Person-Centred and Consumer Directed Mental Health Care: Transforming Care Experiences

Produced for the National Mental Health Commission by the Mental Health and Suicide Prevention Research and Education Group, University of South Australia.

Online Appendices

Appendix 4: Coding analysis

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The following table lists the various codes that were developed as thematic analysis of the consultations occurred.

Coding framework for practitioner and policy maker participants	
PCC conceptually	autonomy CAMHS CTOs emergency genuine listening holistic individualised language mental health does PCC better oppressive person and family centred care provider-led recovery shared decision making trauma-informed
CDC conceptually	autonomy capacity emergency individualised involving the consumer person-led relationships safeguards
Barriers	cultural and linguistic for carers clinician understanding communication

	confidentiality conflict consumer capacity culture empowerment evidence base funding model inconsistencies KPIs lack of choice lack of support for staff leadership limited lived-experience workforce medical model mental health act NDIS funding NDIS is rigid NDIS quality NDIS services constantly changing negative healthcare experience power priorities public perception referral pathways resources retraumatisation rhetoric and reality risk rural setting services are rigid services for CALD communities time pressures families experiencing instability
Practice examples	ACDs communities in control community run organisations connecting with people

	consumer voice consumer wishes dignity in risk emergency evaluation flexibility informed consent least-restrictive person-centred care lived experience leadership measuring effectiveness narrative approaches Pathways to independent living peer review peer work protective empowerment recovery recovery unit rehabilitation Safe wards Safe Haven Safeside shared decision making staff perspectives trauma informed triangle of care
Shifts	accessibility of services advertisement of peer work roles allowing medication withdrawal building rapport consumer as expert consumer capacity consumer voice in case notes education and training flexibility in services focus on trauma human rights focus individualised care

	language leadership listening lived experience mutual respect non-medical treatment prevention reform service delivery social determinants of mental health strengths based approach sustainable workforce transparency

Coding framework lived experience participants – including peer practitioners	
PCC conceptually	can include person and family centred care carers continuity of care fully informed decisions needs options and choices pathways are easy to navigate and supported people author own story doesn't impose or coerce involves carers in planning power empowerment autonomy in decision making shared decision making what works for people - groups where person is at - whole person social context works for safety and quality flexible innovative solutions to issues
CDC conceptually	can shut out carers as autonomy is stronger choice control and autonomy consumer - empowered to control funding on plans consumer can make good or poor-quality decisions dignity of risk is acknowledged doesn't focus on assessment and diagnosis as starting points follows insurance models like NDIS or supportive organisation cultures needs information and knowledge about services to meet needs consumers evaluate the service experts in own lives
Barriers	tensions and conflicts of interests funding program restrictive lack of information about services unrealistic expectations on recovery variable skills amongst workers to work for CDC culture of confidentiality - shuts out carers inconsistent understanding-practice of PCC in clinicians inequities - unjust access

Barriers cont.	lack of commitment and implementation lack of information for consumers about choices and options lack of service flexibility lack of sustained org leadership to shift culture LE workers low numbers under powered MH legislation enables treatment orders - contrary to autonomy no access to talking therapies problems with NDIS limiting choice and access some - complex trauma too hard to service stigma and disempowerment professional expertise imposed over LE MH orders overshadow decision making and consumer experience not pathways of care - outside of pathways variation in provider interpersonal skills for PCC lack of good communication empathy and trust carers needs - pain ignored not understood carers stepping in consumer feel unsafe due to context excluded in CAMHS - overbearing parent information systems and cases notes disempowering lack of services in country areas or other specific community needs lack of specific community knowledge e.g., misgendering - stereotyping lack of time and relationship building lack of transparency in decision making narrow focus - lack of wholistic care paternal objectifying culture of trad medical model physical designs - unsafe feelings for consumers professionals feeling threatened by LE programs have unrealistic expectations about recovery risk aversion- managing risk under resourced and burnt out worker false assumptions about consumer distress lack of communication information with carers professional lens power hierarchies undervalue LE tensions on risks

Practice examples	expert directed care can be good thing safe havens testing autonomy - fluid concept relational recovery - occurs in relationship - not just autonomy health literacy strategies Aboriginal SEWB - deep listening approaches advanced care directives cultural safety family based care plans human rights supported decision making key workers and support coordination Open dialogue passports and information tools peer support models IPS Alt2Sui recovery college responsible autonomy shared decision making training for clinicians- communication &PCC trans health education in curriculums trauma informed care triangle of care work with family working upstream on SDMH- social justice approach power threat meaning framework Scottish model of recovery
Shifts	culture of compassion and kindness funding peer organisations- including peaks more community level care more LE leadership more psychosocial models need diversity intersectional focus reduce iatrogenic harms of services reform MH acts - end limit coercion risk tolerance - reflective -sit with distress - trust the person service based culture strong leadership to drive cultural change to more recovery focused outcomes - not just service outcomes accountable organisation cultural development

Shifts cont.	better information systems focus on systems change more supported reflective supervision nuanced view of lived experience and consumer and carer roles rebalance workforces- more social non diagnostic lens