Concepts in a nutshell

Person centred care

- Includes whole person
- Where people are at
- Authors of own story- What's important
- Enables power & agency
- Does not impose or coerce
- Allows flexibility
- Innovative & tailored
- Includes carers or family centred
- Includes social context

- The person is the expert
- The importance of culture and kin relationships is recognised
- Care received is not limited or defined by time; time is used to build relationships and connection
- Based on strengths, hopes, and dreams not deficits and diagnosis. Skills and gifts of the individual are celebrated

Concepts in a nutshell

Consumer directed care

- Led by consumers
- Empowered to direct funding plans (NDIS)
- Breadth of options
- Requires supportive systems and strong relationships
- Availability of service
- Dignity of risk decision making
- Can shut out carers
- Evaluates providers

- Allows for the defining and allowing risk
- Needs empathetic and non-violent delivery; not re-traumatising people
- Tensions between whether services are solutions focused or problem focused
- Legislation trumps good intentions, imbalance of power and agendas that clinicians have
- Informed consent is needed, but often difficult to define
- Different funding levels (state and federal) contributes to inconsistencies

Concepts in a nutshell

Considering *both* concepts

- These concepts should not be either/or, they are distinct individual concepts that lend themselves to different scenarios
- Psychiatric assessment models/locked wards do not lend themselves to these concepts
- There are assumptions that people know enough about how to navigate the healthcare system for informed decision making, which is not necessarily true. Knowledge about the healthcare system is needed to make these concepts work to their full potential
- Care needs to be consistent and easy to navigate, with informed decision making at the core of decision making

Barriers in a nutshell

Person centred care

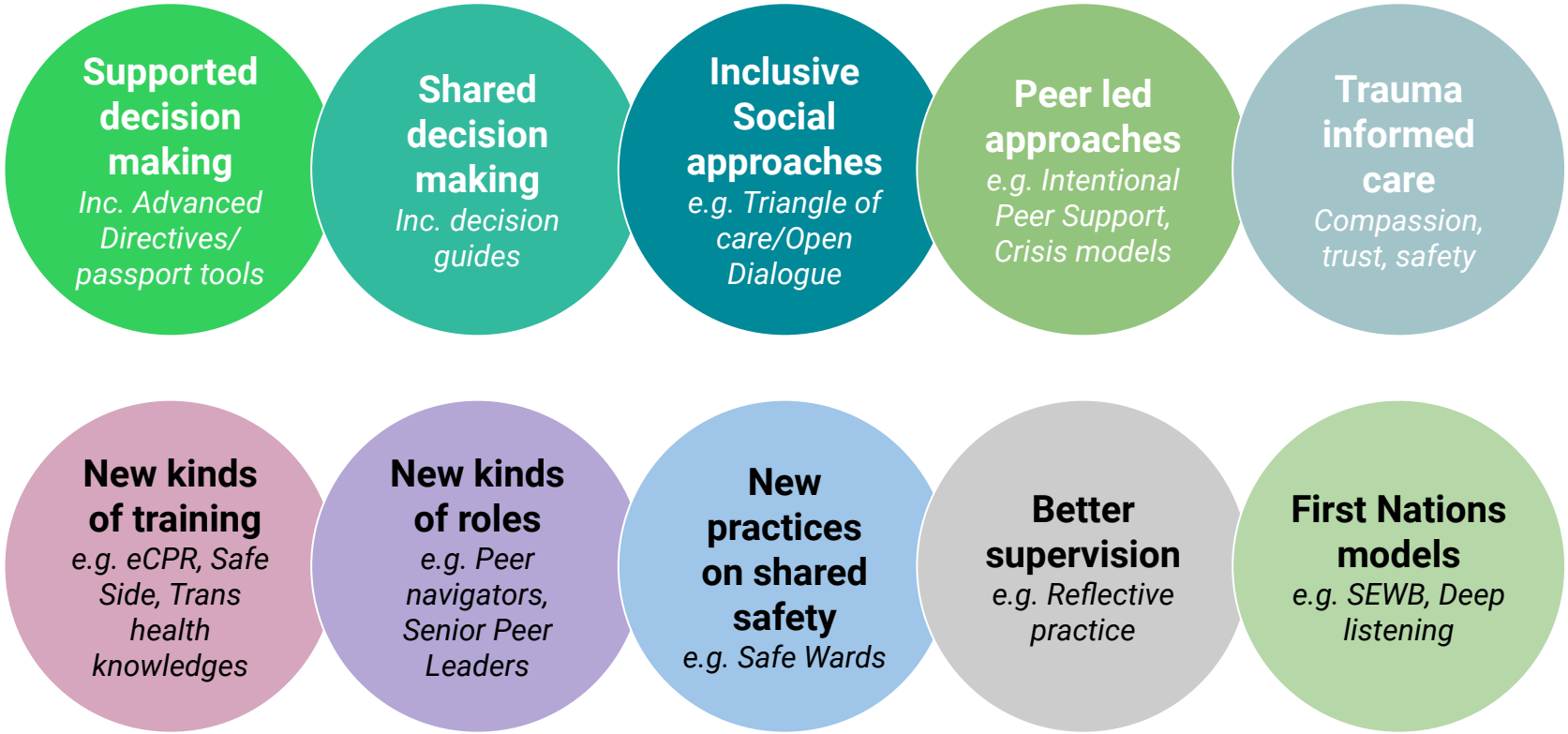
- Paternal culture & medical model exclusion
- Mental health laws restrict autonomy & coerce
- Inconsistent clinician skills
- Lack of true commitment & implementation
- Under resourced & burnt out workforces
- Stigmatising & stereotyping/ lack of knowledge of groups
- Professional power & knowledge can disempower
- Too much focus on risk
- Lack of flexibility
- No pathways for people with complexity
- Restrictive funding and service rules, KPIs
- Lack of specific services

