Furthering Mental Health Care Reform in the ACT

Workshop June 23, 2023

AMA (ACT) LIMITED

General Practice at the Deep End
Canberra Region Australia

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Capital Health Network

Deep End Canberra

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Workshop 1 – Aspirational and Collaborative Ideas

What is it NOT:

- Story Telling
- Critical or Blaming
- Restricted by funding
- About one professional group

Workshop 1

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Program

9-9:15am	Welcome to event Acknowledgement of country Brief background / Deepend AMA role, Introductions	Walter Abhayaratna Peter Tait Tanya Robertson Walter Abhayaratna
9:15-9:30am	Results of the survey: Unpack neutral responses.	 Peter Tait
9:30-11am	Breakout groups: Brainstorming	Louise Stone Aim: Brainstorm the 'perfect mental health service' for the ACT.
11-11:30am	Morning tea	
11:30am-12:30pm	Presentations of discussions in breakout groups. Q&A / comments from plenary. Presentation of CHS reform initiatives. Wind up and next steps	LouiseStone. Louise Stone. Katie McKenzie PeterT

Primary Care Survey Results

Quantitative results

- … high levels of dissatisfaction not surprising ...
- Notable areas for action: **barriers to access** overall, special conditions diagnostic service access and particularly for people with mixed substance use and mental health conditions.
- **Availability and access** are more often problematic; once a person has got in, satisfaction is higher.

Deepend vs not Deepend

- discharge planning from the inpatient units (more of an issue for the Deepend responders)
- much higher barriers to access for Deepend patients

Qualitative results

GPs expected “kindness and competence” with clear communication, shared decision making between the whole team (including the GPs, patients and carers) and safe handover

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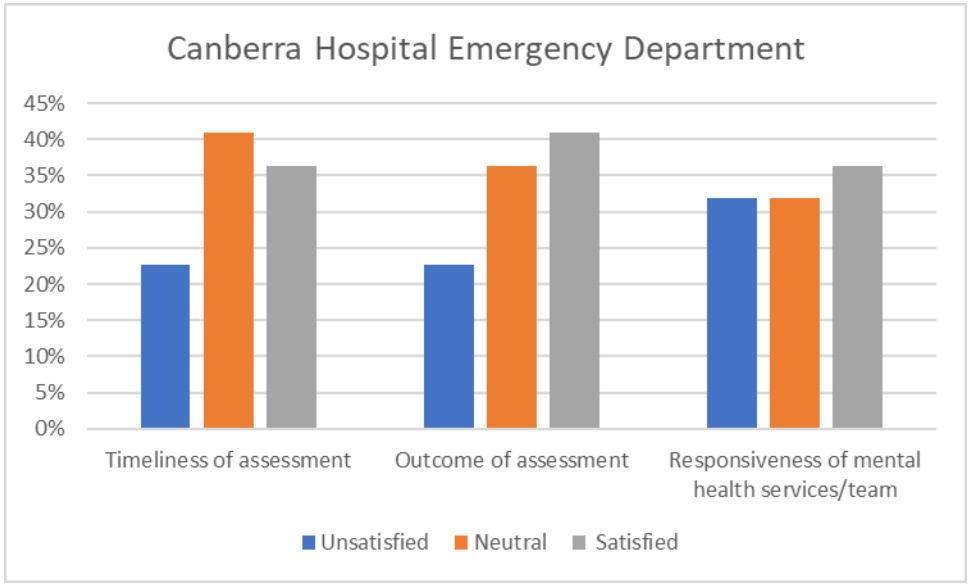
Primary Care Survey Results

Qualitative results – more depth

- Difficulty resolving fundamental disagreements around patient competency, capacity and severity
- Lack of communication, co-ordination and collaboration with primary care services
- Lack of clarity around who is holding duty of care
- The illusion of patient “choice” – autonomy vs capacity
- The lack of respect for GP’s time, competence, capacity and structural limitations
- The damaging impact of moral distress on the GPs doing the majority of the mental health work
- Therapeutic chaos, and the delivery of “homeopathic doses” of care due to inadequate resourcing of services
- Inequity and injustice consequently

What does a ‘Neutral’ response mean?

