Dr Stefanie Roth,

Submission:

‘Adding a Person-Centred (People-Oriented) Model of Care to the Stepped Model of Care’ - and ‘Comments and Suggested Changes to Recommendations and Findings’

Dear Ms Abramson, Prof King and Prof Whiteford

Thank you for the opportunity of participating in the hearing in Brisbane. Conducting a ‘road show’ of this calibre demonstrates your genuine interest in our views and gives me hope that changes to the Mental Health System are more likely than ever before. I appreciated the warm, open and informal atmosphere at the hearing (and would like to apologise for my often unfinished sentences).

As indicated at the hearing, I will attempt to provide a clearer description of the person-centred model of care that I tried to describe using ‘mentos’-lollies and pens in the hearing in Brisbane.

Yours sincerely

Stefanie Roth

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Introduction – The need to add a person-centred model to the stepped care model

Following a discussion about introducing a social and emotional model (Mind Australia) and relational recovery (Tandem Inc.) on the first hearing day in Melbourne, Professor King commented and asked the following questions:

"*Yes. That's fine. Thank you. So I'll ask you the same question as we've asked some others in this situation. What would you want us then to recommend to the government to do? So not a statement about, well - along the lines, you know - because* ***we all recognise families, friends, carers, are all critical for what we see as the consumer-centred approach to mental health care****. We certainly don't see, and I presume you're not suggesting, there's a conflict there. There's just understanding. You have the* ***consumer at the centre****, and then you have the* ***support network*** *around the centre, and you have the other* ***psychosocial supports*** *as well as the* ***clinical supports****. But if we've got things wrong, or we haven't gone far enough,* ***exactly what would you like us to recommend the government to do***?" (Melbourne, 18/11/2019, my highlighting)

My quick answer: We would like you to recommend a ***truly*** person-centred, people- and consumer-oriented system that does not confuse the '*Whole-of-System'-oriented* 'stepped model of care' with an *Individual-oriented or 'Part-of-System'-oriented* 'person-centred model of care'.

Shared goal: People-oriented, person-centred and consumer-oriented approach[1]

Chapter 4.1 includes: "*In formulating draft recommendations that respond to the terms of reference, the Commission's overarching goal has been advancing reform towards the creation of a people-oriented mental health system. This includes both a healthcare system that places at its centre the needs of the consumers of its services, and ensuring that all other relevant systems focus on addressing people's needs and supporting their mental health and wellbeing*."

And the report does suggest a people-oriented, person-centred and consumer-oriented approach. This is expressed in (but might not be limited to) the following aspects:

- putting the consumer, their carers, their family, their kinship group at the centre;
- initiating a cultural shift leading to person-centred care that accommodates individual needs;
- providing person-centred services that take into account their lived experience;
- consumers accepting their treatment;
- coordination in relation to treating co-morbidities;
- collaboration between clinical and non-clinical staff, the consumers and their support systems;
- responsiveness - services should reflect the preferences of consumers, their families and carers, and be delivered in ways that are sensitive to consumers' cultural backgrounds.

Consumer experience "still far from this goal".

In sub-chapter "*Filling the gaps in existing services*" of Chapter 4.1, we find: "*The concept of stepped care, where the level and type of care matches individual needs at any particular time, is not new. The Primary Health Network guidance document, produced by the Australian Government's Department of Health (DoH 2016b, p. 2) defines stepped care as 'an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most*

[1] I understand that the terms ‚people-oriented', ‚person-centred' and ‚consumer-oriented' are used as synonyms in the Draft Report. I am using them here accordingly.

intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as one directional steps, but rather offer a spectrum of service interventions.' Despite ongoing attempts at implementing a stepped care model, the consumer experience reflects a system that is ***still far from this goal***. (My highlighting) I think we all share this aspiration – but also the observation of not having achieved it yet; hence, I am proposing the following recommendation:

Recommendation: Add a person-centred model of care to the stepped model of care!

What a Person-Centred Model should look like

Obviously, a person-centred model needs to put the person (or persons) at the centre: ie the person seeking help and the service provider providing help. If the consumer is living with family and friends or they are closely involved in care, the carer needs to be included as well. Several publications[2] recommend the term 'triangle of care' for this constellation.

In this constellation, it would be adequate that a clinician (GP, Psychiatrist, Psychologist), the 'consumer' and if available, their relatives and/or friends who care about them at first encounter explore with the consumer what happened, how they feel, what the issue is etc. in an empathic, patient and compassionate manner.

In this context many aspects of a 'human being' need to be explored, such as their brain. The brain seems to be of most interest to psychiatrists, coming from the disease or medical paradigm, because they have great knowledge on how to influence it with medication. Also of interest, however, are the person's mind, their thoughts, their feelings, their behaviours, their words, if they are to be treated as a 'human being'. These aspects are of greatest interest to the person themselves and to the persons they interact with in order to conduct everyday life in a social setting including housing, food, health, wellbeing, employment. This is where the support of family and friends, work colleagues, sports mates, support workers, case workers, counsellors, psychologists comes into play.

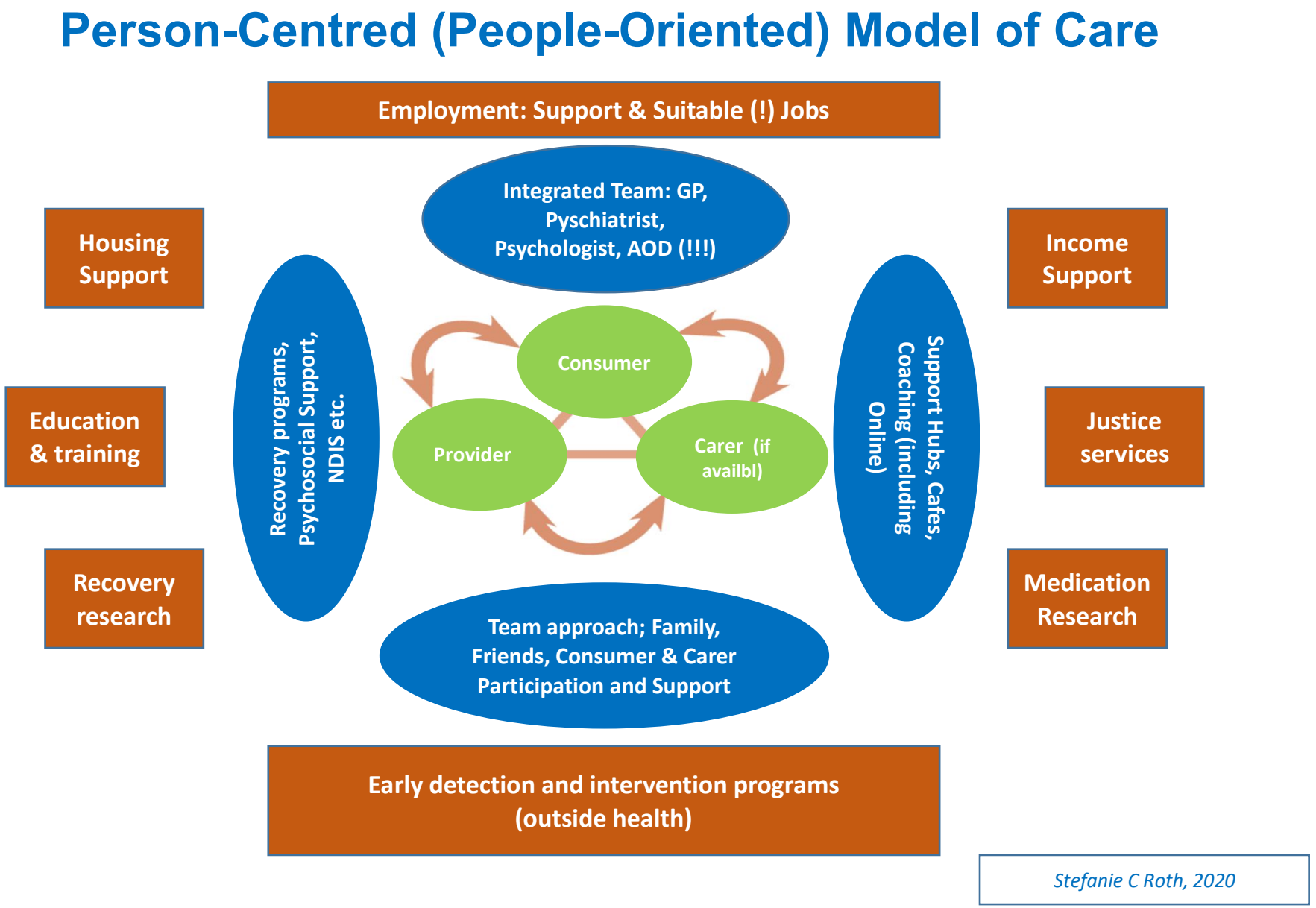
From the first encounters between service provider and person seeking help, all kinds of interventions need to be devised in line with ***true individual needs assessment***, not just those that are mentioned in the stepped model of care. Some of these types of interventions have been mentioned in the hearings and submissions and could be:

