

A New Approach to ACT Mental Health Care Services System Reform

Phase 1 Report



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Forward

During 2022 general practices and primary care organisations in the ACT were increasingly aware that the current ACT mental illness care system was not meeting the needs of people experiencing mental illness, particularly those in the Deep End¹, nor the needs of the practitioners who were working with people experiencing mental illness.

The Deep End group decided, in conversation with the AMA ACT Branch to embark on a project to reform mental health services in the ACT. Initially the Furthering Mental Health Care Services System Reform it has become the New Approach to ACT Mental Health Care Services System Reform project.

The project mission is to co-create a patient centred, coordinated primary and secondary care, compassionate, respectful public mental health service in the ACT.

Principles which guided the project were that we recognise:

- many people and services are working hard to do the best for people with mental health issues but the system is not helping them.
- the initiatives currently being undertaken by Canberra Health Services and the Health Directorate to make changes to Mental Health Services in the ACT.

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.

In doing this we learnt that much reform work was already being undertaken by Canberra Health Services and the Health Directorate in the ACT mental health care system. Our objective was then to inform and support this work.

This report summarises the outputs of this process and offers recommendations for the ongoing reform process.

¹ Deep End Canberra started in 2016 as a collegiate network of practitioners who work with vulnerable and disadvantaged people in the ACT. Members include GPs, Nurse Practitioners, Psychiatrists and other Allied Health Care Workers, who are all providing care in both mainstream and specialist primary care settings. Deep End Canberra members care for vulnerable and at-risk youth, refugees and asylum seekers, people with a disability, people experiencing domestic violence, homelessness and drug dependency, LGBTIQ+ populations, and people in the criminal justice system. Deep End Canberra also has links to academic medical researchers in the field.

Contents

Forward	2
Contents.....	3
Glossary.....	4
Executive Summary.....	5
Major findings.....	5
Major Recommendations.....	5
Principles for design and operation	5
Service Model Ideas and Suggestions	7
Survey Major Results	11
Conclusions from the Quantitative Data.....	11
Conclusions for the Depend – not-Depend comparison.....	11
Conclusions from the Qualitative Analysis.....	11
Qualitative results key points:.....	11
Workshop One and Two Synopses.....	12
Workshop 1 Synopsis	12
Ideas and suggestions from the first workshop	12
Resources shared on the day	14
Workshop 2 Synopsis	15
Overarching themes across all model components	15
Consolidated ideas and suggestions	16
What are the next steps from the workshops?.....	21
Appendices List (included in this document).....	22
Attachments list	22
Appendix 1: Submission to the workshop series from Dr Bree Wyeth, FRANZCP.....	23
Appendix 2: Edited Summary June 23 rd Workshop – Workshop 1.....	25
Appendix 3: Edited Summary 7 th July Workshop – Workshop 2	32
Appendix 4: A New Approach to ACT Mental Health Care Services System Reform Workshops	
Invitees and Attendees list.....	44
Invitees.....	44
Attendees	45

Glossary

ADHD	Attention-deficit hyperactivity disorder
DBT	Dialectal Behaviour Therapy
ED	Emergency Department
EMDR	Eye Movement, Desensitisation, and Reprocessing
DHR	The Digital Health Record
MHJHADS	Mental Health Justice Health Alcohol and other Drug Service within Canberra Health Services
Deep End	Communities with multiple disadvantages and vulnerabilities in need of complex psychosocial and medical supports. Includes: vulnerable and at-risk youth, refugees and asylum seekers, people with a disability, people experiencing domestic violence, homelessness and drug dependency, LGBTIQ+ populations, and people in the criminal justice system.
IAR-DST	Initial Assessment and Referral Decision Support Tool
MH	Mental Health

Executive Summary

Major findings

Access to care is the chief factor to be addressed. This applies to acute, ongoing and special services parts of the mental health care system.

A partnership model of shared care 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.

Shared care is a team effort. Communications are vital to its success. Today these are usually digital / electronic. This requires a rethink of privacy so outdated privacy concepts do not impede timely access to information for quality care.

Workforce is central to care; both professional, peer / lived experience and community workers involved in a person's care need good orientation, education, training and ongoing support to carry their responsibilities well. Organisations who employ these people need consistency of funding and a supportive environment that engenders a cooperative model of service delivery.

This report details our recommendations immediately below. We commend them to you and will continue to work with Canberra health Services and the mental health services teams to see them implemented.

While we make many recommendations for reform, we also are left with some questions that will require more consideration.

Major Recommendations

Principles for design and operation

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

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

Promoting and providing **access is key**. Primary health care principles are applicable here: care needs to be available, accessible, acceptable, affordable and appropriate.

For **values based care**; values may include:

- Patient-need centered. Care 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.
- Communications: easily accessed channels have to be available, open, respectful, and they are time-critical.

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

A caring system encompasses a **continuum of care** from brief, one off through to long term, ongoing intensive care.

Reconsider our language: are we caring for Mental Health or Mental Illness?

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.

Assessment of capacity requires discussion with others (collateral information / history).

Mechanisms to **assign and transfer duty of care** along the management/ treatment pathway have to be clear and well communicated; it should not be assumed. Make who has the Duty of Care explicit at the time of referral between the levels of care services.

Mechanisms for enabling care **teams to build and hold relationships** with people in their care need to be implemented and maintained.

Co-locate services to promote access and facilitate coordination of care.

Joint care-planning [including discharge-planning] system need to be developed and built in to care services.

Improve Communications

Set up better digital platforms 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]. Design multiple ways to connect – phone, email, messaging, etc.. Recognise that multiple languages are spoken in the ACT.

Include diverse viewpoints, honour and elevate the opinions of those with long term relationships with the service user and acknowledge differences of opinion.

Move “clinical” communication to include, honour and respect the vast workforce that is charged with the daily care of people with mental ill health.

Resolve barriers to timely clinical and relevant social communication

Reform privacy laws 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.

Joint decision making could be the expectation rather than the exception in all but the most urgent clinical encounters.

Workforce related

Recognise well trained and well supported peer workers are central to an effective and trusted mental health care system.

Workforce training: Cert IV in Community Care; in mental health first aid; Trauma and shame informed care; computer and IT communications systems; build understanding of complex systems. Orientation program to the sector given complexity ie number of services, types of services (who does what).

Workforce support: Permanent, long term jobs, funding for growth building system capacity – keeping professionals in the ACT. Adequate support for existing staff. Reduce staff turnover. Employers / companies review hours, leave, expectations.

Build personal (patient, family, carers, support workers) and community confidence in delivering care, embedding lived experience.

Build systems and train staff to work with and help people with complex needs and conditions (eg personality disorders, co-morbidities).

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.

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?**

Service Model Ideas and Suggestions

Cross-component matters

Recommendations	Implications for design
Induct new staff and up-skill current staff on the value systems for care.	Education resources and monitoring systems are needed.
Set up recruitment, training and support systems for peer workers.	

Prevention and Early Intervention

Recommendations	Implications for design
Create / expand community belonging and connections programs, through Community Centres/ Community Service Hubs.	
Support community-based care, the Community Hub model (see elsewhere here) with free access to low-intensity group supports, etc. (see workshop 2).	
Build recognition of deterioration into mental health and medical care plans to trigger early intervention.	
Provision of respite services.	
Support for primary care service practitioners may also help prevent deterioration and admission.	

Promote availability of existing services

Recommendations	Implications for design
Provide detailed orientation program to the sector given its complexity (agencies, types of services available). (Links to atlas – below)	
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.	
Create an atlas of mental health services, that details services, intake criteria and wait times.	

Intake and assessment

Recommendations	Implications for design
Provide a real time support / inquiries telephone hot line to an on-call psychiatrist or decision maker (12 to 24 hour red phone). This would also be an early intervention strategy.	
Design service options for people with complexity who usually find access difficult.	Will need to be highly resourced and connected to other services.
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.	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. Link to Care Navigators.
Adopt the IAR-DST for use in the ACT.	Policy commitment and staff education.
Integrate 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.	
Design and implement a capacity assessment system for continuing use along a person's journey in the mental health care system.	Ensure broad stakeholder engagement in design and implementation.
Establish protocols for assignment and transfer of duty of care.	
Co-locate services to promote access and facilitate coordination of care.	Review and re-design service delivery and placement models and options.
Create an early intervention, outreach specialist psychiatry model for assessment and treatment.	
Create an alternative to Emergency Departments or a specialized MH ED.	