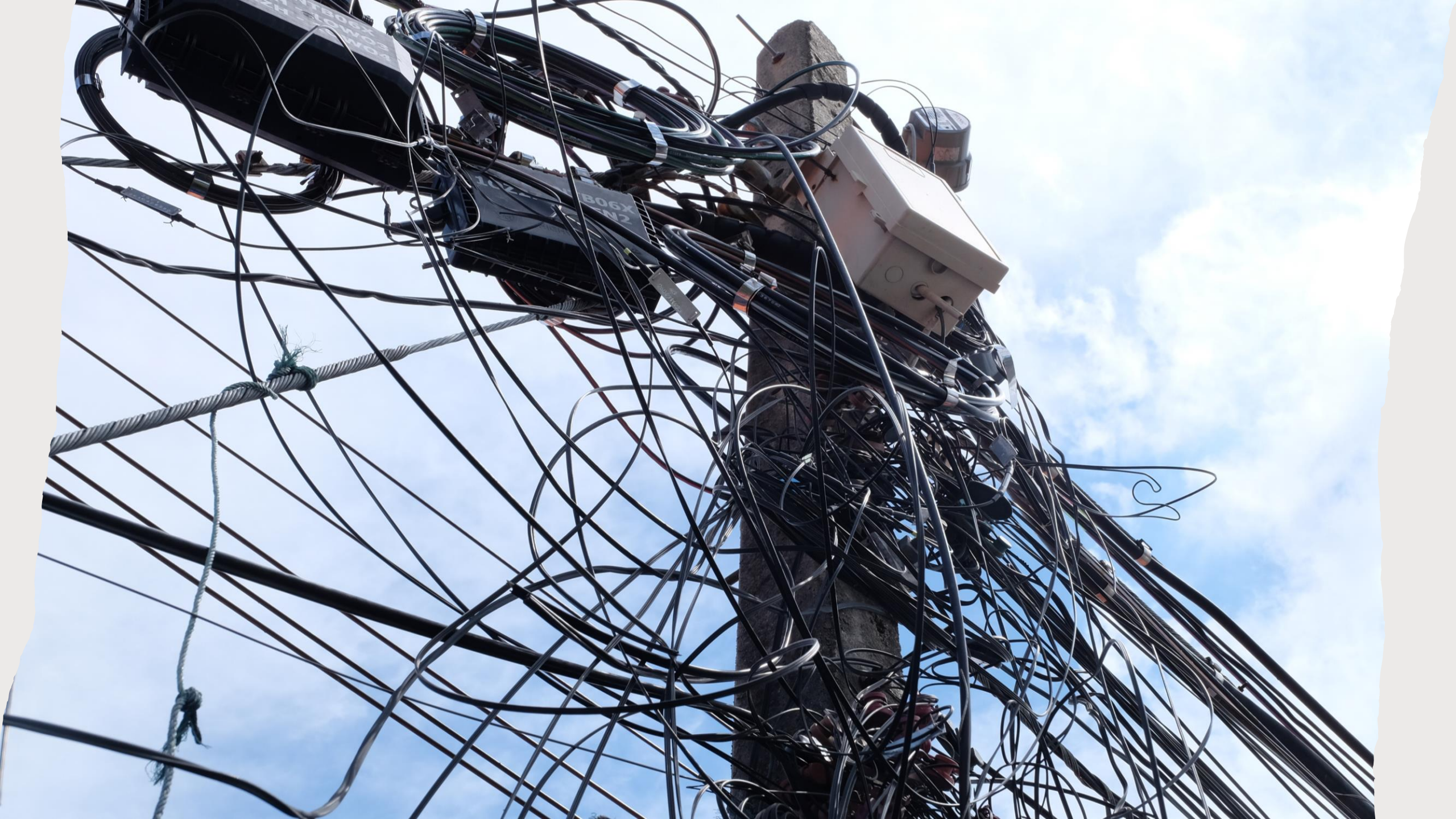
- A middle of the road neither satisfied not dissatisfied?
- A mixed / variable experience?
- Other?