Consumer directed care

- Restrictive funding and service rules, KPIs
- Lack of specific services
- Lack of information about services
- Unrealistic expectations on recovery
- *Inconsistent worker skills*
- *Professional power & knowledge can disempower*

Systemic challenges

- Lack of accountability and uptake of existing recommendations
- Need for systems reform or new systems? *Tinkering doesn't work*
- Funding models of care that reflect service's mission statements
- Continuing inequitable access, gaps, *'no right doors'*
- Significant lack of resourcing of community and crisis mental health services given demands


Supported decision making
Inc. Advanced Directives/ passport tools
Shared decision making
Inc. decision guides
Inclusive Social approaches
e.g. Triangle of care/Open Dialogue
Peer led approaches
e.g. Intentional Peer Support, Crisis models
Trauma informed care
Compassion, trust, safety
New kinds of training
e.g. eCPR, Safe Side, Trans health knowledges
New kinds of roles
e.g. Peer navigators, Senior Peer Leaders
New practices on shared safety
e.g. Safe Wards
Better supervision
e.g. Reflective practice
First Nations models
e.g. SEWB, Deep listening

In a nutshell

Shift 1

If…

There are inconsistent worker skills for including consumers and carers in person-centred ways …

What if …

We strengthened education and training on inclusion, LGBTIQ+ health, cultural safety, carer involvement & trauma informed care?

3 key messages

1. Training of staff at all levels should focus on balancing power between all involved.
2. Lived-experience voices in training processes.
3. A system of regular feedback and open communication within services to develop skills and build provider confidence.

1

What if … we strengthened **education and training** on inclusion, LGBTIQ+ health, cultural safety, carer involvement & trauma informed care?

What's important about this area?

- Culture change - away from risk averse
- Including peer work/LE workforce in training
- Risk of the individual/ their community members
- Inconsistency - across service providers
- How organisations are connected
- Attracting recruiting, retaining good staff.
- Staff to champion and support PCC
- Rural staff shortages – client needs high
- Resources.
- Training of staff-for balance of power
- All discipline staff need TIC training
- Consistency of care practices for consumer
- Practitioners -depth of self knowledge/ hearts

What's missing?