Clearer pathways of assessment for specialized conditions eg ADHD.	Review age cutoffs and review wait times.
Create a Justice Mental Health court to offer diversionary options and case management.	
Make existing service intake criteria more transparent and flexible with a standardised intake form across private and public, federal and state/territory.	
Orient specialist services to the community context of primary care services, carers and family.	

Treatment + bio-psycho-social management

Recommendations	Implications for design
Acute MH services to build meaningful liaison with the primary care sector, for example the Community GP Liaison model.	
Make general and specialized eg DBT, EMDR psychology services more available and accessible.	Resourcing
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.	
Incorporate the principle of shared decision making to treatment and planning.	
Support community based care, the Community Hub model (see elsewhere here) with free access to low-intensity group supports, education, self-care, no referrals, not closed programs, community based; resource library; anytime drop in like men's sheds but not specific cohorts.	

Planning (discharge and follow up), noting different pathways and client needs

Recommendations	Implications for design
Establish protocols for assignment and transfer of duty of care.	
Establish protocols for joint care-planning, including discharge-planning. Incorporate the principle of shared decision making to treatment and planning.	This system need to be developed and built in to care services.

Implement suggestions about content, timeliness, process etc. that are detailed in Workshop 2 write up.	
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Review the system

Recommendations	Implications for design
Implement systems for critical incident review.	
Change the culture of the mental health care services to an outward looking one with codes and standards developed, applied and their use monitored.	
Operationalise a culture within the mental health care services to respect for the GP and the general practice / primary care team's long term, ongoing knowledge of people.	
Further specific suggestions are made in the Workshop 2 write up that cover items suggested above in the cross-component section and around shared planning and care, workforce, privacy law reform and economic considerations.	

Survey Major Results

Conclusions from the Quantitative Data

In many ways the high levels of dissatisfaction are not surprising and accounts over many years, and which the Health Directorate and Canberra Health Services have been trying to address.

Notable areas for action are the special conditions diagnostic service access, and barriers faced in access overall and particularly for people with mixed substance use and mental health conditions.

A further aspect is that availability and access are more often problematic; however, once a person has entered the service, satisfaction is higher.

Conclusions for the Deepend – not-Deepend comparison

The responses are similar overall. This signals that the factors requiring attention sit at a deeper systemic level and action on these will help both groups. Notable differences are discharge planning from the inpatient units (more of an issue for the Deepend responders) and much higher barriers to access for Deepend patients who are usually have greater need.

One factor that is difficult to account for here is that the Deepend services care for a heterogenous population and services have different in-house facilities for treatment. These factors may affect the responses.

Conclusions from the Qualitative Analysis

The survey requested free text responses to a number of questions, and some participants shared additional material. There was an overarching theme that GPs expected “kindness and competence” with clear communication, shared decision making between the whole team (including the primary care services, patients and carers) and safe handover. Primary care practitioners wanted a more respectful (of their knowledge and skills) and collegiate relationship with the mental health services staff.

Qualitative results key points:

- 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

The briefing document by Dr Bree Wyeth (Appendix 1) gives some further depth to the issues.

Workshop One and Two Synopses

The purpose of the workshops was to involve a broad a range of stakeholders in contributing to a process of redesigning the ACT mental health care services.

Workshop 1 Synopsis

The first workshop's purpose was to take a new approach to ACT mental health care services system reform by starting with a focus on the big picture and blue-sky brainstorm what we would like to see a world class mental health care service be, rather than start 'in the weeds' and limit ourselves only to what we assume is possible.

The exploration of issues for the workshop was framed around the following ethical principles: health vs harm, autonomy vs capacity, justice and equity, respect. The format taken was unstructured brainstorming.

Ideas and suggestions from the first workshop

Mental health is as much as social phenomenon as a biological one. Care services need to address the social determinants as well.

A systems approach to reform and change is required; merely tinkering is insufficient.

The question was raised: are we caring for Mental Health or Mental Illness; do we need to change our language (back).

For **values based care**; values may include:

- Patient-need centered. Care 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.
- Communications: easily accessed channels have to be available, open, respectful, and they are time-critical.

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

Promoting access is key, noting the primary health care principles that care has to be available, accessible, acceptable, affordable, appropriate.

A better system for access would be a centralised, single point of access incorporating 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. A new model for Access Mental Health on these lines would help.

Assessment is currently focused on diagnoses; early diagnostic clarity has advantages but sticky labels that outlive their usefulness disadvantage people. Removing no longer helpful diagnoses is important.

Would a functional impact assessment, detailing the impact of a condition on peoples relationships and lives, be more / as useful as a strict diagnostic label?

Standardised, open, transparent assessment tool eg the IAR-DST might be used universally in the ACT.

A person's **right to autonomy versus their capacity to consent** and engage in their care needs continuous and consistent assessment along the treatment journey. Capacity varies over time. Capacity to consent should not be assumed but assessed at each step.

Assessment of capacity requires discussion with others (collateral information / history) with benefits for the assessing clinician and patient. Collateral information from the primary care treating team (where relevant) is an important source of collateral history. Community providers (street workers, shelter workers, program outreach workers) also have in depth knowledge of the person and their situation and condition; their knowledge can be helpful too. Should the requirement for collateral history be incorporated into the Mental Health Act or the Guidelines rather than being a standard of care matter?

How to **assign and transfer duty of care** between primary care and secondary care levels of the system has to be an active and transparent process; it should not be assumed. Making who has the Duty of Care explicit at the time of referral between the levels of care services will be helpful to the referrer and referree.

Making, accepting or refusing to accept referrals requires notification and referral back to general practice refers requires negotiation.

Balancing team-based care with relational care (long term, trusting, one-on-one) need planning and attention; the question is how to hold the relational aspects of good care in a multi-disciplinary team?

The care system needs to be built around the person so that the primary and secondary health care teams, the person's family / significant others, community support service workers, and the person themselves are included as members of the care team. Mechanisms need to be built to bring the GP's / primary care team's experience into the specialist consultation, with the person, to enable shared and collaborative decision making about assessment and management.

Co-location of services to promote access and facilitate coordination of care.

Joint care-planning [including discharge-planning] system need to be developed and built in to care services.

Peer workers / lived experience workers are important members of the care team and we need to ensure they are not exploited as a poorly remunerated and unsupported workforce.

Issues for **education and training of all parts of the workforce** is important to achieving the type of care services people need. Such training may include:

- For GPs - normalising the need for GP support, debriefing and clinical supervision starting early in the training phase to normalise this as standard practice and self-care to help prevent and manage moral distress and expectations.
- For all staff - training should focus on realistic practice not "best" practice; manage expectations for community and GPs about what can be achieved in health care.
- For all staff - training in a compassionate care approach Connecting with People using the UK 4 Mental Health resource (see Resources shared).

The workshop noted the need to:

- Incorporate understanding that people in the deepend, the most severely disadvantaged, affected and complex, need to be prioritised for care and treatment.
- Allow primary care practitioners to escalate inquiries / seek support via telephone calls to a decision maker quickly eg 24 hour on call psychiatrist/red phone.

- Recognise that the current public MH system is inward focussed; GPs are not just receiving or referring parties. How can outward looking codes and standards be developed, applied and their use monitored? How can respect for the GP and the general practice / primary care team's long term, ongoing knowledge of people be operationalised?
- Systems for critical incident review.

The workshop heard from Katie McKenzie on the day that MJHADS is struggling to deliver care at the level needed at current resourcing levels, but despite this are working on reforming the services toward the norms articulated in the workshop.

Resources shared on the day

KPMG did a report in Mental Health on Investment to Save; [KPMG Portrait Report Word Template Option 2 \(mhaustralia.org\)](#)

Equally Well – to help with physical care of patients with MH issues (avoid harm of treatments)
[Equally Well – Quality of life – Equality in life](#)

Mzarek and Haggerty Model (1994) recently updated in the National Mental Health Plan:

[Figure 6: Mrazek and Haggerty's model of the spectrum of interventions for mental health problems and mental disorders – Office of the Auditor General](#)

Compassionate care – there has been a move away from this (compassion thought to be not professional) and this does harm. A move locally to use a UK model called connecting with people (CWP) [4mh home | 4 Mental Health](#) –.

