mental health crisis care.

5 Crisis care must include strong transition and follow-up pathways

The period after discharge from mental health services is associated with significantly elevated risk, including suicide risk in the weeks and months following care (Chung, Ryan, Hadzi-Pavlovic, Singh, Stanton & Large, 2017). Coronial findings across Australian jurisdictions reinforce this, highlighting risks linked to fragmented communication, limited follow-up and gaps between hospital and community-based care.

Crisis services like the UMHCC can play a protective role during these high-risk periods, particularly as clinical oversight decreases. For people recently discharged from inpatient care, the UMHCC provides a free and accessible touchpoint that supports continuity of care during a time of increased vulnerability.

Most guests exit the UMHCC to home, with or without supports, while a smaller proportion require hospital transfer for reasons including medication review, the need for higher-level care, guest preference, or urgent co-occurring physical health concerns. The UMHCC also provides safety planning, service connections and post-exit follow-up.

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Effective crisis response extends beyond stabilisation. Safe transitions, warm handovers and follow-up support are critical safeguards, particularly after emergency department or inpatient discharge. Community-based crisis services provide an accessible touchpoint as people move between hospital, community and home.

6 Lived experience governance is central

The UMHCC Philosophy of Care underpins all elements of the service and was co-designed with consumers, facilitated by LELAN and TACSI. Lived Experience leadership is embedded across operational leadership, governance and decision-making.

An external Lived Experience consultant co-chairs the UMHCC Governance Committee, with representatives participating in governance, quality and safety meetings. This ensures lived experience perspectives inform independent oversight, accountability and continuous improvement, not just daily practice.

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Lived Experience leadership strengthens crisis care when genuinely embedded in governance and decision-making. At the UMHCC, this structural approach supports cultural safety, accountability and responsiveness for people at their most vulnerable.

7 Community-managed organisations are well positioned to deliver crisis alternatives

The UMHCC highlights the importance of organisational context in shaping effective crisis alternatives. Community-managed organisations are well positioned to deliver these models, with approaches grounded in relational practice, recovery-oriented care and strong community connections. These qualities support trauma-informed environments that prioritise psychological safety, engagement and continuity of care.

The UMHCC reflects these strengths, integrating clinical capability with a peer workforce and governance structures that embed Lived Experience leadership. Where these characteristics are diluted, there is a risk that crisis alternatives replicate hospital-based models.

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The UMHCC shows that crisis alternatives are most effective when commissioning protects what makes them distinct from hospital-based care: a community-based ethos, relational practice, peer integration and strong links to local supports. Community-managed organisations are well placed to sustain these features when funding and commissioning arrangements preserve the model's intent, flexibility and relational practice.

Implications for policy and system design

The UMHCC experience provides practical evidence to inform the continued development of Australia's mental health crisis system. Several implications emerge for policy and service design.

1 **Community-based crisis alternatives should be a core system component**

The UMHCC demonstrates that high-acuity mental health crises, including suicidal distress, can be safely stabilised outside hospital settings. Expanding access to community-based urgent care services can reduce reliance on emergency departments while improving the experience of care.

2 **Crisis services can improve system flow and enable earlier access**

The service is not only diverting presentations from emergency departments; it is also supporting people earlier, before distress escalates. This dual function has important implications for reducing pressure across emergency, ambulance and hospital systems.

3 **Workforce design is critical to service effectiveness**

Integrated peer and clinical models strengthen engagement, safety and consumer outcomes. Embedding Lived Experience within both workforce and governance structures is a key feature of effective crisis care.

4 **Crisis care must be part of a connected system**

Safe transitions, follow-up support and strong links to community-based services are essential. Stabilisation alone is insufficient without continuity of care across hospital and community interfaces.

5 **Service effectiveness is shaped by delivery context**

The UMHCC highlights that how services are delivered is as important as what is delivered. Maintaining a community-based, relational model of care is critical to preserving the intent of crisis alternatives.

Conclusion

As Medicare Mental Health Centres and other crisis alternatives expand, the UMHCC provides a practical example of how urgent care, peer integration and clinical governance can coexist within a community-based model.

Careful attention to service design, workforce composition, governance and delivery context will be critical to ensuring these services function as genuine alternatives to hospital-based care and achieve their intended system and consumer outcomes.

Scan to access
Urgent Mental Health Care Centre

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7 days a week

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