Every way it means improvement is needed

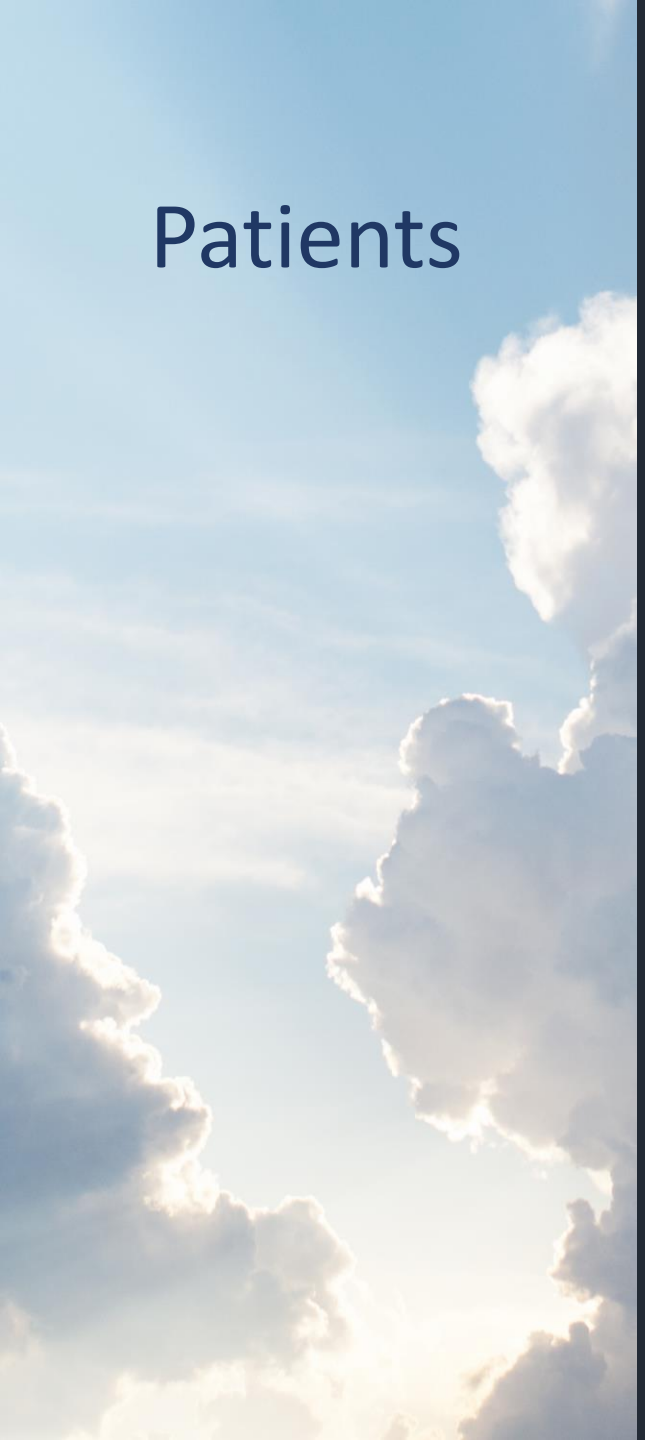
Louise Stone

Blue Sky Thinking



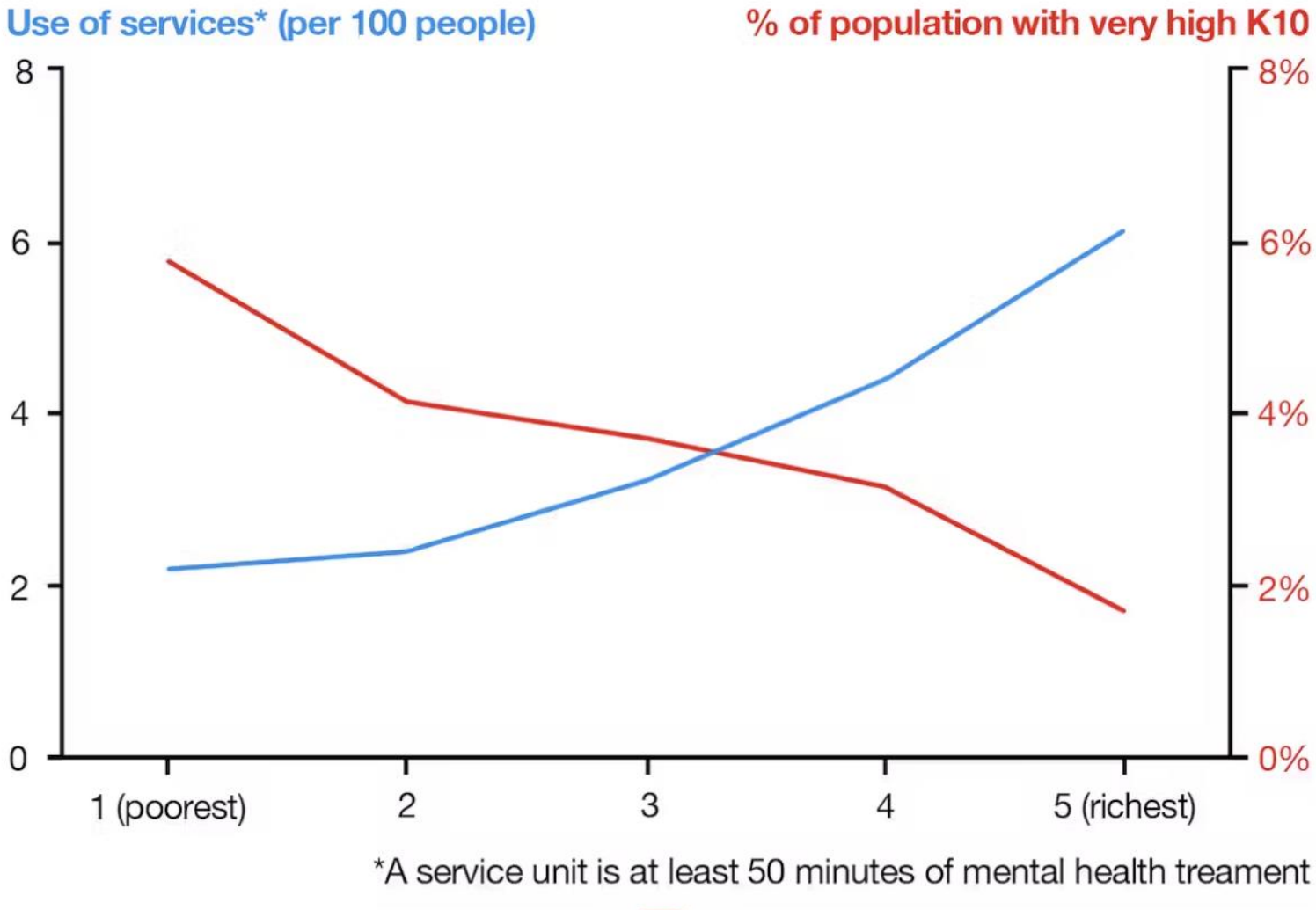
But not too blue

Patients



Mental health service use and disadvantage

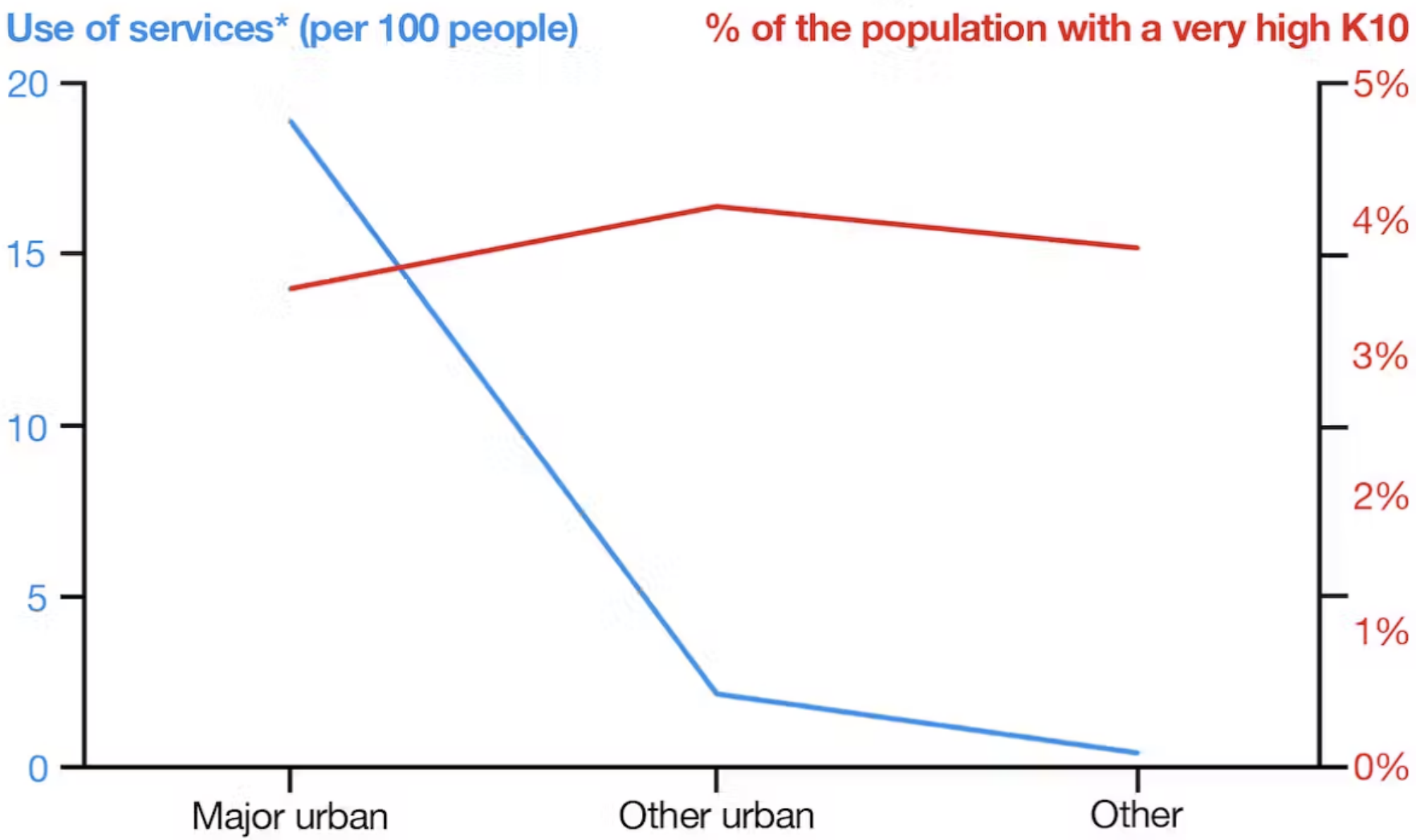