NICE Guidelines for treatment of homeless and disadvantaged people. ([Integrated health and social care for people experiencing homelessness, NICE guideline \[NG214\]](#) Published: 16 March 2022, [accessed 24/6/2023])

Workshop 2 Synopsis

The second workshop took a more structured approach to the purpose, which was 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.

The workshop used the following format for thinking about the components of service redesign and planning:

Model Stages:	Focus Questions for each of these stages in patient journey:
<ul style="list-style-type: none"> • Prevention, recognising secondary prevention is the major focus, with some primary prevention aspects. • Promote availability of existing services, • Intake and assessment; seamless process, • Treatment + bio-psycho-social management, • Planning (discharge and follow up), noting different pathways and client needs, • Regular, periodic review process for the system. 	<ul style="list-style-type: none"> • 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?

Not surprisingly, most emphasis was on doing things differently or introducing new ways and services. This linked into doing more of what is being already done.

Overarching themes across all model components

Overall the ACT is well resourced. Problems arise from design and implementation issues.

Communications: the foundation of shared care. Better digital platforms 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]. Multiple ways to connect – phone, email, messaging, etc. are required. Recognition that multiple languages are spoken in the ACT is important. *Clinical communication can include diverse view points, honour and elevate the opinions of those with long term relationships with the service user and acknowledge differences of opinion.*

Communication can move beyond the increasingly out-of-date medico-legal narrow focus of doctor to doctor and honour and respect the vast workforce that is charged with the daily care of persons with mental ill health.

Resolve barriers to timely clinical and relevant social communication: There is too much anxiety around consensual information sharing. More progressive privacy laws are required where transparency should be an expectation / 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. *Joint decision making could be the expectation rather than the exception in all but the most urgent clinical encounters.*

Workforce training: Cert IV in Community Care; in mental health first aid; Trauma and shame informed care; computer and IT communications systems; build understanding of complex systems. Orientation program to the sector given complexity ie number of services, types of services (who does what).

Workforce support: Permanent, long term jobs, funding for growth building system capacity – keeping professionals in the ACT. Adequate support for existing staff. Reduce staff turnover. Employers / companies review hours, leave, expectations.

Build personal (patient, family, carers, support workers) and community confidence in delivering care, embedding lived experience.

Build systems and train staff to work with and help people with complex needs and conditions (eg personality disorders, co-morbidities).

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.

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?**

Consolidated ideas and suggestions

Prevention, recognising secondary prevention is the major focus, with some primary prevention aspects

Mental health is the responsibility of the “village”, focused on building and maintaining wellbeing (rather than illness vs health approach).

Recognition of deterioration, including building this into mental health and medical care plans, that triggers early intervention into a system that responds in real time may prevent an acute episode or minimise severity. Support for primary care services may also help prevent deterioration and admission.

Community belonging and connections programs, such as the Safe Haven and Community Centres/ Community Service Hubs, promoting inclusiveness and connection the community, providing a range of services and programs, prevent suicide and divert people from ED.

Provision of respite services.

Promote availability of existing services

Additionally to promoting existing services (Safe Haven, Head to Health), participants suggested:

- Orientation program to the sector given its complexity ie number of services, types of services (who does what). Permanent, long term jobs, funding for growth building system capacity, maintaining corporate knowledge, keeping professionals in the ACT.
- Information and education about mental health is needed across the sector about what to expect and for who – not just the worried well (in context of service capacity).
- Connecting GPs/ primary care services better to existing community services. An atlas of mental health services would help.

Intake and assessment; seamless process

Participants recognised that acute care high needs (PACER) and the limited GP advisory line staffed by psychiatrist (1pm – 2pm) were working well. On this, GPs wanted to extend the GP advisory line to a 12 to 24 hour “red phonenumber”.

The system works well when a patient has a clear-cut issue (with a protocol/simple solution and is able to communicate clearly and respond in a way that the services expects (eg pick up the phone, open the door).

Otherwise, the surveys and suggestions from participants suggest this is the component of care that is most in need of reform.

ONE intake point not likely to be helpful. No wrong door is useful, backed up by an integrated approach to intake: who, where, when clearly defined. Staff across the intake services need training about what is available (real time, waitlist), not person dependent.

More connectivity between services, especially open and transparent referral pathways, with improved systems of navigation to support people in their journey, aided by more unified, better, more modes of communication and clinical handover. Use maternity services as a model.

Integrate a broad set of inputs to assessment, including recent and past history across all relevant agencies, carers, primary care practitioners, community support agencies.

Support early intervention with outreach specialist medical / psychiatry support services into primary care to prevent admissions.

Design service options so people with complexity can be seen when not accepted by anywhere else. Highly resourced and linked to other services.

Create an alternative to Emergency Departments to respond to MH emergencies, in the community or a specialized MH ED. Incorporate social function and support functions.

Make existing service intake criteria more transparent and flexible with a standardised intake form across private and public, federal and state/territory.

Specialist services to be informed about the community context of primary care services, carers and family.

Mental Health Courts like Drug and Alcohol Courts, diversionary, referrals to care instead of sentencing, case managing of offenders with mental illness.

Treatment + bio-psycho-social management

Continuity of treatment teams, with linkage and liaison along the patient's journey: intake people following people through the journey, which avoids retelling stories and builds relationship based and trauma/shame informed care.

Allocate a care / case "coordinator" and care system navigators to guide/ walk along with the person to the care needed. Especially for people with really complex needs. This can be supported by lived experience workforce; shame and trauma informed, trusted staff; consistent messaging to people, their family and carers.

Overall more available and accessible general and specialized eg DBT, EMDR psychology services, pathfinders (social workers), extended hours eg Safe Haven, mid-range care ie between hospital admission and community.

Support community based care, the Community Hub model (see elsewhere here) with free access to low-intensity group supports, education, self-care, no referrals, not closed programs, community based; resource library; anytime drop in like men's sheds but not specific cohorts.

Build the capacity for solutions focused brief interventions. Include social prescribing.

Acute MH services to build meaningful liaison with the primary care sector, for example the Community GP Liaison model.

Incorporate the principle of shared decision making to treatment and planning.

Planning (discharge and follow up), noting different pathways and client needs

Improvement in timeliness of information transfer, with advanced interaction with primary care teams prior to discharge from inpatient units with attention to timing of transition between acute and community services (not late Friday afternoon) and with clear transfer of duty of care.

Referrals back to community services should offer and clearly articulate actions the community teams need to take.

Discharge plan content should contain: risk management information; medications (forms and doses), build in follow-up and review plans. Information needs to be for carers and support networks as well as primary care teams.

Clearly and proactively allocate duty of care in patient transitions along the care journey.

Recognise that shared care is shared between and within teams. Consistency of staff and support from the known staff facilitates this.

Modes of communication are important, noting many community services don't have access to DHR (see Communications above).

The idea of care coordinators and navigators to follow people into the community services sector.

Mental health care plans to include signs to trigger early / acute intervention and details of what actions to take and by whom including roles of peer workers, community support workers, etc. (copies of plans available to these workers then). Relapse prevention to be included in plans and be framed to support self management. Involve GP, peer workers, community services need to participate in shared decision making in formulating the plan. Plans to specify clear referral / who to contact details.

Integrate mental and medical health plans. Recognise deterioration in one domain, physical or mental, impacts the other.

Collaborative **shared care** planning using a "digital platform for information sharing" follows the patient so everyone can see what services are seeing patients.

Ensure plans are regularly updated with periodic collaborative reviews of the person's function and wellbeing with all relevant players involved, looking for emerging issues (back to secondary prevention).

Regular, periodic review process for the system (including ideas for current changes)

Review the collaborative shared planning model:

- Recognise and address barriers to proper use eg Asthma plans,
- Make medical records (*health records) more accessible and readable for all persons with a valid role in care including the person themselves.

Review existing service intake criteria to be more flexible particularly for people with multiple, complex needs.

