A New Approach to ACT Mental Health Care Services System Reform

Phase 1 Report Recommendations Revised and Prioritised v240131

Transforming recommendations into action

Introduction

In 2023 Deep End Canberra with support and assistance from the AMA ACT Branch and Capital Health Network undertook a survey of primary care practitioners and subsequently held two workshops to inform co-creation of a patient centred, coordinated primary and secondary care, respectful public mental health service in the ACT.

Our Phase 1 Report, A New Approach to ACT Mental Health Care Services System Reform is finalised. **For more information Email: deependcanberra@gmail.com**

The recommendations from that report are revised and prioritised in this document. We are aware that other processes, for instance the Workforce Strategy and the new Strategic Plan development, are in play and we hope they will be informed by these recommendations. We are also aware that the priorities we have assigned to these recommendations are subject to the constraints that other agencies work within. Nonetheless they are the community's and primary care workforce's ideas for creating an effective mental health care system.

The layout of this document is:

1. Core principles to reform
2. Key themes from the recommendations
3. A list of the recommendations prioritised as needing immediate attention
4. A full list of recommendations in the order of the care model used for the workshops

Core principles to reform and care

A **systems reform approach** is required; tinkering is insufficient.
Ensuring broad stakeholder engagement in re-design and implementation (co-production) is crucial.
Values based care and **Value-based care** are critical.

Key Themes from the Recommendations

1. Agree publicly explicit Values for an effective and trusted mental health care system.
2. Establish a Partnership / Shared Care Model of Care in which primary and secondary care parts of the system recognise they are both parts of the person's care system and have an integrated mutually respectful approach to supporting people with mental illness on their journey of care.
3. Remove barriers to access to care and support for people and the primary health care teams.
4. Improve communications at intake, assessment, treatment and transfer of care phases of the patient journey by establishing protocols and removing barriers.
5. Make Care Planning that involves the person, their family and careers, community support agencies, primary care practitioners and the mental health services sections central to coordinating the person's care management needs.
6. Simplify the pathways into secondary care and reframe pathways from secondary care to primary care as referrals for community care.
7. Ensure a well supported, educated and collaborative workforce with timely access to advice and support.

Immediate Recommendations Summary

These are the Recommendations considered to be requiring immediate action to implement or plan for. We are aware the list is long, but transformation has to start.

Recommendation	Priority
Create / expand community belonging and connections programs Support the Community Hub model that provides community-based care and features free, anytime drop-in access (not referred, open programs) to low-intensity group supports, education, resource library, self-care. Support for the Tuggeranong Community Hub would help demonstrate commitment and proof of concept.	Immediate
Create and publicise an atlas of mental health services, that details services, intake criteria and wait times.	UC has underway
Introduce the care navigators from the beginning of the person's journey through the care system.	In train
Privacy law implementation and interpretation needs redefinition, so that privacy does not impede timely access to information by members of the shared care team. Reinterpret or redefine application of privacy laws by CHS so that transparency should be the default across everyone involved in the person's clinical care to promote clinical and relevant community information sharing to facilitate patient journey through and between the systems.	Immediate
Design multiple ways to connect with people / patients – phone, email, messaging, etc.. Recognise that multiple languages are spoken in the ACT.	Immediate
Ensure all staff are aware of the importance of timely information, for instance at or before discharge / transfer of care.	Immediate
Incorporate the principle of **shared / joint decision making** into all treatment and planning in all but the most urgent clinical encounters.	immediate
Create a shared care model approach as the default across assessment, treatment and discharge planning and ensure relevant treating team members, community support workers and carers are involved.	Begin planning immediately
Explore **co-locate of services** to promote access and facilitate coordination of care. Establish a multidisciplinary community hub (co-location) for intake, assessment, care delivery across the spectrum of severity and recognising the enduring and fluctuating course of mental illness over time requiring different intensity of care at different times.	Begin planning immediately
Design the system to have multiple entry points (no wrong door) with high connectivity between agencies and services, coordinated by triage and retrieval teams to expedite the patient to where the care that is needed can be given. This would include seamless triage that would line up a care site, arrange transport, initiate treatment. This triage service's priority would be to connect the person with mental illness, their family or carers, and the referring primary health care team with the appropriate care service (not gatekeep or be a barrier to access). A new model for Access Mental Health be designed and implemented with broad stakeholder engagement. Staff to be well oriented in-service availability and intake criteria and to take a helpful approach.	Begin planning immediately