Mental health service use vs % of population with a very high K10 score, by area of socioeconomic disadvantage (IRSD scale)



*A service unit is at least 50 minutes of mental health treament

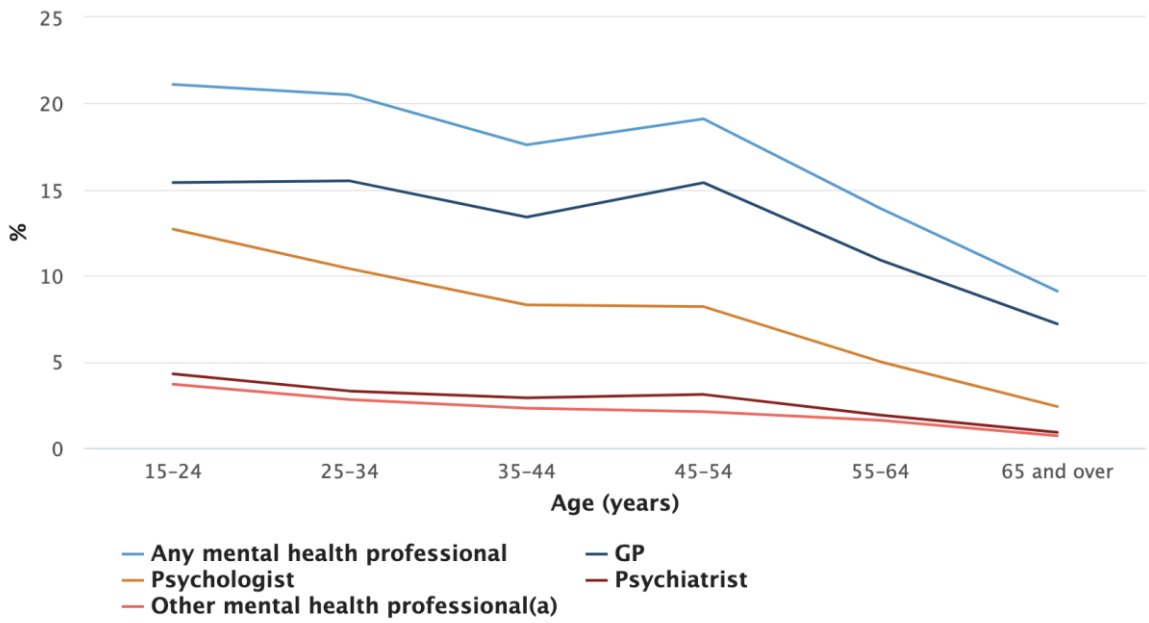
Services aren't always getting to the right people