Strengthen workers ability / capacity to deliver quality care:

- Ensure continuity of funding; replace current grant based / commissioned focused, short-term models where providers (organisations and workers) continually change, with ongoing service models eg Meridian, Grand Pacific, Marathon.
- Orient and train workers to be consistent in the advice and care / treatment they provide within services.
- Multi-mode tools to assist navigation through the system; read, listen, see; multiple languages and cultural sensitivities. [[iSee iLearn model](#)]
- Build confidence and competence in the workforce and community supporters to help people with multiple, complex needs.
- See workforce training and support above.

Establish a new approach to privacy:

- Frame sharing information as the default with opt out options; prevent privacy being a barrier to quality care. Other agencies, supporters and carers need access to timely, correct information. Revise privacy laws to enable this. Note the links to digital information and communication systems.
- Joint decision making could be the expectation rather than the exception in all but the most urgent clinical encounters.

Build the systems to support management of complexity / people with complex needs and conditions:

Key service principles:

- do not pilot without commitment to continue and allowing enough time to see outcomes;
- funding continuity to providers; fund organisations not programs to enable continuity of provider AND workforce.
- Permit flexibility in commissioned services / programs (recognising complexity in people).
- May need to explore rationalization of services to free up and redirect resources.

Increasing resource to deliver a variety of service and treatment options for those that do not “fit”.

Plan not to add services but improve the system of what we have. Let’s not “design another new service”.

Define and commence shared care models.

Take a regional approach; recognise the ACT is central to a region and access to services need to be defined by where people access health care not their residential and / or work address.

Economic aspects:

How do we measure success, define KPIs and outcomes? We need to recognise outputs are not a measure of effectiveness but outcomes are hard to develop and success hard to measure in the short term and for people with a chronic, recurrent mental illness. How do we know what we do is being helpful? Even clinical tools (K10, DASS-21) are not necessarily accurate.

Where can we show savings in a budget? Is this even a useful measure / outcome? Can this be a driver while avoiding the silo issue of where the savings “go”.

At a macro level, can the federal government adjust the Medicare Safety Net so it comes in earlier to support people with higher medical needs.

Concluding remarks

Katie McKenzie, MHJHADS, acknowledged the need for change, outlined steps already underway and committed to continuing.

One agreed idea that emerged was to Community Health Hubs as an opportunity for a community based, regional approach, to trial shared care / one team approach to intake, assessment, treatment and management. The workshop agreed we can advocate for this, building on momentum for a Tuggeranong hub first.

What are the next steps from the workshops?

Are there opportunities for MHJADS to take anything from this work?

Community Health Hubs are an opportunity for a community based, regional approach, to trial shared care / one team approach to intake, assessment, treatment and management. A point for advocacy. Many of us can lobby for this – Darlene cox suggests building on momentum for Tuggeranong first.

Katie McKenzie:

1. Access is a key worry. Structure and how to move forward within MHJADS. Need to lead for their access and intake.
2. Peacock Centre /Adelaide Urgent care centre model - models already underway in Australia. Useful to consider as points of initial contact to avoid ED and provide better / easier initial access.

Bree - Plan to do joint assessments including all (relevant) those that know the person and their situation. Move into the trusted therapeutic space and a consultation process.

Pete Podolski – Also need Education/Housing/CSD/Justice/others; so cross government, multi-directorate approach since many issues are specifically within Health’s remit.

Need better, integrated, trusted digital communication systems for clinical communication.

Consider turning the privacy/confidentiality barrier on its head – share within the treatment community unless otherwise told.

Multi-culturally safe and awareness re MH is very important.

Denise commitment to discharge planning.

Erin CHN/YouthCoalition/HS – linking this piece to the Alliance.

Deep End will try and meet with Minister later in this year.

Directions – willing to engage in any further work.

Bree – participating in further broader consultation already.

Mapping service agencies and roles to identify gaps.

Appendices List (included in this document)

Agenda setting paper from Bree Wyeth

Edited Summary of Workshop 1

Edited Summary of Workshop 2

Participants and Invitee list

Attachments list

Primary Care Practitioner Survey Report

Workshop 1 and 2 Introductory Presentations

Appendix 1: Submission to the workshop series from Dr Bree Wyeth, FRANZCP.

I am grateful for my colleagues and the organizations contributing to these workshops for the opportunity to share ideas and consider practical ideas for a better mental health services for the ACT. My opinions are informed by my experience as a mental health care worker in the ACT over 14 years. I also speak as a family member of a person with a severe mental illness and as a health care worker who has struggled with burnout and moral distress.

In my clinical and personal experience and listening to my colleagues and feedback about what is not working I see key recurrent themes. Some appear to be perennial challenges that defy solutions but deserve wholehearted compassionate acknowledgement like the issues of intersubjectivity in diagnosis and understanding of another person's distress and needs, and the wicked issue of loss of decision making capacity with some mental disorder presentations. Some failures in mental health service delivery have some standards that they can be measured against – like the NSQHS and mechanisms for feedback and redress with various bodies of accountability.

Some key issues that I believe are surmountable often fall to issues of clinical ethics, professionalism and values at the whole of organizational level and within every clinical encounter. Procedures and policies that try to standardize practice can unwittingly worsen defensive and inflexible practices by the staff at the frontlines delivering care. Here the common issues I see are staff stumbling over and misquoting laws including the Mental Health Act, health privacy legislation and using standardized forms from computer software programs that obfuscate meaning.

Some antidotes to the distress and moral outrage people involved in these encounters can apply are values based (* NB recurrent themes from Workshop 1).

As a first step I believe **Honesty and Humility** can be modelled by service leaders and encouraged, rather than seeing this wither in the face of defensive practice (cf defensible practice where individual's are empowered to use their clinical judgement) Defensive practice thrives on systems of inward facing responses to whole of community challenges, like the suicide of a person with mental illness in the community setting. As a Territory we could adopt restorative justice practice as our model for learning from critical incidents instead of the current approaches. This is with the goal of **Collaboration**, encouraging open dialogue and bringing agencies together. To make a Territory wide goal like reducing morbidity and mortality from mental disorders real it will need true collaboration between agencies and wholehearted engagement with persons with illness and their families and carers.

From these values driven perspectives **Transparency and Trust** can grow and help organizations, individual providers and service users feel safer and acknowledge their interdependent dynamic.

To make this vision a reality we clearly need compassionate leadership across the sector and we can make meaningful changes to daily practice.

Working collaboratively could look like this – to use a few common clinical challenges especially communication exchanges as practical examples.

Discharges and clinical handovers can offer and suggest actions for the receiving provider and clearly articulate any further actions from the sender.

Clinical communication can include diverse view points, honour and elevate the opinions of those with long term relationships with the service user and acknowledge differences of opinion.

Communication can move beyond the increasingly out-of-date medico-legal narrow focus of doctor to doctor and honour and respect the vast workforce that is charged with the daily care of persons with mental ill health.

*Medical records (*health records) can be made more accessible and readable for all persons with a valid role in care including the patient.*

Where any service user has a long history of contact with providers this should be available to the care provider with ease to utilize in the latest episode of care.

Joint decision making could be the expectation rather than the exception in all but the most urgent clinical encounters.

Person centred health care should exemplify the practice of formulation not just categorical diagnosis and explain the unique needs of each individual service user.

Appendix 2: Edited Summary June 23rd Workshop – Workshop 1

The introductory presentation that includes the focus questions for the conversations at the workshop is in Appendices.

Purpose

To take a new approach to ACT mental health care services system reform by starting with a focus on the big picture and blue-sky brainstorm what we would like to see a world class mental health care service be, rather than start 'in the weeds' and limit ourselves only to what we assume is possible.

Emerging Recurrent Themes and questions

Systems approach required; tinkering insufficient.

Promoting access is key. [Primary health care principles: available, accessible, acceptable, affordable, appropriate]

Values based care; values may include:

- Patient need centered. Care sits in a persons live journey.
- 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.
- Value-based care: value for the patient, the system and the community.

Communications: available, open, respectful, time-critical.

Autonomy vs capacity needs to be resolved.

How to assign and transfer duty of care?

How do teams build and hold relationships?

Notes

Commenced with introductions and explanation of what Deep End work represents.