Make existing service intake criteria transparent (published) and flexible with a standardised intake form (linked to IAR-DST), initially for ACT public mental health system.	Immediate
Adopt IAR-DST as the standard assessment and referral tool in the ACT.	Immediate
Review procedures to capture a broad set of inputs to assessment, including recent and past history across all relevant agencies, carers, primary care practitioners, community support agencies. Include social function and support functions.	Immediate
Incorporate review of autonomy vs capacity regularly during assessment and treatment.	Immediate
Establish protocols to **assign and transfer duty of care** along the management/ treatment pathway clearly. Make who has the Duty of Care explicit at the time of referral between the levels of care services.	Immediate
Establish protocols for **joint care-planning**, including discharge and follow up planning, and incorporating the principle of shared decision-making.	Immediate
Incorporate primary care practitioners in the Mental Health Coordinating Group and make the reform process a standing item on the agenda.	Immediate
Orient specialist services to the community context of primary care services, carers and family by establishing a Community of Practice to bring the primary and secondary care workforces together, building on existing forums.	Immediate

Recommendations listed in order of model and service structure

A system working with clear values

Recommendations	Priority
The principles and values of the Mental Health Services are included explicitly in orientation and in-servicing.	Short term
Adherence to principles and values will be monitored as part of performance appraisal.	Longer term

A confident caring workforce

Well educated, well oriented and well supported workforce of professional, peer / lived experience and community workers involved in a person's care is central to an effective and trusted mental health care system, patient care and staff self-care.

Recommendations	Priority
Provide detailed orientation program to the sector given its complexity (agencies, types of services available). Revise education resources and monitoring systems to ensure new staff are inducted and current staff up-skilled on the value systems for care.	Tba
Set up recruitment, training and support systems for peer workers.	Part of workforce strategy
Create and publicise an atlas of mental health services, that details services, intake criteria and wait times.	UC has underway
In addition to formal qualifications, ensure staff have or have opportunity to receive education in: mental health first aid; how to work with and help people with complex needs and conditions (eg personality disorders, co-morbidities); trauma and shame informed care; computer and IT communications systems; understanding of complex systems.	Part of workforce strategy
Ensure workforce support: Permanent, long term jobs; funding for growth and building system capacity; access to external supervision.	Part of workforce strategy

Timely clear communications

Enhance communication and sharing of information as a principle where sharing pertinent information is the default and confidentiality issues the exception.

Privacy Concerns

Recommendation	Priority
Privacy law implementation and interpretation needs redefinition, so that privacy does not impede timely access to information by members of the shared care team. Reinterpret or redefine application of privacy laws by CHS so that transparency should be the default across everyone involved in the person's clinical care to promote clinical and relevant community information sharing to facilitate patient journey through and between the systems.	Immediate

Legislative reform may be required as an adjunct.	Longer term

Communications in general

Communications including digital / electronic modes **are vital to shared care** success: easily accessed channels have to be available, open, respectful, and they are time-critical.

Recommendations	Priority
Set up better "digital platforms for information sharing" that are interagency, interconnected, universally accessible to all services and people involved (services and organisations; consumers and carers) in a person's care [possibly with levels of access assigned].	Short term
Design multiple ways to connect with people / patients – phone, email, messaging, etc.. Recognise that multiple languages are spoken in the ACT.	Immediate
Ensure all staff are aware of the importance of timely information, for instance at or before discharge / transfer of care.	Immediate

Prevention and early intervention

Recommendations	Priority
Create / expand community belonging and connections programs Support the Community Hub model that provides community-based care and features free, anytime drop-in access (not referred, open programs) to low-intensity group supports, education, resource library, self-care.	Immediate
Improve Health Literacy: build personal and community confidence in delivering care by establishing a program to inform and educate the public and health sector about mental health, service availability, criteria, self-help and other options, who services are for and what to expect.	Short to mid term
Provide of respite services.	Longer term
Create an early intervention, outreach specialist psychiatry model for assessment and treatment. Members of this team should be the person's usual mental health team.	Mid term
Provide social work and similar service options to help prevent the social stressors that can precipitate deterioration in mental health.	