Mental health service use vs % of population with a very high K10 score, by area



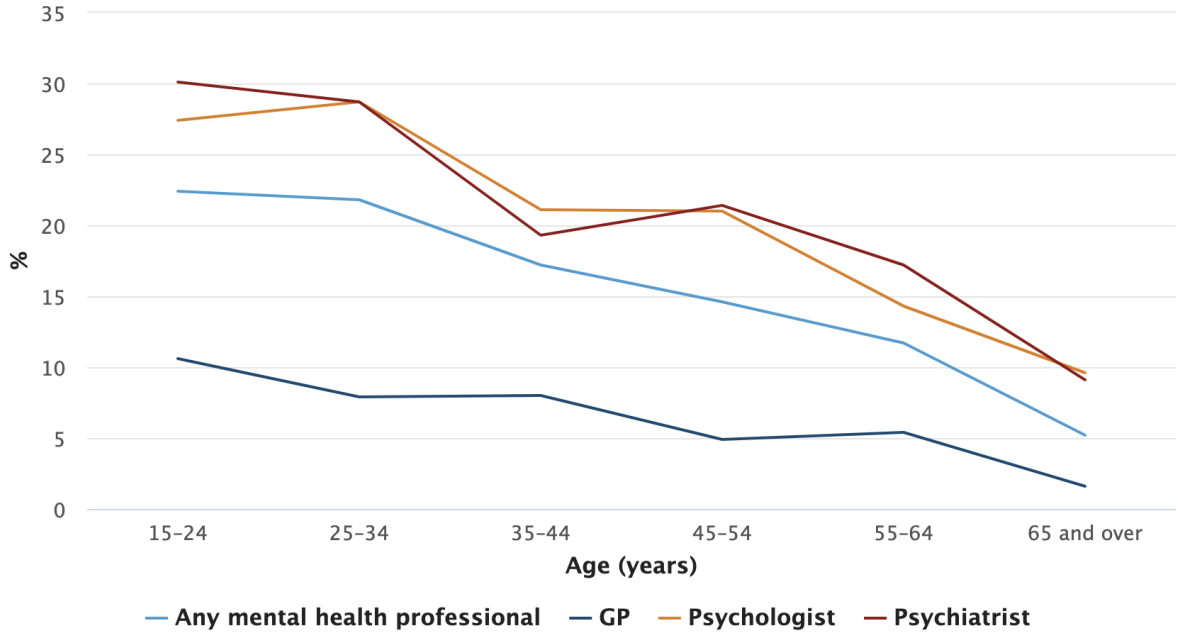
*A service unit is at least 50 minutes of mental health treament

Proportion of people 15 years and over, saw a health professional for own mental health in the last 12 months



(a) Includes mental health nurse, social worker, counsellor or occupational therapist.

Proportion of people 15 years and over, delayed or did not see a health professional for own mental health when needed due to cost in the last 12 months



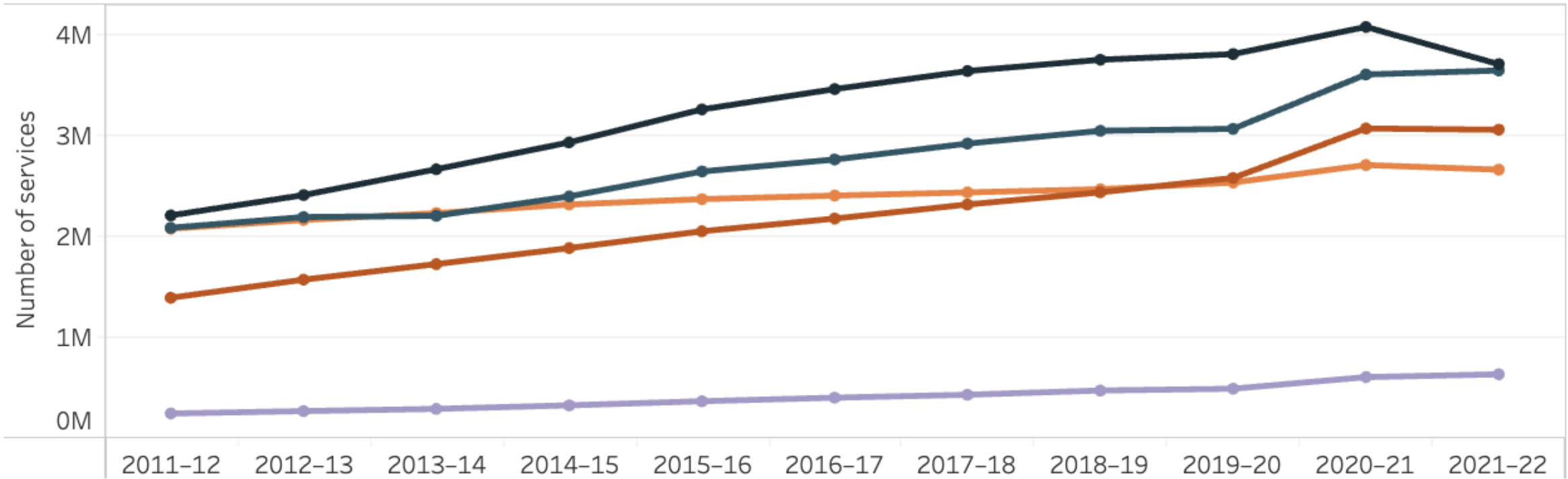
Source: Patient Experiences, 2021-22, Table 27.3 and Customised data.


Patients

Illnesses


Patients
Illnesses
Health
Professionals

Spotlight data: Has the provision of Medicare-subsidised mental health-specific services increased over the past 10 years?