Peter Tait did a brief presentation about the data from the primary care survey and then we had a discussion about why respondents may have chosen neutral as their response (approximately 30% across the survey)

What does neutral mean?

- Prefer not to say
- Too complex a decision; easy to fence sit
- Ambivalent and mixed thoughts
- Spread of experience – could not universally come to a decision
- Normalised low expectations are met
- Which responders used neutral? Was it the same people or a scattered sample?

Dr Louise Stone introduced some qualitative analysis and discussed four domains:

Patients

Mental illness is a chronic, fluctuating, multi-dimensional disorder not just a biomedical disease.

Every episode of illness is like only one chapter of a book and the mental health system doesn't put the whole story together.

Mental illness is hard to quantify, subjectively reported and "performative" – for eg DASS is not precise but a story a patient is telling that day.

Low health literacy.

[Should we focus on a functional assessment primarily rather than a specific diagnosis?]

The Illness

Mental illness not biological; there are socioeconomic determinants. Childhood experience. A natural / normal reaction to adverse circumstances. [So is a non-medical model system solution needed?]

Health Professionals

What is a "good job" in mental health care? How can we build a system that builds towards that?

Moral distress of Drs burning out in their job makes them feel they are the problem. Very often they consider they have a time management problem when it is a complexity allocation problem. 20% of junior doctors are dropping out of medicine.

Recognition that it is all Health Care Workers in the MH space.

Peer workers – we need to ensure they are not exploited as a poorly remunerated and unsupported workforce.

All workers need respect, and specific, available supports.

Systems

Blue sky thinking does not mean that everyone can get everything. So, patient centred wrap around care – is this really possible? We (government, health care workforce, community) need an honest conversation at a community level about what is realistic.

Systems are complex – Commonwealth/State/Stigma.

Research is hard and not done.

[Aim to optimise care for the most incapacitated.]

If everyone received the care they needed, would the system break?

We then broke into small groups tackling a series of topics. Discussion and feedback included:

Feedback from Health vs Harm

Early and correct diagnosis with joint care plans have the opportunity to change trajectory (though Denise Riordan later pointed out in the young waiting for diagnostic certainty before labelling is important too and that too many diagnostic labels are either self attributed or provided and hard to undo)

Use of tools like [IAR-DST](#) would be helpful if consistently used across all services for standardizing communications.

Avoiding harm through co-location of services

KPMG did a report in Mental Health on Investment to save

[KPMG Portrait Report Word Template Option 2 \(mhaustralia.org\)](#)

Equally Well – to help with physical care of patients with MH issues (avoid harm of treatments)

[Equally Well – Quality of life – Equality in life](#)

Mzarek and Haggerty Model 1994 – National health plan recently updated by U of C Psychologist – Peter Tait to approach for input.

[Figure 6: Mrazek and Haggerty’s model of the spectrum of interventions for mental health problems and mental disorders - Office of the Auditor General](#)

Compassionate care – there has been a move away from this (compassion thought to be not professional) and this does harm. A move locally to use a UK model called connecting with people (CWP) [4mh home | 4 Mental Health](#) – training MH staff in ACT with 4 modules to go back to compassionate care approach. Compassionate care would be trauma and shame informed care.

Feedback from Justice and Equity

“Choice” – disengaged; not really a choice. How do we support those who may not have the capacity to engage or agency (transport/phones/support).

Feedback from values based health care

Note ACT Wellbeing Framework informing budget

Bundled care models.

Compassion based care.

Integrated care.

Trauma informed and shame informed care.

Strength based solutions focused care.

Feedback from Respect

Embedding multi-disciplinary teams into general practice. Support team approach; support referral to address /social determinants’ eg social workers.

Align systems with general practice values. [this is person centered, whole person, continuing, long term care]

Flexible funding to support team environment and align with values.

Acknowledge no back up for GPs for duty of care.

Mentorship and partnerships with universities to support GP trainees in setting / developing [realistic?] expectations.

Access to MH services easier for GPs and alternate referral options.

Navigator / peer workforce to support patients and GPs

Pressure on acute MH services leading to inappropriate discharge, therefore acknowledge and provide improvement to public MH services.

Normalise GP debriefing / clinical supervision sessions to support GPs' own mental health.

Communications to support male GP providers to be accessible, relieving pressure from female GPs.

Recognise values driven care leads to moral distress therefore right people in the right place. System is not values driven.

Support and flexibility to funding models to attract GPs back to practice.

ACT GP Network to support GPs eg a community of practice.

Expand role and staffing of GPLUs to support GP – acute service communications and patient navigation.

Provide professional advice line for GPs to manage patients.

Access MH triage system is not collaborative or advisory; would be great to have psychiatrist support / clinical advice for GPs, longer than the 1 hour psychiatrist number.

Health Pathways, although need to review MH referrals to support easy, clear access to referral options.

Female only GP network support.

Options for women GPs: eg childcare, work flexibility, to support other pressures.

Team based care.

Feedback from Autonomy and Respect

Provide 24-hour safe places [eg the Safe Haven model?] as effective and helpful places for managing lower acuity psychological distress, holding (chronic) suicidality, while imparting strategies to help people manage future distress.

Access to therapies eg DBT ongoing.

GPs need education about their options under the MH Act to facilitate assessment. If MH service doesn't comply with their requirements under the MH Act, this needs to be prosecuted.

Close collaboration between early psychosis services and GPs.

Consult Liaison opportunities for GP s to psychiatrists (Bat Phone).

Recognise emergency [department?] MH presentations are "life threatening emergencies" = Cat 1.

Require 24 hour access and assessment similar to cancer.

Access MH operates as a barrier rather than a conduit to care; wastes an inordinate amount of time in other parts of the health system, including GPs.

External review of the interpretations of the MH Act. In practice in ACT, narrow interpretation used to exclude rather than treat.

Sent in later:

1/Duty of Care and where this rests when making a referral through Access Mental Health. Making who has the Duty of Care explicit at the time of referral may clarify areas of concern, this would potentially be helpful to the referrer.

2/ Community Safe Houses are seen to be effective and helpful in managing lower acuity psychological distress.

3/ Meridian has peer support workers as a significant proportion of the workforce. There is significant potential for peer support employment to be expanded in mental health generally. It is essential that these workers are appropriately trained and supported. [Lived experience / peer support workers valued: valued translates into training, good remuneration, adequate support and potential for career pathways if wanted.]

Notes from other feedback on the day

- Values based – approach everyone with curiosity, kindness and humility.
- Values based: kind and compassionate care.
- Value-based care: value for the patient, the system and the community.
- Mental health care is a community effort – not [just] hospital focused.
- MH is chronic and a unique lived experience to everyone so any interface is merely a chapter in their life long journey of mental health and illness, and does not mean [the story is] “finished” after one episode.
- Mental Health vs Mental illness – do we need to change our language (back)

People with mental illness are a heterogenous cohort. One care model may not fit everyone; but the values should remain consistent.

Outreach services need to differentiate models for acutely unwell people versus people requiring non-acute care.

Should we use the “deep end” as our cohort to exemplify values-based care?

In MH evidence-based vs spectrum of care [spectrum of delivery] should be considered as there can be other approaches – unpopular but helpful – to promote and permit strengths based – solutions focused, and narrative therapy “how is the story you are telling working for you”? Team based approach to care – normalising the need for GP support and supervision starting early in the training phase to help prevent and manage moral distress and expectations.

Balancing team-based care with relational care (long term, trusting, one-on-one); how to hold the relational aspects of good care in a multi-disciplinary team?

How to bring the GP’s / general practice team’s experience into the specialist consultation, with the person, to have shared / collaborative decision making about assessment and management?

Issues around multi-disciplinary team approach: how does the GP fit in? How does the team support the GP?

Support, debriefing and clinical supervision needs to be built into GP training [U/G and P/G] and normalised as standard practice / self care; this will help prevent and manage moral distress.

Training should focus on realistic practice not “best” practice; manage expectations for community and GPs about what can be achieved in health care.

Duty of Care: what actually is it in this situation and who holds it? Making who has the Duty of Care explicit at the time of referral may clarify areas of concern; this would potentially be helpful to the referrer.

So, how is duty of care assigned and then transferred?

Access Block, unaccepted referrals or referral back to GP without notification or negotiation.