A Shared Care Model: for intake and assessment, treatment, discharge and care planning

A partnership **shared care model** (a system of care teams) that actively includes the person with the mental illness, their family and carers, the primary care team, the specialist mental health care service teams, community support agencies and other agencies such as Alcohol and Other Drug teams is the foundation for high quality ongoing care and outcomes.

Recommendations	Priority
Create a shared care model approach as the default across assessment, treatment and discharge planning and ensure relevant treating team members, community support workers and carers are involved.	Begin planning immediately

Explore **co-locate of services** to promote access and facilitate coordination of care. Establish a multidisciplinary community hub (co-location) for intake, assessment, care delivery across the spectrum of severity and recognising the enduring and fluctuating course of mental illness over time requiring different intensity of care at different times.	Begin planning immediately
Create and support systems for active holding while people await action of referrals.	Short term
Incorporate the principle of **shared / joint decision making** into all treatment and planning in all but the most urgent clinical encounters.	immediate
Design service options for people with more severe mental illness and/or complex needs who usually find access difficult. Will need to be highly resourced and connected to other services.	Mid to long term

Intake and assessment

Recommendations	Priority
Adopt IAR-DST as the standard assessment and referral tool in the ACT.	Immediate
Make existing service intake criteria transparent (published) and flexible with a standardised intake form (linked to IAR-DST), initially for ACT public mental health system.	Immediate
Advocate for the standardised intake form (linked to IAR-DST) to be used universally across public and private systems in the ACT and nationally.	Longer term
Provide GPs with a real time support / inquiries telephone hot line to an on-call psychiatrist or decision maker (12-to-24-hour red phone).	Short term
Design the system to have multiple entry points (no wrong door) with high connectivity between agencies and services, coordinated by triage and retrieval teams to expedite the patient to where the care that is needed can be given. This would include seamless triage that would line up a care site, arrange transport, initiate treatment. This triage service's priority would be to connect the person with mental illness, their family or carers, and the referring primary health care team with the appropriate care service (not gatekeep or be a barrier to access). A new model for Access Mental Health be designed and implemented with broad stakeholder engagement. Staff to be well oriented in-service availability and intake criteria and to take a helpful approach.	Begin planning immediately
Introduce the care navigators at this point in the person's journey.	In train
Incorporate review of autonomy vs capacity regularly during assessment and treatment.	immediate
Create an alternative to Emergency Departments or a specialized MH ED. Could be comprised of after-hours community based response, including on-call psychiatrist, and separate section in ED, both with staff that have appropriate advanced clinical skills.	Mid term
Review procedures to capture a broad set of inputs to assessment, including recent and past history across all relevant agencies, carers, primary care practitioners, community support agencies. Include social function and support functions.	Immediate

Design and implement a capacity assessment system for continuing use along a person's journey in the mental health care system.	Short term
Create a Justice Mental Health court to offer diversionary options and case management.	Longer term
Review pathways and wait times for assessment of specialized conditions eg ADHD, including introducing some flexibility to age cutoffs for transitioning.	Longer term

Ensure continuity

Redesign the system to have continuity, connection (across agencies and levels of care), navigator supported/ guided, person journey focused, shared within and across teams care.

Recommendations	Priority
Ensure the system encompasses **a continuum of care** from brief, one off through to long term, ongoing intensive care.	Short term
Establish protocols to **assign and transfer duty of care** along the management/ treatment pathway clearly. Make who has the Duty of Care explicit at the time of referral between the levels of care services.	Immediate
Discharges and clinical handovers can offer and suggest actions for the receiving provider and clearly articulate any further actions from the sender.	Short term
Establish and maintain mechanisms for enabling care **teams to build and hold relationships** with people in their care. Care navigators play a key role.	Short term
Review the systems to make them less complex; for example, one main team linked to one person across the whole ACT with different components that can step people up and down.	Short term
Mental health plans to involve GP, peer workers, etc.. Focus on what action peer workers, community support workers need to take. Clear referral / who to contact details included in plans (copies of plans available to these workers then).	Short term