- Counselling, Coaching and Psychotherapy
- Open Dialogue
- Assertive Community Treatment
- LEAP (Listen, Empathise, Agree and Partner)
- Many more…

Care plans and Care coordination, as suggested in the Draft Report, will have to take their starting point from this individual needs assessment and then take the broader societal context (housing, employment, income etc.) into account. Figure 1 further illustrates this model of care:

[2] Refer
https://mhaustralia.org/sites/default/files/docs/a_practical_guide_for_working_with_carers_of_people_with_a_mental_illness_february.pdf
Worthington, A, Rooney, P, Hannan, R 2013, *The Triangle of Care, Carers Included: A Guide to Best Practice in Mental Health Care in England, Second Edition, 2013,* Carers Trust, London. The Carers Trust is acknowledged as the copyright holder of the concept.

Figure 1: Person-Centred (People-Oriented) Model of Care



Why is the Mental Health System "still far" from a person-centred experience?

While aiming towards providing a person-centred mental health system, the stepped model of care is bound to fail because:

- It is conceived from a 'Whole-of-System' - level perspective; and
- It follows the medical or clinical disease paradigm; and
- Plainly: "steps" are made up of squares whereas "centres" are made up of circles or spirals.

Stepped Model of Care and Person-Centred Model – Different System Perspectives

The ***stepped model of care*** has a ***'whole-of-system' perspective*** – not surprisingly, because it is used for resource planning and government policy. It asks ***quantitative*** questions like: "How much money for which services?" "How many people need to access these services?" "How many positions do we need?" Etc. Qualitative questions like "What kind of psychosocial support, what are the specific needs of this consumer etc." have to be second order issues in a 'whole-of-system'-perspective. Hence, they have to be addressed at the individual level by the local service provider who should follow a person-centred model.

The ***person-centred (people-oriented) perspective*** has a ***'part-of-the-system'-perspective***. It puts the recipient of Mental Health Services and their interactions with providers and carers (or relatives and friends) in the centre of the model. From there it asks ***qualitative*** questions like "What kind of integrated clinicians do you need? What kind of psychosocial support, what kind of therapies and/or programs? How can we best work in a team with your supports? How can we ensure longevity of relationships? What broader societal supports such as housing, employment etc. do you and the people who support you need?" Quantitative aspects are important, but are assumed to have been solved under the 'whole-of-system'-perspective. They must form the basis for the person-centred perspective to work and for providing "wrap around" services. (Hence the 'building blocks of a people-oriented mental health system' provided in the Draft Report (refer Figure 4.2 in the Draft Report, provided in Attachment 1) don't cut it for being truly person-centred!)

(In the ***Brisbane hearing*** I pointed to the analogy of the stepped care model representing the ***macroeconomic*** perspective, while a person-centred model needs to represent the micro-economic perspective. The ***microeconomic*** level is where the 'production of goods' happens, - transferred to the mental health space this means: this is the level where the 'production of healing' needs to happen. However, this can only happen if qualitative questions become the centre of concern at the individual (or 'part-of-the-system'-) perspective.

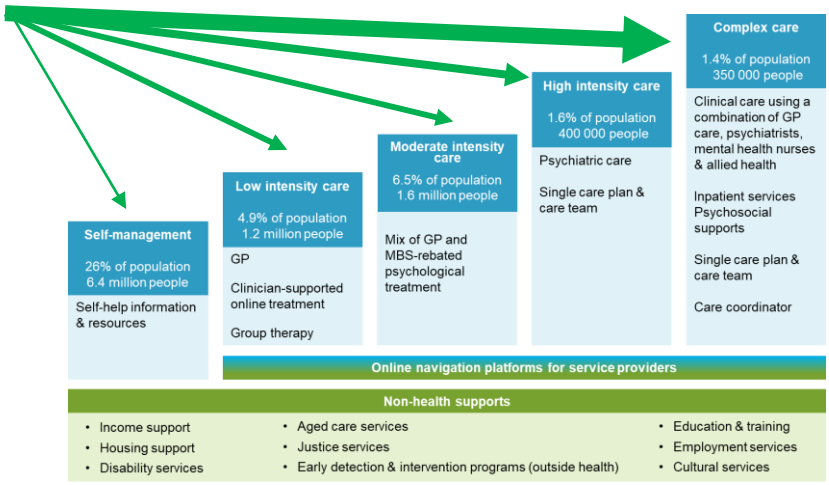
The difference of the 'whole-of-system' and 'part-of-system'- perspectives are represented in the following figure:

Figure 2: Two Models of Care – two different system perspectives

'Whole-of-System' Perspective - Mostly Quantitative – top down:

- How much funding?
- How much demand?
- How much of what kind of services?