Would a better system be a centralised triage and retrieval team to expedite the patient to where the care that is needed can be given? Seamless triage, line up care site, transport, treat. Single point of access. A new Access MH model?

Much discussion about escalation of inquiries / support calls to a decision maker quickly eg 24 hour on call psychiatrist/red phone.

Conversation about Mental Health Treatment orders by Denise

Review of the Act underway including how it might be interpreted; and also new draft guidelines for implementing the MH Act. Guidelines can be determined by the Chief Psychiatrist.

Capacity varies over time. Assessment of capacity is always undertaken at a single point in time (with limited sources of information). Discussion with others (collateral information / history) benefits assessing clinician and patient. Could seeking collateral information from the primary care treating team (where relevant) be incorporated into the Act or the Guidelines?

Would using a universal, consistently applied capacity assessment tool help?

ED describe challenges they have on different days of the week – completely different care people get on a Tuesday than a weekend or after 5 on a Friday.

Recognition that the current public MH system is inward focussed; GPs are not just receiving or referring parties. How can outward looking codes and standards be developed, applied and their use monitored? How can respect for the GP and the general practice / primary care team’s long term, ongoing knowledge of people be operationalised?

Community providers (street workers, shelter workers, program outreach workers) also have in depth knowledge of the patient and their situation and condition. How to bring them into the collateral history taking.

How to improve the handover between different members of the patient’s care teams.

We need systems for critical incident review.

Standardised, open, transparent assessment tool eg the IAR-DST might be used universally in the ACT.

Joint care-planning [including discharge-planning] system need to be developed and built in.

Noted focus on diagnoses; noted advantages / disadvantages of early diagnostic clarity and sticky labels that outlive their usefulness. Removing no longer helpful diagnosis as important.

Would functional impact assessments be more / as useful?

Noted NICE Guidelines for treatment of homeless and disadvantaged people. ([Integrated health and social care for people experiencing homelessness, NICE guideline \[NG214\]](#) Published: 16 March 2022, [accessed 24/6/2023])

How to incorporate understanding that people in the deepend, the most severely disadvantaged, affected and complex, need to be prioritised for care and treatment? How to improve availability of and access to services?

What would an interagency, interdisciplinary model look like?

Appendix 3: Edited Summary 7th July Workshop – Workshop 2

Workshop Purpose

The second workshop's purpose was 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.

Introduction

This document has five parts:

1. This introductory section outlining principles, workshop aim and planning framework,
2. A summary of overarching themes that arose from all the tables,
3. A section detailing suggested next steps to take.
4. A submission received from Bree Wyeth to set out her suggestions (see also the Appendices).
5. Responses presented within the framework of the model / service stages for each of the focus questions.

Principles from Workshop one and from the floor

- Patient need centered.
- Empowered consumers and carers.
- Preventive.
- Compassionate, respectful, responsive, inclusive.
- 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.

Format for planning

Model Stages:	Focus Questions for each of these stages in patient journey:
<ul style="list-style-type: none">• Prevention, recognising secondary prevention is the major focus, with some primary prevention aspects.• Promote availability of existing services,	<ul style="list-style-type: none">• 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?

<ul style="list-style-type: none"> • Intake and assessment; seamless process, • Treatment + bio-psycho-social management, • Planning (discharge and follow up), noting different pathways and client needs, • Regular, periodic review process for the system. 	
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Overarching themes across all stages

Communications: the foundation of shared care. Better digital platforms 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]. Multiple ways to connect – phone, email, messaging, etc. are required. Recognition that multiple languages are spoken in the ACT is important.

Resolve barriers to timely clinical and relevant social communication: There is too much anxiety around consensual information sharing. More progressive privacy laws are required where transparency should be an expectation / 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.

Workforce training: Cert IV in Community Care; in mental health first aid; Trauma and shame informed care; computer and IT communications systems; build understanding of complex systems. Orientation program to the sector given complexity ie number of services, types of services (who does what).

Workforce support: Permanent, long term jobs, funding for growth building system capacity – keeping professionals in the ACT. Adequate support for existing staff. Reduce staff turnover. Employers / companies review hours, leave, expectations.

Build systems and train staff to work with and help people with complex needs and conditions (eg personality disorders, co-morbidities).

Mental health education across the sector.

ADS and MH and Justice Health systems connection / integration with the primary care sector and each other.

How do we bring the differing cultural approaches to mental illness (in our multicultural, multilingual society) into this reform?

Feedback from Tables (presentations and notes)

Notes in plain text are from report back notes and discussion.

Italic sections are copied from Bree’s submission.

Some responses are relevant to and occur in more than one place.

Cross-component factors

Working well

The ACT system is relatively well funded, lots of good services – eg WOKE (training, carers, skills, access DBT), Safe Haven, Directions Health (homeless, high-needs, outreach model, mobile service, free and accessible model).

Sector-wide systems thinking, understanding social determinants, good intentions.

Social workers in general practice pilot

We need more of

Carer-inclusive practice. Understanding the opportunity costs for carers of caring; so more carer supports.

Accountability – who is responsible for different things, who takes responsibility? Allocation of responsibility / duty of care.

Work toward coordination and collaboration (not competition) of services under ACT commissioning processes. Long term, stable funding to give long term employment opportunities and maintain corporate knowledge and skills in the sector.

Done differently

Clinical communication can include diverse view points, honour and elevate the opinions of those with long term relationships with the service user and acknowledge differences of opinion.

Adequate support for existing staff. Reduce staff turnover. Employers / companies review hours, leave, expectations.

Cross-border / Australian Capital Region assessment, intake, treatment and discharge issues to be resolved.

New things

Mental Health vs Mental Illness: clarification of definition.

Mental health to be seen as a whole of community issue, not siloed into professions.

Why are drug and alcohol and mental health services disjointed? And Justice Health and other primary care services. Improved step out services / pathways.

More progressive privacy laws. Carers don't know what's going on. Transparency should be an expectation. Too much anxiety around consensual information sharing.

Knowing what we know and where the gaps are.

Digital health solutions that are interagency, interconnected across services. multiple ways to connect – phone, email, languages etc..

Co-location of services – NGO/MHs – supporting people closer to home avoiding ED.

Co-design of services; eg Peacock Centre in Tasmania, Adelaide Urgent Care Centre. Walk-in models.

Model Stage-based responses

Prevention

Mental health is the responsibility of the “village”, focus on wellbeing (rather than illness vs health)

Cost of living etc, early in life (best start)

MH prevention sits across every aspect of life in the community.

Working well

Safe Haven – peer led support, Head to Health

We need more of

Increased effectiveness of navigation services, eg more unified, better, more modes of communication.

Broad education about what to expect and for who – not just worried well (in context of capacity).

Done differently

New things

Well being is a good frame for the prevention space.

Universal basic income.

Opportunistic support; eg gaol a good time to fill in paperwork.

Early intervention to prevent need for acute services – primary prevention, and early community based recognition of onset of illness.

Recognise deterioration and early intervention as acute episode prevention. Reduce wait times.

Specialist services reach into primary care to prevent admissions and medical / psychiatry support in place.

Mental health plans to include signs to trigger early / acute intervention. Plan to include details of what action to take. Relapse prevention in plans; support self management. 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 management plans available to these workers then).

Integrate mental and medical health plans. Recognise deterioration in one domain, physical or mental, impacts the other.

More community engagement; Community belonging and connections programs. Plus formats such as the Safe Haven model. More community [based] programs: inclusiveness and connection the community; suicide prevention. Diversion from ED – reduce system overload.

Community Centres providing a range of services and programs (eg education, health care) to foster connection and belonging. Communal (for everyone) so reduce stigma / shame and trauma. [eg First 1000 days programs]. Regional. Mental wellbeing spaces. Offer quiet, sensory friendly space.

Community service Hubs to help with belonging and connection across cooking/social hubs/health etc. Everyone goes there –no stigma to go. A service between Life-line and Safe Haven. Mental health wellbeing spaces – scattered around the ACT. Walk in service. An alternative to ED. (Darlene added that these community hubs coming in Canberra so how can MH fit in – Katie agreed)

Promote availability of existing services

Working well

We need more of

Safe Haven – peer led support, Head to Health

Done differently

More connectivity between services, especially referral pathways. And connecting GPs better to existing community services. An atlas of mental health services would help.