Bio-psycho-social Treatment

Recommendations	Priority
Make general and specialized eg DBT, EMDR psychology services more available and accessible.	Mid-term

Care and discharge planning

Recommendations	Priority
Establish protocols for **joint care-planning**, including discharge and follow up planning, and incorporating the principle of shared decision-making.	Immediate
Institute discharge plan content protocols: risk management information; medications (forms and doses), build follow-up and review into the discharge plans. Information for carers and support networks as well as primary care teams.	Short term
Build recognition of deterioration into mental health and medical care plans to include signs to trigger early / acute intervention. Plan to include details of what action to take, who to contact.	Short term

Integrate mental and medical health plans. Recognise deterioration in one domain, physical or mental, impacts the other.	Short term
Ensure care coordinators for people with complex needs are included in plans.	Short term
Ensure plans are regularly and collaboratively (all relevant players involved) reviewed and updated. Especially assess client status and look for emerging social and clinical issues.	Short term
Accessible information – Provide primary care teams and community services access to DHR.	Short term
Ensure discharge to primary care teams occurs when the primary care teams are available to follow up.	Short term
Implement suggestions about content, timeliness, process etc. that are detailed in Appendix 1 below. [may remove]	?

An ACT Mental Health Care system that supports the Shared Care Model

Recommendations	Priority
Incorporate primary care / general practice in the Mental Health Service planning system	
Incorporate primary care practitioners in the Mental Health Coordinating Group and make the reform process a standing item on the agenda.	Immediate
Orient specialist services to the community context of primary care services, carers and family by establishing a Community of Practice to bring the primary and secondary care workforces together, building on existing forums.	Immediate
Institute a Community GP Liaison to build meaningful liaison between acute MH services and the primary care sector at the operational level.	Short term
Strengthen primary care / general practice and Mental Health Service operational relationships	
Change the culture of the mental health care services to a community looking one with codes and standards developed, applied and their use monitored.	Short term
Operationalise a culture within the mental health care services of **respect for the GP and the general practice / primary care team**'s long term, ongoing knowledge of people.	Short term
Maintain organisational and workforce capacity. Consistent, long-term funding for employing organisations maintains skills and knowledge within the system. **Revise funding and commissioning arrangements** so they promote a supportive environment that engenders a cooperative model of service delivery. **Commit to funding ongoing models** of care that are evaluated and modified regularly rather than a series of episodic pilots or short-term commissioning contracts.	Ongoing

System Design

Implement systems for **critical incident review**.	Short term

Connection and even integration of ADS, Mental Health and Justice Health systems with the primary care sector and with each other would benefit people on their journey through these systems.	Mid term
Reconsider our language: are we caring for Mental Health or Mental Illness?	Long-term

System monitoring and review

Recommendations	Priority

Other / orphan / support aspects

Recommendations	Priority
Support for primary care service practitioners may also help prevent deterioration and admission.	
An unanswered but important question raised was **how do we bring the differing cultural approaches to mental illness (in our multicultural, multilingual society) into this reform**?	

Appendix 1 - Principles for design and operation

A **systems reform approach** is required; tinkering is insufficient.

Ensuring broad stakeholder engagement in re-design and implementation is crucial.

Values based care may include:

- Patient-centred Care, that is responsive to their needs and priorities and sits in a person's ongoing, multi-episode, life journey.
- Curious, kind, respectful, compassionate, humble, responsive.
- Trauma and shame informed.
- Management to be skills-based, strength-based, solutions-focused.
- Care and treatment services need to encompass a continuum of care from brief, one off through to long term, ongoing intensive care recognising mental health care is largely a community based activity.

Value-based care is also important in a resource constrained circumstance and ideally delivers value for the patient, the care system and the community.

The **autonomy vs capacity** of people experiencing a mental illness needs to be resolved. Capacity varies over time. Capacity requires continuous and consistent assessment along the treatment journey. Capacity to consent should not be assumed but assessed at each step.