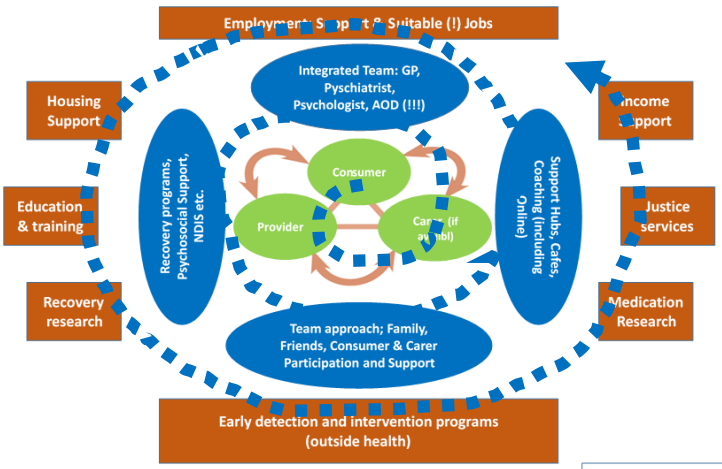
Stepped Model of Care



'Part-of-System' Perspective – Mostly Qualitative – wrap around:

- What are the issues?
- What kind of care, treatment support do you need?
- How can we best help you to reach your potential?

Person-Centred (People-Oriented) Model of Care



Stepped Model of Care and Person-Centred Model – Different Paradigms

The draft report promotes a cultural change in the Mental Health System. Many submissions (before the draft report was issued) suggested a paradigm change. Many commentators - as emerged during the hearings - believe that a cultural change will only be possible if a person-centred model of care is added to the stepped care model. (Actually, I don't think cultural change will automatically follow from introducing, implementing, operationalising and adhering to a person-centred model of care, but the likelihood will be much higher. Without it, we won't have a chance.)

Shifting the paradigm from the medical (or disease) to the mental health paradigm – as presented in Figure 3 - could mean for a more appropriate language to be practised by replacing

- "Disorder" with "Illness";
- the question "What's wrong with you?" with "What happened?";
- the term "Disability" with "Recovery",

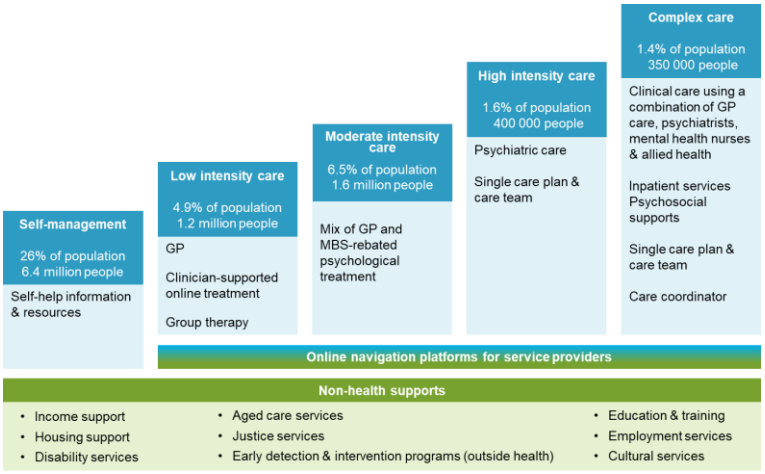
- “Services” with “Relationships”;
- “Provision of Information” with “Provision of Emotional Support”;
- “Problem solving” with “Sustainably coping with ongoing distress”;
- “Risk management” with “Health Care”
- etc.

Figure 3: Two Models of Care – two different paradigms?

‘Medical’ or ‘Disease’ Paradigm

1. What’s wrong with you?
2. Disorder
3. Fixing with medication
4. Disability
5. Services
6. Information
7. Problem solving
8. Risk management
9. Etc.

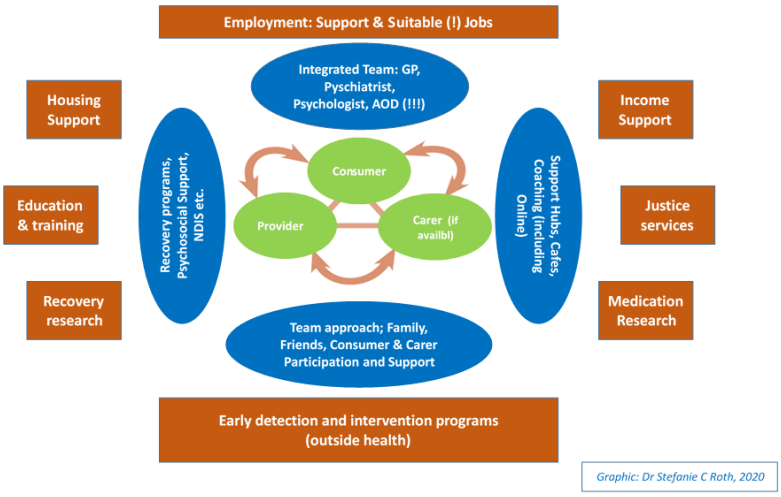
Stepped Model of Care



Recovery Paradigm:

1. What happened?
2. Illness
3. Healing through a variety of approaches
4. Recovery
5. Relationships
6. Emotional Support
7. Sustainably coping with ongoing distress
8. Health Care
9. Etc.

Person-Centred (People-Oriented) Model of Care



Stepped model of care and individual needs assessment

When searching for guidance on individuals’ needs assessments within the stepped model of care, I did not find anything about how these needs are assessed *from an individual perspective*. The stepped model of care *claims* to match needs, but on which evidence base?

The publications about the stepped care model are written from a system oriented perspective. They talk about funding and level of care. They ***assume*** individual needs based on already developed medical treatment and care service models that will be assigned towards the particular individual who is seeking help.

The stepped model of care views needs from a system or population or community perspective: eg "What level of care is needed (eg online, GP, expert etc.)?" and "How much of this care is needed?" It is based on pre-conceived – and practised and researched – concepts about what level and type of care certain clusters of individuals with a particular diagnosis need– nothing wrong with that! However, it does not start with the question of what a particular individual needs, hence it cannot claim that it provides for person-centred needs assessment.

Building a Holistic Mental Health System needs both perspectives: Adding the person-centred perspective to the system perspective

As eluded to above, the model of stepped care reflects the whole-of-system or top-down perspective. It talks about problem identification expressed in intensity of care needed, types of care to be offered and hence, funding needed for offering these types of care. Not surprisingly, this model builds on years of 'problem definition' through science and practical treatment and wants to channel this knowledge and hence the service streams towards the consumer.

This channelling of science and knowledge outcomes as services towards the consumer has been happening for many years with some success, however, it also transpires that despite a plethora of reviews and changes, there are still shortcomings in the system. This could stem from the failure to reflect on the 'part-of-the-system' or bottom up perspective.

From the perspective of the person, every person's problem is different from the other person's problem. ***So, what a person-centred system needs, is: identifying the problem in collaboration with the person to be treated in order to find the best solution***. A therapeutic conversation needs to take place.

This means that the person needs to be heard. This could be in a crisis call with lifeline, or when talking with their family and friends or – most importantly for treatment – with their psychiatrist and/or psychologist and other psychosocial supports. (Alas, my 'consumer'-relative has never met a psychologist on the ward in their six admissions, nor in the community mental health service during the last three years of the five years they have been in treatment).

For a particular individual, their issues with mind, thoughts, feelings, words, behaviours, including in social interactions seem to be completely special and specific and different to other's problems.

However, the 'expert' listening to them will - in their trained mind - see patterns: diagnoses, treatment options, care options etc. This is where the 'top-down' perspective comes in providing treatment and therapy or referrals.