- Need to focus - dignity of risk to the individual
- Peer support within systems for trust voice access-
- ED - lowest level of MH training/knowledge
- Carer voice in education and training
- Wider social education to challenge stigma
- Need wider understanding of emotional distress &
- emotional resilience
- Essential and critical for all

Any other ideas?

- Assuming people have capacity, rather than not
- How we as observers of the system are able to evaluate systems around PCC
- Learn from consumers seek feedback from consumers/carers. Regularly.
- Consumers carers deliver training in PCC/ Orientation.
- Regular feedback. Encourage open communication, or written

In a nutshell

Shift 2

If…

Mental Health laws can enable coercion and are contrary to true person centred care and autonomy…

What if …

We embedded supported decision making, advanced directives and ‘nominated’ support people into law and used them properly?

3 key messages

1. Tribunals need equitable balance of power to improve outcomes and create a forum for people to be heard.
2. Consistency is key - need to reduce the variance in how people are treated and what decisions are made.
3. Approaches should be relationships based, reduce the presence of police forces during times of crisis.

2

What if … we embedded supported decision making, advanced directives and 'nominated' support people into law and used them properly? **(power and voice)**

What's important about this area?

LE having a forum to be heard /understood
Medical model difficult to shift
Care under legislation based on empathy
Tribunals need equal balance of power Improve environments / move beyond clinical settings
Embed experts by experience- in LHNs
Facilitate least restrictive practice before orders are in place.
Maximize informed consent, voluntary care, rights, responsibilities.
Strengthen use of Advanced Directives
Safety Plans: Consumer preferences are built in
Duty of care – avoid Police attending first
Be relationship based
Includes / requires health literacy.
Embed respect/ promote positions of trust

What's missing?

Peer support workers work with clinicians
Staff need to know and practice their role
Beyond tokenistic involvement of LE
Psychosocial too - move beyond the medical model
Port Pirie study – Effective MHN /Police responses
Improve LE involvement in rural areas
LE also required in Community teams
Trust is a fundamental/ essential requirement.
Safe place to share stories, wants and needs.
Bring shifts to real life with consumers/ families
Co-design is now known about by all.

Any other ideas?

Consistency is key - reduce variance
Need to learn across systems
Foster change without criticism
Need for minimum standards of practice and values
Recovery is through the relationship.
Police can improve skills and qualification in MH – reduce restraints/ assaults
Must be clear who the lawmakers are?
Who/Where is power embedded ?
Basic needs (housing) are still needed/ essential.
Lofty ideal.
Multiple system actors. Can include a non-family persons
Essential element is trust.
Care continuity for YP moving to adult systems

In a nutshell

Shift 3

If…

It's rhetoric vs reality:
there's a lack of true commitment and implementation of person centred care in public services…

What if …

We had a national program for strong leadership and championing for organisational change in public mental health services?

3 key messages

1. Nationally consistent approaches to minimum standards for mental health services to improve trust.
2. Consistency across the different states and territories in Australia is a challenge.
3. There will need to be leadership championing change within all disciplines to ensure consistency across the mental healthcare landscape.

3 **What if** … We had a national program for strong leadership and championing for organisational change in public mental health services? **(commitment / action)**

What's important about this shift?

Snr Policy leaders that use own LE for good
Ensure psych students have own experience of therapies
Effective complaints and genuine responses
Leadership:accountable and communicates well
Reducing discipline hierarchies which impact consumers
Encouraging supportive, caring, tolerant culture
Improve national consistency of MH legislation?
Have national parameters /requirements for each LHN
Avoiding stigma and discrimination/checks and balances
National approach enables easier funding & navigation of services
National approach builds trust and knowledge, literacy
Increase transparency and accountability
Easier to fund when everything is the same
Vic Royal MH Commission – amazing recommendations
Embed characteristics of strong leadership:
We need shared definitions of what 'good' is, actions and pathways
Strong leadership requires collaboration
REMEMBER our why!