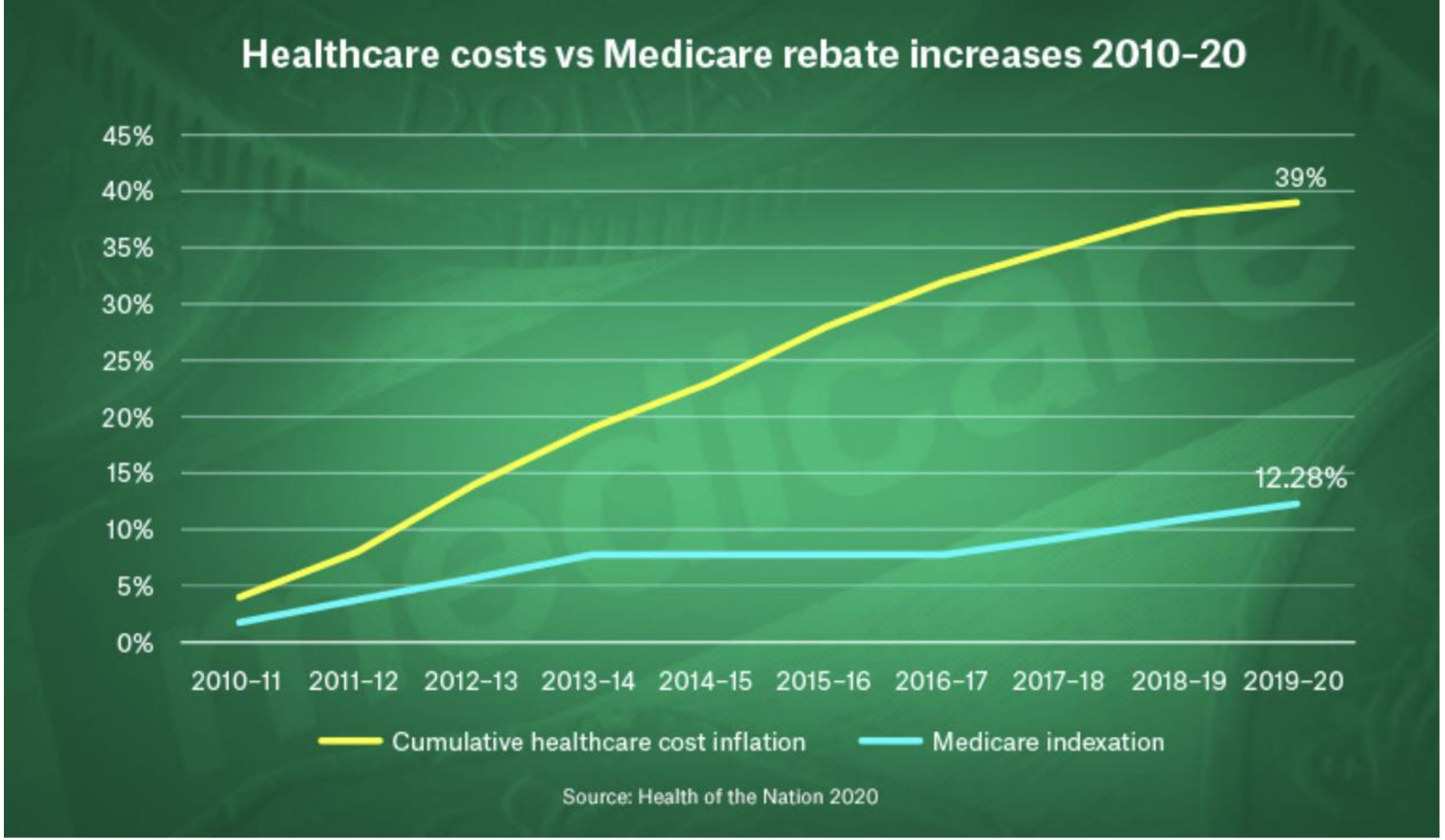


Average annual change (%) from 2017–18 to 2021–22 in the number of services.

- Clinical psychologists
- General practitioners
- Other allied health providers
- Other psychologists
- Psychiatrists