Consequently, building a system, needs to reconcile both perspectives: the 'whole-of-system' and the individual 'part-of-the-system'- perspective; ie the specific, the unique, the individual with the general, the science, the treatment typology, the services. What we are lacking currently, is the 'human perspective' that comes with treating 'consumers' as human beings through a person-centred model of care.

What other commentators say about adding a person-centred perspective

Despite the intention of initiating a 'cultural shift', *the* ***report is perceived as falling short in providing a people- and consumer-oriented and person-centred system***. This was expressed in the hearings, of which I am presenting some key aspects in the following:

Mind Australia highlights that the report needs more emphasis on a ***social and emotional model of mental health***:
*"And finally, the social and emotional model of mental health. The final report must provide a greater focus on the social and emotional model of mental health which strongly considers that social and economic determinants, and the relational aspects of mental health, are crucial to recovery. A social and emotional model of mental health would place a person at the centre of their supports with a greater focus on the wellbeing of their most important interpersonal, day-to-day relationships." (*Robyn Hunter, Melbourne, 18/11/2019*)*

Tandem Inc talk about ***relational recovery***, ***interdependence*** and the need for ***human contact***.
"*First of all, understanding what relational recovery means. That it's time to move from the individualistic model of recovery to one that's relational. So it talks about interdependence. (…)*
And so, in order to support families, you need to provide them with support in their own right so they understand the experience. (…) That it's about all of the things that, I guess, contribute to a meaningful life, and that means that people are able to access all sorts of modalities. (…)
(…) people want human contact. They want to be able to sit with someone when they're distressed and actually talk through and work through what the issues are." (Marie Piu, Melbourne 18/11/2019)

Mental Illness Fellowship of Australia suggest an "***ecological model – person centred model***" to be added to the stepped care model that works for planning purposes on a systemic level; refer:
"*The five steps, the characterisation of people's complexity of mental health issues and other issues is very helpful for planning purposes at a systemic level. (…).*
So for planning purposes it is a great model. But it's not a model for understanding how a person gets access to the system. That has to be an ecological model – person centred model and there are many around but that is not currently in the report. A person centred model, the person at the centre, their family and friends and so on around them – well initially their strengths and resilience and capabilities, family and friends, you have then their interaction with psychosocial support services or clinical services, and with specific community services that will support people with mental health issues, housing, employment, justice, all of those. Then just the general community itself, access to sporting clubs and other activities of interest." (Tony Stevenson, Brisbane 3/12/2019)

'Person-Centred' versus 'Consumer-Centred'? - Stigma not the sole barrier to seeking help

There is a risk that people who do not seek help, are being left out of a 'consumer-oriented' system. A ***consumer*** is defined as someone who ***purchases goods and services*** for personal use. However, it is estimated that ***54% of people*** with mental illness do not seek help[3], ie ***do not demand*** '***services***' from the Mental Health System.

[3] Refer Whiteford HA, Buckingham WJ, Harris MG, et al. Estimating treatment rates for mental disorders in Australia. Australian Health Review 2014; 38(1): pp. 80-85. Quoted in Submission 343 to this Inquiry.

Building a ‘consumer-oriented’ system runs the risk that people who do not seek help are left out.

So, ***why do people with mental health issues not seek help***? It appears that ***stigma*** is seen as the sole barrier to seeking help in the draft report. I ***disagree***, there are more reasons!

In my submission 164, I raised the point that ***mental illness itself puts up barriers to help seeking***. If a person believes that there is no hope und that nothing will change, they will not find the motivation to initiate change. Hence, they won’t be able to ‘demand’ services but need to gently be introduced to the idea that change is possible.

In their submission 343 Mental Illness Fellowship of Australia also list more barriers than stigma, such as

- lack of trust in service systems due to previous poor experience with services;
- functional impairments in psychosocial disability, which can include confused thinking, delusions and paranoia, or lack of awareness of their own condition;
- the burden of stigma, shame and fear of disclosure in the context of mental illness;
- difficulties with literacy, concentration and appointment-keeping, which may affect a person’s ability to engage with services; and
- the impact of the disability symptoms themselves, such that those with anxiety and trauma may require significant support to attend appointments where they are exposed to strangers and may feel threatened, judged or vulnerable.

***Recommendation: A truly person-centred Mental Health System should include these considerations and develop adequate recommendations to address and research (!) these barriers <u>in addition</u> to addressing the acknowledged ‘stigma’-barrier*.**

Aspirations versus Requirements – Lack of Person-‘Centricity’ Evidence

Professor Copolov, in the Melbourne hearing, observed “*a lot of what is happening both with the National Mental Health Service Planning Framework and the like are expectations, goals and aspirations and we actually think there should be more in the terms of requirements*”. (David Copolov, Melbourne 18/11/2019)

This sentiment aligns with a presentation I gave at the Leading Reform Summit 2019 in Brisbane (refer Figure 4) , where I shared my observation that there seems to be a growing pile of documents including Plans, Standards, Guidelines, Reviews, Inquiries, Reports on all Government levels that express the aspiration of a person-centred (people-oriented) system, yet my own experience and the experience in the carer support groups is that we do not find *Evidence* of person-centred practice. It feels almost as if documents “breed documents”.

Figure 4: Carers' Lived Experience of Absence of Person-Centred Practice

Not only governments but also we carer and consumer representatives produce statements, reviews, briefing notes over statements, reviews and briefing notes etc., on the one hand saying that services are person-centred and on the other hand saying that they need to be person-centred. **Yet words – as we all know – need to be followed by deeds to make practice happen!**

Recommendation: In reforming the Mental Health System rely less on aspirations, goals and expectations and build in monitored qualitative effective requirements.

I base my judgement regarding lack of person-centricity on the following recent personal experience with a service that claims to put people first (Refer Figure 5):

Figure 5: Evidence for Aspiration of Person- Centricity

I don't doubt their good intentions, it is the devil in the detail that makes people-centricity fail; for example the following people-'disregarding' issues were experienced between October 2019 and January 2020:

- Three letters remained unanswered; (receipt was acknowledged in one case after chasing the recipient via phone and in another case verbally);
- No direct call line to case worker or treating doctor; consumers always have to go through reception or after hours call line – how do they then develop a *healing relationship*?;
- Letter received "out of the blue" advising about a 'requested' appointment (that had never been requested by either consumer or carer) at a certain date and time, no human signature provided, only with a signature block of 'Executive Director' of respective Health Service – ie absolutely impersonal computer generated letter, with the 'high departmental level' signature block even raising anxiety about why the Executive Director is writing; (Proof of this can be provided on request)
- Community health service closed over the Christmas and New Year weeks; - this is one of the worst parts of the year for a mentally ill person; they dread to go to hospital, yet Emergency or the Psychiatric ward would be the only option;
- 18 Minutes wait time (proof can be provided on request) on the phone to the health service which transferred to the out-of-hours line because of the holiday period closure (refer above); - in this case, we only wanted information about a meeting time, but imagine this happens to a person in distress!
- Case worker on leave for 4 weeks over this risky period with no backfill nominated;
- While in psychiatric hospital care, no planned family meetings (meetings adhoc and unprepared); and no shared release plan or release meeting – just a phone-call with "they said, you can pick me up now".