What's missing?

More inclusive – end service signs of security/ danger/ violence
National program? Hard to conceptualise? How is this communicated
How do we report shifts – be transparent, overcome disillusionment
Ending culture of you being the problem
We don't have one already?
LE leadership across everywhere is missing
MH legislation: *where is the real listening to the consumer voice?*
Legislative changes are needed to make this happen …
Unintended consequences: Leadership can forget the impact of their decisions
Missing LE and diversity from leadership at high levels: *are decisions meaningful ?*
*F*ocus on broader determinants and avoid silo's
We often see people as one dimensional
Validate consumer capacity to speak out/ power, capacity

Any other ideas? \

Therapists who experience 'trauma coming up' -need supervision
Discipline leadership - e.g., Psychologists develop new services to meet need
Shifting clinician culture – clinicians have to adapt and accept LE, collaborate
Holistic thinking and sharing – the wholes, not the parts, joining the dots
The need for shared tools that are valuable across stages of a person's journey:
The need to demonstrate / showcase practice from new spaces, e.g., Urgent Mental Health Care Centre
Do capability building to move people and new leaders to where they can be

In a nutshell

Shift 4

If…

Services are too narrow and brain focused. Recovery requires action on social stressors and marginalisation, and helping to reduce crisis…

What if …

We focused on *‘relational recovery’* and funded new programs which worked holistically to respond to intersecting social issues and crisis upstream?

3 key messages

1. Need to work within a biopsychosocial model of care, with greater understanding of the nuances of identity and the ‘whole person’
2. Current systems have service providers working at a high pace, reducing their ability to provide holistic care.
3.

4

What if … we focused on *'relational recovery'* & funded new programs which worked holistically to respond to intersecting social issues and crisis upstream? **(whole person / community)**

What's important about this shift?

Trustworthiness, intentional care and connection
Person is seen and heard
Focus on what people need as they see them
May work for most, but not for all
Keep biomedical in mind, but vast majority needs wellbeing model
Social 'illnesses' require a different approach
Not 'treating' the person/symptoms, but the stigma
Targeted well-being services, a space that is safe,
Safe space with others from same community – focus on specific issues
Public campaigning to reduce/end stigma
Multi-D/wellness team
One size fits all does not always work
We to learn, reflecting, and evaluate
Sustainability (build on others learning by doing)We need permission, room, and flexibility for outcomes

What's missing?

Ending violence/ coercion - take time to engage properly
Teach services ECPR - best practice ways of connecting
Build on social thinking and peer models.
Aust. health system needs to work with whole person and context
Need a serious coordinated program- for Continuity- consistent care
Person needs a plan, flow, continuity of treatment - multi pronged approach, with systems that talk to each other
Need an NDIS type system -package of care, of choice in providers, etc.
Build more inclusive services pathways for LGBTQI+ folk?
A greater understanding of the nuances of identity/ whole person
Transparency ..accountability

Any other ideas?

Every provider is a person –Start from interpersonal skills as the heart of a MH discipline

Too many people working at high pace, going into machine mode -instrumental way of relating and communicating

Use empathy as a basis of relationship – education and sharing with the consumer, to understand and be informed

The need for local, responsive, and adaptable models (not reactive, cookie cutter band aid offers)

More focus on root causes of crisis - which looks different for everyone … *what's underneath?*

In a nutshell

Shift 5

If…

Stigma and stereotyping occurs and mistakes are made due to workers not knowing about culture, gender and sexual diversity, or life situations…

What if …

We strengthened lived experience leadership (numbers) in service governance and funded more senior lived experience workforce positions in public services?

3 key messages

1. We need different kinds of risk tolerance
2. Need to recognise those involved in receiving and delivering care as a person, not their ‘label’ or their job title.
3. Nationally consistent approach to training at all levels.

5

What if … we strengthened lived experience leadership (numbers) in service governance and funded more senior lived experience workforce positions in public services? **(inclusion / influence)**

What's important about this shift?