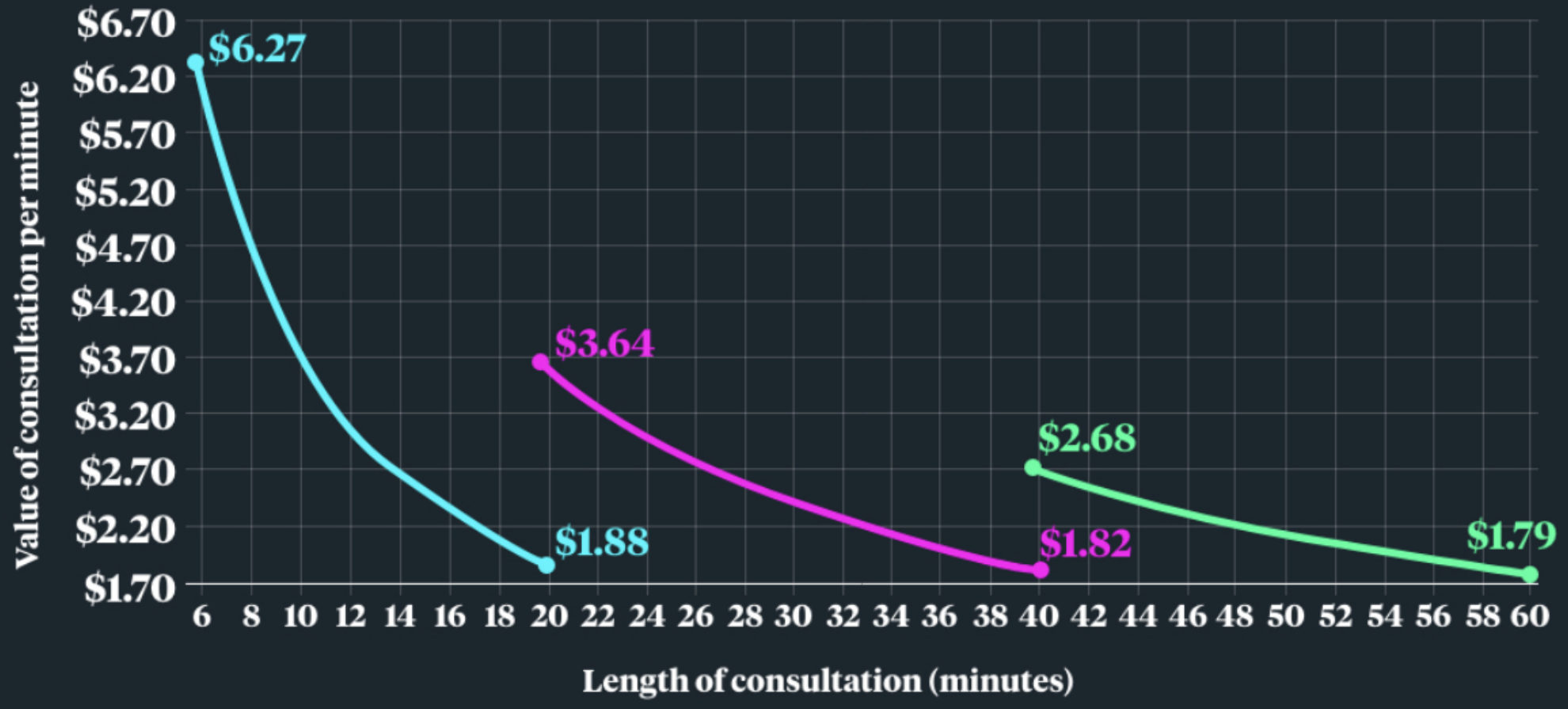
Select a measure

- ○ Number of patients
- ◉ Number of services
- ○ Rate of services (per 1,000 population)
- ○ Services per patient



Healthcare cost increases have outpaced Medicare rebate indexation.

Medicare Benefits Schedule rebates drop in value every minute



Source: Royal Australian College of General Practitioners

Our health system is dependent on volunteer GP labour.

Governments nudge GPs into financially unsustainable bulk billing, by feeding the narrative that this is what the public deserve.

GPs enable public dependency on cheap primary care by donating increasing amounts of time, energy and skill for the sake of their vulnerable patients.

The inability to care for our most vulnerable patients and the moral distress of realising how deeply financial exploitation extends are destroying the workforce.

The only way to effectively manage this unhealthy dependency is to walk away, and mental health generalists are leaving.


Patients
Illnesses
Health Professionals
Systems

Autonomy

I was concerned for his safety and contacted Access MH who put me through to HAART who after much begging visited him but not until the next day, interrupting his latest suicide attempt. After the subsequent involuntary admission and stay at Step Up Step Down, he was referred to a Community MH team. Concerned for his safety again I contacted Access who directed me to the Community Team who directed me back to Access MH because they had not yet seen patient. Several times his psychiatric appointment was rescheduled when he was in this vulnerable space. Eventually he had ongoing Community MH case management but there was no correspondence from them to me, despite my calling twice to request updates. Meantime he was finally seen by Next Step psychology following on from a referral the inpatient Psych unit had recommended I make after a much earlier discharge, only to be deemed too unwell and suicidal for psychotherapy.

Table 1: Autonomy

How do we resolve fundamental disagreements between GP and MH teams around a patients' competence, capacity and illness severity?

GPs hold some of the most complex patients in the MH system. At times, these patients cannot be safely managed in General Practice. Who gets to decide whether these GPs accept duty of care? How do we resolve disagreements on who should hold duty of care, and how do we know where duty of care rests?

Respect

Message to phone HAART team about a patient: phoned the GP number (the number provided), went to Access MH, on THE line in queue for 7 minutes 2nd in queue, 38 minutes 1st in queue, total 45 minutes. In this case, the combined staff time, including GP, nurse and CEO, attempting to get an appropriate response to C1 was in excess of 10 hours. This was an opportunity cost for other people who are not able to receive care as a consequence.

There are daily battles to have referrals accepted , closures reversed, poor clarity in referral pathways so the majority of patients seem to fall through the cracks. I am left struggling to manage difficult psychosocial problems with no solutions without any support.

Table 2: Respect

Health workers, particularly GPs, are experiencing significant moral distress, when they know what a patient needs, but are unable to provide it. Moral distress reduces workforce capacity and causes significant harm. In GP, women doctors have three times the risk of suicide as the general population, and high rates of mental illness. This is why many of them are leaving.

How do we support GPs to reduce this risk?

Table 3: Respect

GPs describe a bimodal view of their competence. There are structures that assume they have little clinical skill (eg their assessments are over-ridden by telephone triage, or they are offered simple strategies for complex patients) or they are required to cope with the most complex, multimorbid patients in the system with little support.

How can we create respectful clinical partnerships in mental health that acknowledge the skills and capabilities of all the people in the care team?

Help vs Harm

My patient] has chronic schizophrenia. He is usually quite stable on a depot anti psychotic but several times in the past when he is transferred to PO medications he generally does not take his tablets and then relapses into psychosis. His history is complicated by polysubstance abuse, particularly alcohol with secondary cirrhosis. A few months ago Community Mental Health stopped his depot again as he wanted to transfer to oral medications and they felt he was stable enough to do so. This decision concerned us as there is a clear pattern of his deterioration when he invariably ceases oral meds. He remained stable for a few weeks but then failed to present to see us and then failed to present to collect his medications from the pharmacy. We then found out he had a 9 day admission to AMHU after being found by police agitated and confused with a gunshot wound to his calf.

ACT mental health staff have not taken my referrals seriously through Emergency Departments when I am recommending an inpatient admission for serious mental health issues. Patients are discharged in the same amount of distress and represent in following days. No support organised by mental health doctors other than to see me again. If I could help- I would have!

Table 4: Help vs harm

Often care seems to be “homeopathic”, too small an intervention to make a difference, or triage without treatment. How do we remove these therapeutic dead ends to reduce healthcare waste? How small an intervention is too small?