Orientation program to the sector given complexity ie number of services, types of services (who does what). Permanent, long term jobs, funding for growth building system capacity – keeping professionals in the ACT.

New things

Improved systems of navigation; internet, phone, in person. Safe Haven model. Measure outcomes within services.

Increased effectiveness of navigation services, eg more unified, better, more modes of communication.

Broad education about what to expect and for who – not just worried well (in context of service capacity)

Intake and assessment

Working well

Acute care high needs (PACER)

GP advisory line staffed by psychiatrist (1pm – 2pm)

The system works well when a patient has a clear-cut issue (with a protocol/simple/short solution and is able to communicate clearly and respond in a way that the services expects (eg pick up the phone, open the door).

We need more of

Increased effectiveness of navigation services, eg more unified, better, more modes of communication.

Continuity and consistency of staff; increase support / attractiveness of work / recruitment and retention (a broad ACT issue) and training.

Safe Haven – peer led support, Head to Health.

Done differently

Extend GP advisory line staffed by psychiatrist [note previous suggestions about a 24 hour / all day “red phonenumber”]

Alternative to ED to respond to MH emergencies. Embedding within the community – availability.

Clearer pathways of assessment eg ADHD.

Have a service option so that a person with complexity can be seen when not seen by anywhere else; allows other services to manage ‘simple things’ effectively. Highly resourced and linked to other services.

Currently patients access services based on their ability to say the right things, respond to texts / calls.

Transparency in service intake criteria / outcomes / patients falling through the cracks.

Review existing service intake criteria to be more transparent and flexible. What is the triage category for ED MH admissions?

HAART assessments: currently re-triaging occurs eg patient seen by psychiatrist and GP, thought to be suicidal by both, re-triaged by HAART.

Recognise deterioration and early intervention. Reduce wait times. Specialist services reach into primary care to prevent admissions and medical / psychiatry support in place.

No wrong door; but one door is too hard; maybe not only one door.

ONE intake point not likely to be helpful. Integrated approach to intake: who, where, when clearly defined. Staff across the intake services need training about what is available (real time, waitlist), not person dependent.

Conjoined drug and alcohol and mental health services.

New things

Patients have to start over at each transfer – no clinical handover. Lots of community services don't have access to DHR – disjointed care.

Improved systems of navigation; internet, phone, in person. Safe Haven model. Measure outcomes within services. Soft handover to the person who can help /shepherding. Care navigators.

Whole of person: social determinants, disability, mental health question.

Standardised intake form: private and public, federal and state/territory.

Dedicated Mental health (ED).

Non-ED emergency / urgent / crisis access options. [Note Integrated Care LaNS model]

Wherever patient seeks access, they will be given the caring support needed including assisted direction to who they need to see.

Person centered assessment. Standardised, consistent, streamlined and shared assessment; use of tools eg IAR-DST.

Joint decision making could be the expectation rather than the exception in all but the most urgent clinical encounters.

Person centred health care should exemplify the practice of formulation not just categorical diagnosis and explain the unique needs of each individual service user.

Clear (open and transparent) pathways of referral from primary carers to - Access MH, Mind Map and CAMHS, Head to Health. These open and communicated. Build into shared care approaches. Use maternity services as a model.

Clinical communication can include diverse view points, honour and elevate the opinions of those with long term relationships with the service user and acknowledge differences of opinion.

Where any service user has a long history of contact with providers this should be available to the care provider with ease to utilize in the latest episode of care.

Specialist services to be informed about the community context of primary care services, carers/ family.

Continuity to treatment teams. Continuity along the patient's journey: Intake people following people through the journey – avoids retelling stories/builds relationship based and trauma/shame informed care.

Justice MH court: diversionary options and case management.

Treatment + bio-psycho-social management

Working well

Bimberi, Dhulwa, the Eating Disorders and Perinatal mental health services are improving.

EAP, sometimes uni services.

We need more of

Accessible psychology services

- Pathfinders (social workers)
- Affordable, adequate numbers, adequately trained.
- More effective recruiting of workforce / staffing.
- More training options,
- Extended hours eg Safe Haven
- Mid-range care ie between hospital admission and community.

Specialist services eg DBT, EMDR.

Trauma informed, lived experience practices; review environment, staff education and training; reducing barriers to access eg peer workforce.

Co-design and co-location models. NGO and services.

Done differently

Conjoined drug and alcohol and mental health services.

New things

Social prescribing.

Mental Health Courts like Drug and Alcohol Courts, diversionary, referrals to care instead of sentencing, case managing of offenders with mental illness.

Early intervention respite, practical care.

Free access to low-intensity group supports, education, self-care, no referrals, not closed programs, community based. Resource library. Role for people running the centres, anytime drop in like men's sheds but not specific cohorts.

Support community based care. Community hub model (see elsewhere here).

Continuity to treatment teams. Continuity along the patient's journey: Intake people following people through the journey – avoids retelling stories/builds relationship based and trauma/shame informed care. Case management – one point of contact, thrive better.

Build the capacity for solutions focused brief interventions.

Allocate a care / case "coordinator". System navigators to guide patients to the care needed once access achieved.

Acute MH services to build meaningful liaison, for example the Community GP Liaison model (per submission to Legislative assembly)

New GP Psychiatry advice line 12 / 24 hours per day may help with some demand on Access Mental Health.

How do we provide wrap around supports – how do decisions get made about what and when services are allocated?

Linkage and liaison along patient journey. Heavily resourced services to hand-hold and walk along with the person who has really complex needs; lived experience workforce; shame and trauma informed, trusted staff, consistent messages. Care navigators.

Planning (discharge and follow up), noting different pathways and client needs

Working well

Pre-discharge planning and h/o ORT/MH for justice patients who have a predicted discharge time.

We need more of

Done differently

Discharges and clinical handovers can offer and suggest actions for the receiving provider and clearly articulate any further actions from the sender.

Discharge planning and follow up; currently no planning for discharge, no bridge to community.

Timeliness of information. Advanced interaction with primary care teams prior to discharge from inpatient units. Clear transfer of duty of care.

Timing of transition between acute and community services.

New things

Patients have to start over at each transfer – no clinical handover. Lots of community services don't have access to DHR – disjointed care.

Care coordinators or Liaison officers; community liaison models.

Mental health plans to include signs to trigger early / acute intervention. Plan to include details of what action to take. Relapse prevention in plans; support self management. 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).

Integrate mental and medical health plans. Recognise deterioration in one domain, physical or mental, impacts the other.

Collaborative **shared care** planning – everybody involved – “digital platform for information sharing” follows the patient so we can see what services are seeing patients.

Social work involvement and continuity of care with services.

Consistency of staff and support from the known staff.

Review the collaborative shared planning model - recognise and address barrier to use properly eg Asthma plans

Shared care: a system of care teams.

How to clearly allocate duty of care transitions in a shared care model? Where does duty of care and risk lie and responsibility?

How do we provide wrap around supports – how do decisions get made about what and when services are allocated?

Discharge from Justice – planning and coordination.

Discharge plan content: 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.

Communication can move beyond the increasingly out-of-date medico-legal narrow focus of doctor to doctor and honour and respect the vast workforce that is charged with the daily care of persons with mental ill health.

*Medical records (*health records) can be made more accessible and readable for all persons with a valid role in care including the patient.*

Discharges and clinical handovers can offer and suggest actions for the receiving provider and clearly articulate any further actions from the sender.

Ensure plan are regularly updated – periodic patient reviews; collaborative reviews, all relevant players involved. Especially assess client status and look for emerging issues (back to secondary prevention).

Build personal and community confidence in delivering care – embedding Lived Experience.

Review the system

Working well

We need more of

Done differently

Review existing service intake criteria to be more flexible (system review).

System doesn't handle complexity; how do we better address whole people and avoid rejecting people because they don't fit into a box / not help with half their problems?

Consistency within services. Less person dependent responses.

Conjoined drug and alcohol and mental health services.

New things

So many different groups related to MH care – how to deliver comprehensive and cohesive care?

Continuity of funding, current grant based / focused, terms end, providers continually change; eg Meridian, Grand Pacific, Marathon.