LE leadership provides critical, big picture insights on access issues, safety, risk tolerance, gaps and impacts

LE leadership lifts role, credibility and value of consumer and carer perspective. Need commitment in funding to grow roles

Up scaling the diverse representation and recognition of lived experience leadership in diverse communities, including peer workers

Clinical / peer work misunderstanding exist that get in the way of outcomes

More carer peer workers and advocates are needed

A coordinated, national approach and model of service for LE/PW would be great..

LE perspectives on risk and safety need to be included into funding agreements and KPIs, and shaped by inclusive governance

Minimum staffing requirements need to

What's missing?

The important of conversations which reduce stigma and promote humanity and person first. LE can lead the way, weaving in different professional knowledges too. **See every person/ not label or work title.**

Acknowledging Intersectionality, dual roles multi-layered identities, where people have consumer, carer, worker and identity group connections.

More involvement of LE in all levels of governance and service delivery is necessary. Real co-production and co-design rather than consultation and tokenism.. **Need national approach,** training for all parties, all levels, **properly funded**

Clarity around what LE leadership means and how to utlise - need special and skilled leaders

Helping LE leaders navigate different interests / conflicts in organisations and communities

Any other ideas?

Make sure peers in LE positions and leadership positions have **a justice orientation** and are grounded in **peer values,** distinct from clinical positions

LE leaders in advisory settings need to effectively navigate to **avoid co-option,** and replicating status quo

Open dialogue as a demonstration of great people centred practice, that is holistic, and works with/in persons social context - needs national roll out and training

Progress stigma/ inclusion education important for CALD communities and mental health workforce. Led by LE present across workplaces/ projects. Example Curtin University https://study.curtin.edu.au/offering/unit-pg-mental-health-recovery--cmhl5000/

Specific skill sets: peer skills in supporting uniqueness, mutuality, acknowledging difference, emotional intelligence, self care

In a nutshell

Shift 6

If…

Services are risk averse and often impose ‘fixing’ responses on consumers which can cause harms and future avoidance of help…

What if …

We promote practices that emphasise dignity, personal safety, and cultural safety?

We fund crisis response models that emphasise connection, reflection and working together on crisis and life stressors?

3 key messages

1. Rolling out alternatives to ED presentation nationally and ensuring these are peer-led and accessible.
2. Having risk tolerant services that include safety strategies (e.g. emotional safety), changes to organisational structure to allow this.
3. There is a need for peer-led prevention services to minimise the need for crisis care.

6

What if … we promote practices that emphasise dignity, personal safety, and cultural safety? We fund crisis response models that emphasise connection, reflection and working together on crisis and life stressors? **(risk / safety)**

What's important about this shift?

Risk tolerance - people are asking for this we need more risk tolerant approaches to funding and services, including national roll out of crisis centres (ED alternatives).

Professional skills: we need people with empathy, non judgment, time to connect. We need better ways to connect **- new kinds of compassionate approaches** and training

The Safe Side model is more person-centred and holistic - a model of care (US) that gives a common language, inclusive and friendly

What's at the heart? Peer led, tolerance to risk, creativity, true LE consultation & ongoing engagement

The conflict of people needing to manage additional costs for these kinds of services… **The alternative should be free** or else this is a big barrier

What's missing?

LHN's need improved support and guidance structures for responding to risk in sophisticated ways e.g. just restorative model - how to shift LHN to a place where people - **we need top level understanding**

Spaces can be re-traumatising - **the need for safe, kinder spaces**

Move away from the deficit model, expert medical model…

Risk tolerance and understanding how to enable risk awareness and a range of safety strategies (including emotional safety) - underpinned by organisational structures and peer led approaches to enable great practice *- let's stop doing the same thing!*

Any other ideas?

New kinds of models include Alternatives to Suicide, Suicide Narratives, Emotional CPR

Local Suicide Prevention Collaborative- lots of LE participation, grass roots, community based...Brilliant work

Zero suicide initiatives to be spread AUS wide

We need more preventative services to minimise needing to respond to crisis in the first place, and effective acute crisis response centres

What does it mean to be truly accessible?