Culture Change needed – "Melt the Iceberg of systemic failure"

In the 'Key Points' of the Draft Report, the commission states that "*Changes recommended are substantial*". I think there is ample agreement amongst those who participate in this inquiry that *substantial* changes are needed. I have developed a graphic that illustrates what these substantial changes, I believe, need to look like in order to bring a culture change to the system that ensures practical person-centricity. (Refer figure 6)

The following Graphic 'Mental Health System Cultural Change: "Melt the Iceberg of systemic failure!" ' shows an Iceberg. This metaphor is used because we know that the part of Icebergs above water usually is much smaller than the part below water.

In the following graphic the part above water depicts elements of current mental health system change efforts. The dollar signs illustrate that these are the system change activities that are funded – and hence supported.

The elements depicted below water are what is missing in the current system change efforts – hence many people still struggle or die – illustrated by the crosses.

The Message is that we need a change of Perspective:

From ….

- Risk Management
- FTE (Full Time Equivalent) Positions in Policy areas of Departments
- The Physical Disease or Medical Paradigm
- System focus

To ….

- Health Care
- FTE in Hospital and Health Services (the 'coal face')
- Mental Health Paradigm that see the human being
- Person focus

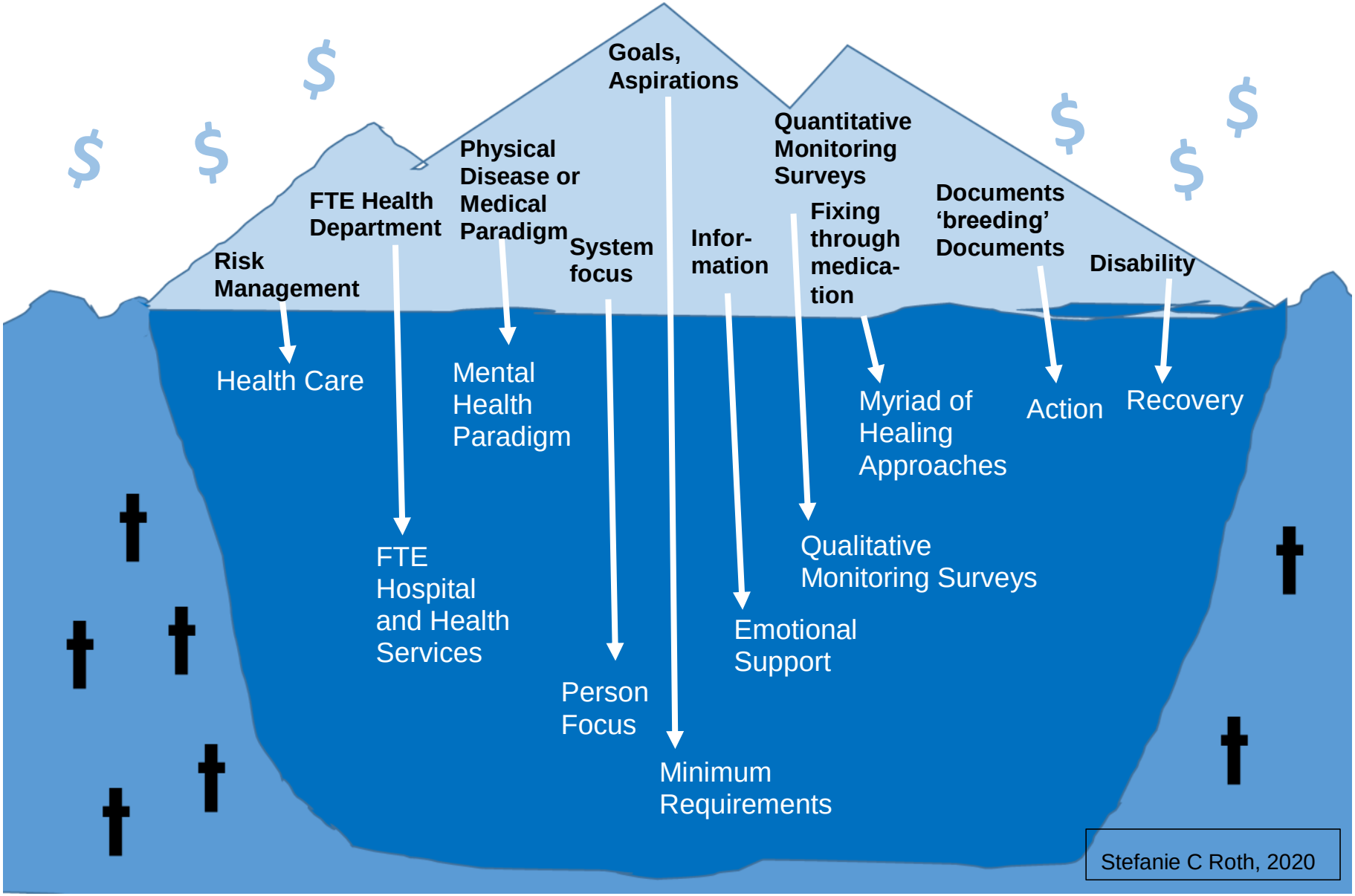
From ….

- Expressing Goals and Aspirations in multiple plans
- Providing Information
- Asking frustrating Level of care - questions in quantitative monitoring surveys
- ‘Fixing’-Approaches
- Producing more and more documents
- A Disability (Disorder) focus

To ….

- implementing minimum requirements
- Providing Emotional Support
- asking meaningful questions about the quality of Care in qualitative monitoring surveys
- ‘Healing’-Approaches
- Implementation and Action
- Recovery

Figure 6: Mental Health System Cultural Change: "Melt the Iceberg of Systemic Failure!"



Proposed Changes to Findings and Recommendations

My comments to findings and recommendations of the Draft Report and suggested changes are presented in red colour below. (Apologies for the confusing numbering which is taken from the draft report through 'cut and paste'.)

INFORMATION REQUEST 3.2 — OUT-OF-POCKET COSTS FOR MENTAL HEALTHCARE

We are seeking more information on the out-of-pocket costs of mental healthcare that consumers or their carers incur. We are interested in surveys that have been undertaken, particularly if they capture costs outside of the government funded healthcare system, such as estimates of the cost of travel to services, medications not covered by the Pharmaceutical Benefits Scheme and consultations outside the Medicare Benefits Schedule.

Comment: I know consumers who were not able to afford mental healthcare before the NDIS; based on their approved NDIS plan, they now can. I could imagine that a review of NDIS plans could provide an indication of out of pocket costs that consumers (and carers) occur.

DRAFT FINDING 5.1 — THE LINK-ME TRIAL MAY IMPROVE ASSESSMENT AND REFERRAL PRACTICES

The decision support tool, developed as part of the ongoing Link-me Trial, can improve GP assessment and referral practices by identifying the mental health needs of people going to the GP and providing the GP with tailored treatment recommendations.

The extent to which this tool leads to clinical benefits and cost savings relative to usual care, should be used to inform actions taken by governments and commissioning authorities (PHNs or RCAs) to ensure that consumers are matched with the level of care in line with the stepped care model that most suits their treatment need identified in line with the person-centred care model[4].