Commissioning supposed to be flexible and responding but how can it with funding constraints. What will happen to innovation and additional meeting emerging needs?

Where can we show savings in a budget (health economics)? Can this be a driver but avoid the silo issue of where the savings “go”.

Regional approach; ACT as a whole a region.

Audit how many calls to Access Mental Health go through vs are made.

Joint decision making could be the expectation rather than the exception in all but the most urgent clinical encounters.

New approach to privacy; sharing information as the default with opt out options. Prevent privacy being a barrier to quality care. Other agencies, carers, need access to timely, correct information. Needs revision to privacy law. Links to digital communication systems.

Health privacy and information sharing – levers to share to enable access and smarter digital systems for all providers.

Remove data and privacy barriers to information sharing (in the person’s interests).

How does the system cope with complexity – how can we work better? Increasing resource to deliver in this complex space when they “don’t fit the boxes and keep getting rejected” Some need more - screen and realise you need a variety of service and treatment options for those that do not “fit” Build the systems to support management of complexity / people with complex needs and conditions.

Plan not to add services rather than improve the system of what we have. Let’s not “design another new service”.

Define and commence shared care models.

Training opportunities sector wide and connected to training /workforce retention.

Stable services and funding and continuation.

How do we measure success and KPI and outcomes? Outputs are not effective measure; outcomes are hard to develop in the MH space. How do we know what we do is being helpful? How do we measure success in a chronic, recurrent condition?

Clunky tools for improvement with K10 for example

Key service principles:

- do not pilot without commitment to continue and allowing enough time to see outcomes;
- funding continuity to providers; fund organisations not programs to enable continuity of provider AND workforce.
- Permit flexibility in commissioned services / programs (recognising complexity in people).
- May need to explore rationalization of services to free up and redirect resources.

Macro level review – commonwealth – Medicare safety net – comes in earlier for those with higher medical needs; adjust safety net to support people.

Multi-mode tools to assist navigation through the system; read, listen, see; multiple languages and cultural sensitivities. [iSee iLearn model]

What are the next steps?

Are there opportunities for MHJADS to take anything from this work?

Community Health Hubs are an opportunity for a community based, regional approach, to trial shared care / one team approach to intake, assessment, treatment and management. A point for advocacy. Many of us can lobby for this – Darlene Cox suggests building on momentum for Tuggeranong first.

Katie McKenzie:

1. Access is a key worry. Structure and how to move forward within MHJADS. Need to lead for their access and intake.
2. Peacock Centre /Adelaide Urgent care centre model - models already underway in Australia. Useful to consider as points of initial contact to avoid ED and provide better / easier initial access.

Bree - Plan to do joint assessments including all (relevant) those that know the person and their situation. Move into the trusted therapeutic space and a consultation process.

Pete Podolski – Also need Education/Housing/CSD/Justice/others; so cross government, multi-directorate approach since many issues are specifically within Health's remit.

Need better, integrated, trusted digital communication systems for clinical communication.

Consider turning the privacy/confidentiality barrier on its head – share within the treatment community unless otherwise told.

Multi-culturally safe and awareness re MH is very important.

Denise commitment to discharge planning.

Erin CHN/Youth Coalition/HS – linking this piece to the Alliance.

Deep End will try and meet with Minister later in this year.

Directions – willing to engage in any further work.

Bree – participating in further broader consultation already.

Mapping service agencies and roles to identify gaps.

Appendix 4: A New Approach to ACT Mental Health Care Services System Reform Workshops Invitees and Attendees list

Invitees

Health and Medical (Peaks and service providers)

AMA ACT, ASMOF, Deepend Canberra, Capital Health Network, CHS MHS staff (TCH AMHU, Calvary Acacia Ward, OPMHU, CAMHS), Specialist Youth Mental Health Outreach (SYMHO), Access MH/HAART, Emergency Departments (TCH and Calvary (now Northside Hospital)), Community MH Services, Eating Disorders Hub, RACGP, RANZCP ACT Branch, Directions Health, Junction YHS, Youth Coalition.

Commissioned Services

Catholic Care/Marymead, Next Steps, Headspace, A Gender Agenda, Meridian, Relationships Australia, Head to Health.

Consumers and other interested parties

ACT Mental Health Community Coalition, Mental Health Foundation ACT, ACT Mental Health Consumers Network, Canberra Mental Health Forum, Health Care Consumers Association, Canberra Alliance for Harm Minimisation and Advocacy, Carers ACT, Advocacy for Inclusion, Youth Coalition ACT, ACT Disability, Aged and Carer Advocacy Service (ADACAS), Women's Health Matters, Directions Health, YWCA Warm Connections Counselling Service, Safe Haven Belconnen.

Government

Canberra Health Services (Katie McKenzie ED MHJHADS, Denise Riordan Director Clinical Services MHJHADS, Dinesh Arya ACT Chief Psychiatrist and Care Co-ordinator; Elizabeth Moore Office of Suicide Prevention and Well-being, directors of each branch of the Mental Health Services (Adult Acute Mental Health Services, Adult Community Health Mental Health Services, Child & Adolescent Mental Health Services, Territory-wide Mental Health Services), Mental Health Workforce Planning group.

Attendees

Attendee	Organisation	Sector	Attended		
			W1	W2	Both
Fouzia Jabeen	Women's Health Matters	Consumer / Peak			
Bronwyn Hendry	Directions Health Services	Consumer / Peak	Y	Y	y
Stephanie Stephens	Directions Health Services LTD	Consumer / Peak	Y	A	
Kate Gorman	Health Care Consumers' Association	Consumer / Peak			
Catherine Joseph	Mental Health Carers Voice (Carers ACT)	Consumer / Peak		Y	
Dr Denise Riordan	Canberra Health Services	Canberra Health	Y	Y	y
Bree Wyeth	Directions Health Services	Deepend	Y	Y	y
Tanya Robertson	Junction Youth Health Service	Deepend	Y	Y	y
Peter Tait	Deepend Canberra, Directions Health	Deepend	Y	Y	y
Dr Susan Boden	Narrabundah Family Medical Practice	Primary Care			
Dr Stephen Moulding	Narrabundah Family Medical Practice	Primary Care			
Erin Barry	Youth Coalition of the ACT	Consumer / Peak		Y	
Anne-Marie Svoboda	GP Liaison Unit Canberra Health Services	Canberra Health S	Y		
Darlene Cox	Health Care Consumers Association	Consumer / Peak	A	Y	
Joo-Inn Chew	Deepend Canberra	Deepend	Y	A	
Bernadette Simonsen	Interchange Health Co-operative	Primary Care	A	Y	
Louise Stone	ANU	Deepend	Y		
Tom Skelton	Meridian	Primary Care	Y	A	
Katie McKenzie	Canberra Health Services - MHJHADS	Canberra Health S	Y	Y	y
Kalvinder Bains	Canberra Health Services - MHJHADS	Canberra Health S			
Azra Sabir	Canberra Health Services	Canberra Health S			
Shaun Bayliss	Canberra Health Services	Canberra Health S			
Dr Jane Laloma	Meridian	Primary Care	Y	Y	y
Melinda Choy	ACT Health	Canberra Health S		Y	
Pete Podolski	Canberra Health Services - MHJHADS	Canberra Health S		Y	
Stephanie Lentern	Capital Health Network	Capital Health Network	Y	Y	y
Anais LaGall	Capital Health Network	Capital Health Network	Y		
Mike Hall	NCH ED	Canberra Health S	Y		
Emily Jehne	Interchange / Justice Health	Primary Care		Y	
Chris Ward	MHF ACT	Consumer / Peak		Y	
Camille Falkiner	Office of the Chief Psychiatrist	Canberra Health S			
Monica Upward-Garcia	ACT Health Directorate	Canberra Health S			
Erin Stewart	Mental Health Community Coalition ACT	Consumer / Peak		Y	
Josephynn Tran	Meridian	Primary Care		Y	
Elizabeth Moore	Canberra Health Services	Canberra Health S	Y		
Dinesh Arya	Canberra Health Services	Canberra Health S			
Melanie Poole	Mental Health Community Coalition ACT	Consumer / Peak			
Participant numbers:			16	18	8

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