Funders need training to understand the **unique value/ why** of these new approaches

Everyone needs training in recovery oriented care, cultural safety and trauma informed care

In a nutshell

Shift 7

If…

Consumers want safe and confidential areas to paint, yarn, and weave, but services aren't able to allocate funds to provide those services due to funding KPIs not allowing it, even though the guidelines say that care should be *'culturally sensitive'*...

What if …

We funded lived experience organisations to develop programs and workforces grounded in local culture, community knowledges, and peer methods?

3 key messages

1. Potential of creating spaces for peer workers across programs, local sites, being innovative, significant benefits for inclusion and outcomes.
2. Outcomes of success to be defined by people with lived experience and consumers.
3. Peer workers need to be highly skilled, with adequate support and mentoring.

7

What if … we funded lived experience organisations to develop programs and workforces grounded in local culture, community knowledges, and peer methods? **(flexibility / accessibility)**

What's important about this shift?

Services need to be more inclusive and MH literate, esp on different perspectives and experiences of different communities.

Help diverse communities navigate system and improve access issues.

LE owning the outcomes and defining what is valuable and what success means

A sense of place and belonging is in programs and services - as guided by LE

Ensure flexibility during uncertain times (Pandemic/ Natural disasters. Embed peer workers to support and help navigation

Capture good data on homelessness, CALD accessibility/ use and for other priority groups. Show data / be data driven on outcomes.

What's missing?

Deep listening (Aboriginal concept) - could we change/add 'active listening'

Ensure peer workers are highly skilled, trauma informed, can avoid retraumatising, able to support in crisis/ first aid. Ensure support, mentoring, supervision.

Need: Time and resources for funding positions, Organisations need Codesign capability, and involvement registers - and support processes

Ensure good quality physical settings and office space for peers, meeting rooms, workshop venues for community work

Accessibility and funding considerations - fund programs/ places in community health centres, neighbourhood houses. Fund positions across in accessible sites for community.

Any other ideas?

E.g. Settings that allow people to share experiences and feelings, without fear of outcomes.

In a nutshell

Shift 8

If…

There's often no pathways of care for people living with complex issues and trauma: it's too hard…

What if …

We funded peer programs & organisations to educate services, advocate for better pathways and help consumers and families navigate systems?

3 key messages

1. Need to ensure adequate coordination and collaboration within and between services to end cycles of crisis (including follow-up services).
2. Funding and KPIs need to allow for individualised treatments.
3. Needs to be clearly defined yet flexible pathways that ensure people get consistent and continuous access to care.

8

What if ... we funded peer programs & organisations to educate services, advocate for better pathways and help consumers and families navigate systems? **(Better pathways)**

What's important about this shift?

Ensuring that the individual's specific needs are met through appropriate supports/services (not just what funding allows/doesn't allow).

Acknowledge and address social determinants (housing, etc; provide advocacy, etc. - whatever the individual needs support with.) Remove silos. Embed capacity across

Navigators across services need to be highly valued And also navigation support and liaison within services/ across populations.

Needs supporting information services and systems - break down barriers

Coordination of care - open communication between service providers - willingness to remove of barriers (e.g. mental health vs AOD challenges - in limbo)Acute care / support services. Address legal processes and share information

What's missing?

Develop funded, supportive and effective pathways for people needing crisis care and who experience complexity. Ensure funding agreements recognise, define and fund responses to issues (eg CPTSD).

Consistent education regardless of role or industry.

Determining what needs are not being addressed for the individual

Consider dedicate navigation service and people

Any other ideas?

Considerations for when people want to opt of care, providing all other psychosocial supports/therapies

Additional considerations/issues in rural areas - higher prevalence of medication, etc. Amplified in these settings

Conflicts between being able to provide what the person needs vs the funding that is provided - funding models based on diagnosis and prescribed models of care, but it's ignoring what the person needs