DRAFT RECOMMENDATION 5.1 — PSYCHIATRIC ADVICE TO GPs

In the medium term (over 2 – 5 years)

The Australian Government should introduce an MBS item for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP. The effectiveness of the new item should be evaluated after several years.

Comment: The above recommendation is based on the assumption that the GP is the sole entry point for consumers into the Mental Health System. In our experience this is not always the case. Consumers might enter into the system through presentation to Emergency in a situation of psychosis. After release, they often don't see the need of maintaining a relationship with a GP because they feel "not sick". How is this issue being addressed through the recommendations in the Draft Report?

[4] Please note chapters above regarding the introduction of a person-centred (people-oriented) care model.

DRAFT RECOMMENDATION 5.2 — ASSESSMENT AND REFERRAL PRACTICES IN LINE WITH CONSUMER TREATMENT NEEDS

In the short term (in the next 2 years)

Commissioning agencies (PHNs or RCAs) should define and promote best-practice in initial assessment ~~and referral~~ of consumer (and if available carer) needs for mental healthcare, to help GPs and other referrers match consumers with the level of care as described in the stepped care model that most suits their treatment needs identified in line with the person-centred care model.

Best practice is to be further defined as a set of requirements (in line with Prof Copolov's comments made in the Melbourne hearing) and could mean the following:

'Treatment and recovery needs are to be established in processes of communication between service provider, consumer and (if available) carer based on active listening, empathy, unconditional positive regard, compassion and in good therapeutic alliance with the view of reaching partnering agreements on treatment and recovery perspectives and if possible plans. An adequate communication model will need to be developed to ensure this because in our experience clinical psychiatric staff are not trained in this adequately. This communication model can be based on examples like the CFRED (Connect, Focus, Relieve distress, Enable coping, Decide next steps) model and/or the CARE (Connect, Attend to needs, Reconfirm, Empower) framework used by Lifeline Australia and/or the LEAP (Listen, Empathise, Agree, Partner) approach promoted by the LEAP Foundation and initiated by Dr Xavier Amador[5]. '

(These are only suggestions of course, other communication models might suit as well.)

In the medium term (over 2 – 5 years)

Commissioning agencies (PHNs or RCAs) should establish mechanisms for monitoring the use of services that they fund to ensure that consumers (and if available carers) are receiving ~~the right level of care~~ the quantity and quality of service agreed in the initial person-centred needs assessment. If service use is not consistent with estimated service demand, commissioning agencies may need to make changes to initial assessment and referral systems (or work with providers to do so).

DRAFT RECOMMENDATION 5.9 — ENSURE ACCESS TO THE RIGHT LEVEL OF CARE

The Australian, State and Territory Governments should reconfigure the mental health system to give all Australians access to mental healthcare, at a level of care in line with the stepped care model that most suits their treatment needs identified in line with the person-centred care model, and that is timely and culturally appropriate.

[5] Further information on this can be found in my initial submission 164 to this inquiry.

DRAFT RECOMMENDATION 5.8 — INCREASE CONSUMER CHOICE WITH REFERRALS

In the short term (in the next 2 years)

The Australian Government should amend the MBS regulations for referrals to require:

- that general practitioners and other referrers advise people that they can use an alternative to any provider mentioned in a referral to a specialist or allied health professional
- that all referrals to specialists and allied health professionals include a prominent and easy to understand statement advising people that they can use an alternative to any provider mentioned in the referral.

Comment: above recommendation is supported, however, it does not fully address the problems.

In my experience, consumers decline referrals for services that might help them. The result is more strain on families and relatives (ie carers). If the treating clinician had entered into an empathic and compassionate communication when first meeting the client instead of offering a referral, some healing could have been initiated. It should be part of 'best practice' that more of a healing effort is made at first contact. A person-centred approach would cater for this. (I'd be happy to elaborate on this, if needed. Give me a call!)

DRAFT RECOMMENDATION 5.5 — ENCOURAGE MORE GROUP PSYCHOLOGICAL THERAPY

Changes should be made to MBS rules to encourage more group therapy.

In the short term (in the next 2 years)

- The Australian Government should change MBS rules so that group therapy is allowed with a minimum of 4 people (instead of 6 people), and with less than 4 people, as long as the course of group therapy began with at least 4 in the group.
- The Australian Government should create new Medicare items for group sessions that run for 'at least 90 minutes' and 'at least 120 minutes'.
- The Australian Government should clarify — and communicate with referrers and providers — that unless explicitly stated otherwise, referrals for MBS-rebated Psychological Therapy Services and Focused Psychological Strategies can be used for either group therapy or individual therapy — at the discretion of the psychological therapist receiving the referral after discussion with the consumer.

Comment: Counselling and Coaching should be added into MBS.

DRAFT FINDING 5.2 — THE EFFECTIVENESS OF MBS-REBATED PSYCHOLOGICAL THERAPY

Despite evidence for the clinical effectiveness of psychological therapy, there is no well-resourced and rigorous evaluation of the effectiveness of MBS-rebated psychological therapy (Psychological Therapy Services and Focused Psychological Strategies).

DRAFT FINDING 5.2 — THE EFFECTIVENESS OF MBS-REBATED PSYCHOLOGICAL THERAPY

The clinical evidence suggests that of those people with mental illness *who are best treated* through individual face-to-face psychological therapy, most need more than 10 sessions (the current MBS limit) for their condition to significantly improve.

More flexibility around the number of rebated sessions available per year would mean more people with mental illness could get the treatment they need, but this would need to be trialled.

Comment: This observation aligns with carer experiences.

DRAFT RECOMMENDATION 5.4 — MBS-REBATED PSYCHOLOGICAL THERAPY

MBS-rebated psychological therapy should be evaluated, and additional sessions trialled.

In the short term (in the next 2 years)

The Australian Government should commission an evaluation of the effectiveness of MBS-rebated psychological therapy. As part of this evaluation, the Australian Government should undertake trials allowing up to 20 sessions of individual or group therapy in total over a year for consumers whose clinical condition requires more than the current 10 sessions. The trials should allow a GP to re-refer a consumer after the first 10 sessions rather than the present 6 sessions.

The Australian Government should change the MBS so that the maximum number of sessions of MBS-rebated psychological therapy (Psychological Therapy Services and Focused Psychological Strategies) is per 12-month period, as opposed to per calendar year.

In the medium term (over 2 – 5 years)

Based on the results of these trials and evaluation, the Australian Government should determine whether to:

- roll out the trialled changes above
- continue funding psychological therapy through the MBS, or whether some other mechanism is more appropriate
- make any other changes to increase the effectiveness of MBS-rebated psychological therapy.

Comment: This recommendation makes sense. However, it does not address the issue that people with schizophrenia for example are not 'assertively' referred to therapy as the guideline recommends. Refer https://www.yourhealthinmind.org/mental-illnesses-disorders/schizophrenia/treatment

DRAFT RECOMMENDATION 7.1 — PLANNING REGIONAL HOSPITAL AND COMMUNITY MENTAL HEALTH SERVICES

In the short term (in the next 2 years)

State and Territory Governments should determine, through regional service planning, the numbers of public acute mental health beds in hospitals, specialist mental health community

DRAFT RECOMMENDATION 7.1 — PLANNING REGIONAL HOSPITAL AND COMMUNITY MENTAL HEALTH SERVICES

treatment services and subacute/non-acute mental health bed-based services that would meet the specific needs of each region and undertake to provide these on an ongoing basis.