Equity and Justice

- *The “Choice” model a serious barrier to care. Person doesn't want depot antipsychotic so MH Team stops that and is reluctant to resume it despite deterioration in clinical state / wellness of the person because it is the person's choice.*
- *Unfortunately, the current MH system is focussed on the human rights of people to refuse treatment, rather than equal consideration of their human right to receive treatment when they do not have capacity to make that decision for themselves and are at risk, which is what mental health acts are designed to facilitate. This serves as a barrier to care and results in unnecessary harms to clients who continue to deteriorate.*

Equity and Justice

- *There are many instances of letters to me about patients being difficult to contact and therefore the service assumes care has been refused. Being difficult to contact is often PART of their mental health issues eg anxiety/distrust/depression/sleep cycle disruption means patients may not answer calls. Many lose their phones or do not have them. Expecting patients with mental health disorders to be organised is like expecting patients with COPD to walk up 3 flights of stairs to their appointment!!*

Table 5: Equity and justice

Who decides when a patient “chooses” to disengage, and when they are unable to engage? How do we deal with patients who lead chaotic lives and are unable to engage?

Table 6: Equity and justice

Young people are learning how to perform mental illness on TikTok, so they can access the care they believe they need. Is this manipulative behaviour, or is it understandable and patient centred? What do patients need to demonstrate in order to access acute care? Are these unconscious requirements likely to be equitable?

Table 7: Equity and justice

Do we have structural impediments to care that exclude certain patients who live with disprivilege? Is this unconscious demand management, and if so, could the system survive if we were to make access equitable?

Table 8: Equity and justice

How do we measure equity across the system?

How can we optimise the system against need, instead of ability to navigate?

The ‘perfect health service’ for the ACT

To co-create a patient centred, primary – secondary care coordinated, respectful public mental health service in the ACT.

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Feedback, thoughts ideas and ….

What's already happening - Katie McKenzie

ACT Government | Canberra Health Services

Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS)

Katie McKenzie
Executive Director, MHJHADS

ACT Government | Canberra Health Services

Introduction

MHJHADS in Numbers

- 115 beds in 4 locations (including the Withdrawal Unit) 6 more to come online in a month (adolescent inpatient unit) and 12 more next year in the eating disorder residential treatment centre.
- 37 beds at Calvary are in addition to this
- We have approximately 1500 consumers cared for in the community
- The Access intake line receives approximately 3000 calls per month
- There are approximately 380 detainees in AMC, we provide primary health care to all of them (with the exception of the 30 transferred to Winnunga) and mental health care to 72 detainees
- At any given time there are about 20 young people in Bimberi
- A range of complex court-based services

Challenges in the Past 12 Months

- Dhulwa
- WorkSafe
- Introduction of DHR
- Oversight of detainee health care
- Audit
- Critical incident in AHMU

What we are Currently Working on

Dhulwa
CAMHS Day Program (opening today)
Adolescent Inpatient Unit (opening next week)
Relocation of CAMHS from Callum offices
Evaluation of adult community model of care
ADS review
Suicide prevention within CHS and our role in the broader system of suicide prevention
Integration between SYMHO and

Areas for Exploration and Thoughts for the Future

Crisis response – should MHJHADS do more in this space?

Peer workforce – where should MHJHADS trial peer workforce?

Service response to co-occurring AOD and moderate to severe mental health

Eating disorder day program

Northside planning – what services? What beds? Better integration for older people.

Questions

What's next

Workshop 2 - July 7th
9am – 1230pm
here

1. Solidify goals and proposals from first workshop.
2. How do we make reform happen?

A New Approach to ACT Mental Health Care Services System Reform

Workshop July 7, 2023

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Mission: to co-create a patient centred, primary – secondary care coordinated, compassionate, respectful public mental health service in the ACT.

Workshop 2

- to take the principles and values, service component ideas and questions from the first workshop, and initiate some broad design features,
- then make a plan for how to make reform happen.

New Approach to ACT Mental Health Care Services System Reform

Program

Time	Action
9-9:10am	Welcome & Scene setting
9:10-9:40	Round 1 self introduction and Workshop 1, 0.5 minute maximum response. Outline model to focus discussion (alternatives OK).
9:40 - 11am	Breakout groups: solidify goals and proposals from first workshop.
11-11:20am	Morning tea
11:20-12:30pm	Report back Where do we do with this next to progress reform?

Workshop 2

Principles for a redesigned Mental Health Care Service:

- Patient need centered.
- compassionate, respectful, responsive.
- Trauma and shame informed.
- Management to be skills-based, strength-based, solutions-focused.
- Encompass a continuum of care from brief, one off through to long term, ongoing intensive care.
- Values-based.
- Value delivering.

Workshop 1 – brief reflection

- Your name, organisation and
- very brief idea/ reflection you bring from the first workshop or the write up document.

Workshop 1 – Model for discussion

Model components:

- Promote availability,
- Intake and assessment,
- Treatment / bio-psycho-social management,
- Planning (discharge and follow up), noting different pathways and client needs,
- Review process.

Workshop 2 – Small groups

Model components:

- Prevention,
- Promote availability,
- Intake and assessment,
- Treatment / bio-psycho-social management,
- Planning (discharge and follow up), noting different pathways and client needs,
- Review process.

Focus questions for each of these stages in patient journey:

- What is working well?
- What do we need more of? How?
- What needs to be done differently? How?
- What new thing do we need? How?

Workshop 2 – Where do we do with this next to progress reform?

- What happens to the outputs from today?
- What are we the participants going to do next?
- What are we in our organisations going to do next?