Comment: How will the needs be established from a person-centred perspective – if not through the person-centred model of care presented above? Also: Many hospital admissions could be avoided if there were alternatives. Carer meetings often share experiences when carers urged their loved ones to go to hospital or took them themselves, only to be sent home, without any support. This creates the impression that hospitals do not know what to do with certain cases like suicide attempts, self-harm etc. If there were other options created under a person-centred care model (including compassionate trauma informed treatment etc.), the costly hospital system could be avoided. This should be integrated into above recommendation.

DRAFT RECOMMENDATION 8.1 — IMPROVE EMERGENCY MENTAL HEALTH SERVICE EXPERIENCES

In the short term (in the next 2 years)

- State and Territory Governments should provide more and improved alternatives (YES!!) to hospital emergency departments for people with acute mental illness, including peer- and clinician-led after-hours services and mobile crisis services.
- State and Territory Governments should consider best practice approaches to providing paramedics with access to mental health resources when undertaking medical assessments in the field.
- Public and private hospitals should take steps to improve the emergency department experience they provide for people with a mental illness. This could include providing separate spaces for people with mental illness, or otherwise creating an environment more suitable to their needs.

In the long term (over 5 – 10 years)

- State and Territory Governments should, when building or renovating emergency departments, design them to take account of the needs of people with mental illness.

Comment: The Director of the Hospital and Health Service (HHS) in my catchment area says that they are only funded to 60%. It looks like Health Departments put positions into policy and plan development to produce person-centred words instead of putting them in the HHS to ensure person-centred practice!

DRAFT RECOMMENDATION 10.1 — CONSUMER ASSISTANCE PHONE LINES

Assistance phone lines offering support for people with mental ill-health and their carers should facilitate better exchanges of information between service providers.

In the medium term (over 2 – 5 years)

- In its funding contract with existing assistance phone lines, the Australian Government should require providers to implement timely referral processes that minimise the need for consumers to repeat information.
- The phone line that will be part of the Australian Government's mental health portal, Head to Health, should use a similar approach to referrals. The range of services listed on Head to Health should be expanded. The Australian Government can also consider funding an advertising campaign, to raise community awareness of the phone line and the online portal.

Comment: Above recommendation has a 'Whole-of-System'-influenced understanding of "assistance phone lines". Most of these phone lines do not provide "information" as such. They provide emotional support. That is different to just information and referral. This links to what is said about the need for a person-centred model, practised for example at Lifeline and others.

DRAFT RECOMMENDATION 10.2 — ONLINE NAVIGATION PLATFORMS TO SUPPORT REFERRAL PATHWAYS

Commissioning agencies should ensure service providers have access to online navigation platforms offering information on pathways in the mental health system.

In the short term (in the next 2 years)

- All commissioning agencies (PHNs or RCAs) should, either individually or collaboratively, develop and maintain an online navigation platform, including detailed mental health referral pathways. The HealthPathways portal model, which is already used by most PHNs, can be used to contain this information.
- Access to these platforms should be expanded beyond health, in particular to schools and psychosocial service providers. Each commissioning agency should also, either individually or collaboratively, fund a small dedicated team supporting the users of the online platform.

In the medium term (over 2 – 5 years)

- All online navigation platforms should incorporate the ability to book consultations with service providers directly from the platform.

Comment: A Mental Health Official in a Conference once said: "We do not treat people, we just refer them on." For us carers, it often feels like our loved ones are being referred on and on until they drop out of the system again into our care, even though we are often the ones who are ignored by the MH System for our care in the first place. In relation to the above recommendation: The point can't be to make referral pathways more efficient, but to make the treatment (that these pathways lead to) more effective!

DRAFT RECOMMENDATION 10.3 — SINGLE CARE PLANS FOR SOME CONSUMERS

Governments should support the development of single care plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers in collaboration with carers (if available).

In the medium term (over 2 – 5 years)

The Department of Health should:

- Develop, ~~and~~ promote and implement protocols for developing single care plans in collaboration with consumers (and if available carers) based on the implementation of the triangle of care and a partnership approach between consumers, carers and mental health services. Single care plan protocols should ensure that communication and interaction modalities (refer Draft Recommendation 5.2) are implemented that empower and enable consumer to develop human agency for their recovery and enable service providers to support carers in their roles of empowering consumers in the recovery process. These protocols should include provisions for sharing consumer information between service providers, and allocating responsibility for plan development, follow-through and updating the consumer's primary treating clinician (unless otherwise agreed by their treating team).
- amend the MBS to include ~~a~~ specific items to compensate ~~a~~ clinicians for their time developing and overseeing a single care plan, including relevant meetings with consumers and carers (if available).

DRAFT RECOMMENDATION 10.4 — CARE COORDINATION SERVICES

All people with severe and persistent mental illness who require care coordination services due to their complex health and social needs should be receiving them. Governments should set a national benchmark for all commissioning authorities, to ensure such services are available and any gaps are addressed.

In the short term (in the next 2 years)

The Department of Health should:

- Based on the Triangle of Care – develop and implement best practice standards in collaboration with consumers and carers for what is going to be defined as a care coordination service for severe and complex mental illness including AOD comorbidity diagnoses. These standards need to ensure that consumer and carer needs are established through an appropriate communication model (refer Draft Recommendation 5.2). The Care Coordination service should ensure that communication and interaction modalities (refer Draft Recommendation 5.2) are implemented that empower and enable consumer to develop human agency for their recovery and enable service providers to support carers in their roles of empowering consumers in the recovery process. The success of this service depends on and should be measured on establishing effective therapeutic alliance and robust relationships with the consumer.

All commissioning authorities should:

- assess the number of people who require care coordination services in their region of responsibility through appropriate mapping activities – in collaboration with carers (if available) and current not-for-profit care and support providers - , and the extent to which they are already accessing effective care coordination through existing programs, including the National Disability Insurance Scheme (NDIS)
- streamline care coordination arrangements from a person centred care perspective in collaboration with consumers and carers (if available) and ensure that people with a severe and persistent mental illness and complex needs requiring support from multiple agencies have access to effective care coordination.

In the medium term (over 2 – 5 years)

All commissioning agencies should ensure that care coordination programs are available to match local needs, including for those people with severe and persistent mental illness and complex needs who do not qualify for the NDIS, and people with severe mental illness who require care coordination only for brief periods of time in line with agreed efficacy benchmarks.

DRAFT RECOMMENDATION 13.3 — FAMILY-FOCUSED AND CARER-INCLUSIVE PRACTICE

Family-focused and carer-inclusive care requires mental health services to consider family members' and carers' needs and their role in contributing to the mental health of consumers and their recovery process.

In the short term (in the next 2 years)

- The Carer Experience Survey questions should be updated in collaboration with consumers and carers to include question relating to the quality and efficacy of treatment and care, including consumer and carer needs assessment, relational recovery strategies and therapeutic alliance.
- Where this is not already occurring, State and Territory Government mental health services should routinely collect responses to the updated Carer Experience Survey. The data collected should be sufficient for each Local Hospital Network to compare and assess the level of carer-inclusive practice across its services and the efficacy of care towards achieving relational recovery outcomes.
- The Australian Institute of Health and Welfare should use the data to report publicly on survey take-up rates and survey results, including in relation to recovery outcomes achieved by the mental health system, at the state and territory level.

In the medium term (over 2 – 5 years)

- To improve outcomes for children of parents with mental illness, the National Mental Health Commission should commission a trial and evaluation of the efficacy of employing dedicated staff to facilitate family-focused practice in State and Territory Government mental health services.
- The Australian Government should amend the MBS so that psychologists and other allied health professionals are subsidised:
  - to provide family and couple therapy, where one or more members of the family/couple is experiencing mental illness. These sessions should count towards session limits for psychological therapy
  - for consultations with carers and family members without the care recipient present. Consistent with existing items that are available to psychiatrists, there should be a limit of four subsidised consultations with carers and family members per 12 month period unless recovery benchmarks cannot be achieved.

DRAFT FINDING 16.2 — POLICE RESPONSES RELY ON COMMUNITY MENTAL HEALTH SERVICES

The effectiveness of police responses to mental health related incidents relies heavily on mental health services being available in the community. Police responses are limited by a 'bounce back' problem — where individuals referred to mental health services by police are unable to access appropriate treatment and care, and are discharged without support. Police can respond multiple times to the same individuals experiencing mental health crises.

Comment: TRUE!

DRAFT RECOMMENDATION 16.1 — SUPPORT FOR POLICE

A systematic approach should be implemented to support police respond to mental health crisis situations.

In the short term (in the next 2 years)

All State and Territory Governments should implement initiatives that enable police, health and ambulance services to collectively respond to mental health crisis situations. The approach undertaken in Queensland should be considered. PLEASE NOTE: this is not main stream yet – only practised at selected sites and poorly resourced.

The initiatives should ensure that:

- mental health professionals are embedded in police communication centres to provide real-time information on the individual to whom police are responding, to advise on responses and referral pathways, and to prioritise deployment of co-responder resources
- police, mental health professionals and/or ambulance services (draft recommendation 8.1) are able to co-respond to mental health crisis situations if necessary
- roles and responsibilities of all service providers are clearly defined
- approaches are tailored to meet the needs of particular groups, such as Aboriginal and Torres Strait Islander people.

DRAFT RECOMMENDATION 16.2 — MENTAL HEALTHCARE STANDARDS IN CORRECTIONAL FACILITIES

National mental health service standards should apply to mental healthcare service provision in correctional facilities to the same level as that upheld in the community. YES !!

In the short term (in the next 2 years)

The Australian Commission on Safety and Quality in Health Care should review the National Safety and Quality Health Service Standards to ensure that it applies to mental health service provision in correctional facilities.

Comment:

Above recommendation – as all recommendations in this section – sound wonderful. What will be done to implement them? All in the realm of aspirations …

DRAFT RECOMMENDATION 20.3 — TRADITIONAL HEALERS

Traditional healers have the potential to help improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people as have healing and compassion informed approaches for all people with Mental Illness.

In the medium term (over 2 – 5 years)

- The Australian Government should evaluate best practices for partnerships between traditional healers and mainstream mental health services for Aboriginal and Torres Strait Islander people and all other people with a Mental Illness who could benefit.
- This evaluation should incorporate the knowledge and views of Aboriginal and Torres Strait Islander people and seek to improve the evidence about how a partnership between traditional healers and mainstream mental healthcare can most effectively support ~~Aboriginal and Torres Strait Islander~~ all people with mental illness and facilitate their recovery in their community.

DRAFT RECOMMENDATION 22.3 — ENHANCING CONSUMER AND CARER PARTICIPATION

Consumers and carers should have the opportunity to participate in the design of government policies and programs that affect their lives with the perspective of increasing their involvement in treatment and care plans. Consumer and Carers also are to be provided with the opportunity of informed consent for their treatment.

In the short term (in the next 2 years)

- The Australian, State and Territory Governments should ensure that they collaborate with consumers and carers in all aspects of mental healthcare system planning, design, implementation, monitoring and evaluation.
- COAG should instruct the National Mental Health Commission to monitor and report on total expenditure by individual jurisdictions on systemic advocacy in mental health that is provided by peak representative bodies.

In the medium term (over 2–5 years)

The Australian, State and Territory Governments should strengthen systemic advocacy by:

- extending the funding cycle length for peak bodies to a minimum five years to improve business planning and capability development
- concluding contract renewals at least one year before expiry
- reporting their total funding to peak bodies that represent mental health consumers and carers through the annual Report on Government Services.

DRAFT RECOMMENDATION 22.4 — ESTABLISHING TARGETS FOR OUTCOMES

Accountability for mental health outcomes should include measurement against predetermined quality and efficacy performance targets.

In the medium term (over 2 – 5 years)

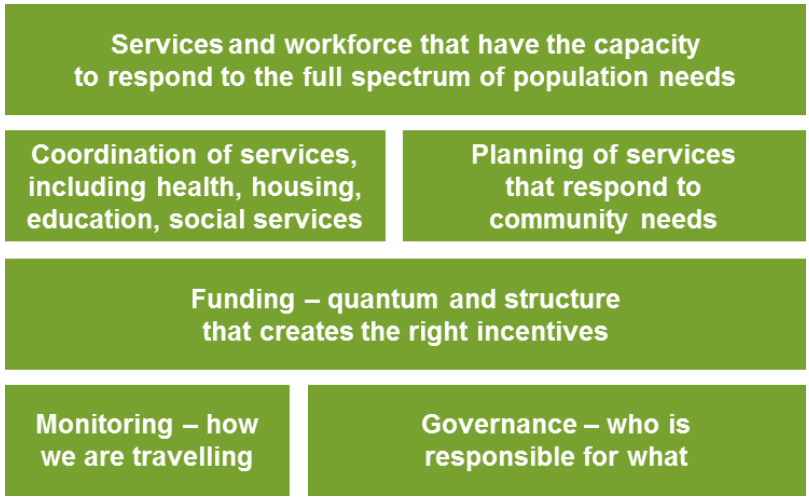
The COAG Health Council should agree on a set of targets in collaboration with consumers and carers that specify key mental health and suicide prevention outcomes that Australia should achieve over a defined period of time.

To ensure these targets reflect an appropriate balance of ambition and reality, it should develop a process for setting them that, among other things, involves collaboration with consumers and carers and results in measurable minimum quality requirements. Following this collaborative process, the COAG Health Council should publish the targets and an explanation of how they were set and how they will be monitored and reported.

Attachment 1: Building blocks of a people-oriented mental health system

Figure 4.2 of the Draft Report: The building bocks of a people oriented mental health system

Figure 4.2 ***The building blocks of a people-oriented mental health system***



These building blocks sound appropriate from a system-centred perspective. However, as long as a person-centred individualistic concept of needs assessment is missing, these building blocks will remain meaningless in implementing a truly person-centred perspective.