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Finding the Path: Service access and navigation for serious mental illness in Australia

Recommendations from a Thought Leaders' Forum

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Executive Summary

Improved access to quality mental health services has been a key target in Australian health policy for over 25 years. However, during this period, successive National Mental Health Strategy documents have failed to ensure people with mental illness can navigate an increasingly complex service system or access timely and appropriate services.

The Finding the Path project was designed to inform health system change which would ensure people with serious mental illness can access quality services. Using a health systems framework,¹ its four primary objectives were to:

1. Analyse national, state and territory policy and programs for mental illness (macro)
2. Describe system-level responses for mental illness, focused on access and navigation (meso)
3. Explore mental health consumer, carer and provider experiences with services (micro)
4. Develop recommendations for improved mental health policy and program implementation

This report focuses on objective four, developing recommendations. Mental health consumers, carers, service providers, planners and policy-makers were invited to attend a Thought Leaders' Forum in August 2018. Participants were provided with a summary of key findings from the Finding the Path studies and asked to respond to questions related to macro, meso and micro-level policy implementation and service provision (Appendix 1).

Thought Leaders were resolute that co-design should not be simply consultation but a genuine working partnership. They offered a great deal of specific advice on the importance of people with lived experience as active partners at all levels of design, implementation, monitoring and evaluation: in policy, service planning and workforce development, and in the formulation and review of individual mental health care plans.

They also emphasised that a cohesive service system should provide a range of psycho-social services relevant to the needs of consumers; care consumers can trust to be demonstrably based on good quality research and evaluation and of consistent quality; supported with sufficient dedicated resources to ensure that consumers can rely on these services being there now and in the future; and that the service system has a workforce sufficient in size and capability to ensure all the previous criteria are met.

Thought Leaders highlighted the continuing need for better mental health literacy for health and social services as well as the whole community. Mental wellbeing education must be targeted and delivered with the objectives of developing communities that: understand mental wellbeing, incorporating it into their daily lives; know how to look after their own mental health and support the mental health of others through education, prevention, support and treatment as required; ensure that the broad range of social and health service providers are able to confidently recognise and appropriately respond to the mental health needs of people so there truly is 'no wrong door' for access to care.

Recommendation One – Evaluation and research

As a matter of urgency, the Australian Government should invest in high-quality mental health research and a comprehensive national Monitoring and Evaluation Framework to provide valid, independent and reliable information for evidence-informed policy, planning and management decisions. The Framework should include specifications and resources that will ensure nationally consistent quality and quantity of data collection and reporting methods. It should also include a well-articulated Theory of Change describing short-term outputs, medium-term outcomes and long-term objectives, and a small number of carefully selected national indicators (wellbeing outcomes) for monitoring progress against objectives.

The issue

There have been many attempts at mental health services reform over the past few decades, yet people with mental illness, their families, and their carers continue to experience difficulties in navigating and accessing suitable services. Furthermore, it is difficult for most people to determine exactly what progress successive National Mental Health Plans have made towards achieving their objectives. Key stakeholders appear to have no common understanding of what the ultimate objectives of national mental health policy are, explicitly how they will be achieved, who is responsible for which inputs and outputs, who will contribute resources for each component, and by what date these objectives must be achieved. To date, the National Mental Health Commission has created only half of the 24 indicators recommended in the Fifth National Mental Health and Suicide Prevention Plan,¹ stating the delay was due to the inadequacy of existing data collection.

Policy [is] based on older/incomplete or fragmented data; a national approach to national data is needed

Mental Health Consumer Peak

Finding the Path included a systematic analysis and comparison of Australian chronic disease and mental health policies. The analysis found the most significant and consistent difference between policies for chronic physical conditions and mental health policy was that chronic disease policy made repeated and explicit linkages between proposed and existing policies, identifying specific strategies and programs with which new proposals would align. In contrast, mental health policy was routinely described in broad terms, lacking specific proposals. Without specificity in policy formulation and design, it can be extremely difficult to accurately monitor progress towards achieving policy objectives or to make well-informed timely management decisions.

¹ endorsed by the Council of Australian Governments Health Council on 4 August 2017

Recommendation Two - National Consumer Peak Body

The Australian Government should fund, endorse and utilise a National Consumer Peak Body to ensure, among other functions, that people with lived experience are not merely consulted but are active participants in the processes of policy formulation, and service planning, monitoring and evaluation. The authentic participation by representatives of this peak body and other relevant community members should be a regulatory requirement for all policy and/or service planning and evaluation processes and at all levels of government. Explicit guidelines which define, describe and guide authentic participation in policy and service planning should be produced and distributed by the Australian Government as soon as possible.

The issue

At all levels of government, collaboration with people with lived experience about the relevance, quality, safety, and effectiveness of mental health services should be the norm during policy formulation and service planning. However, there appears to be considerable inconsistency in the processes for and depth to which people with lived experience are partners on matters of policy or practice.

Simple dichotomies, for example, government compared with non-government organisations, or health service providers compared with service users, are not helpful perspectives and may even suggest adversarial relationships that frustrate progress rather than cooperative

partnerships which promote best practice. In reality, there are many diverse groups of people and organisations who have an interest and involvement in mental health services including, non-government community mental health organisations, peer workers,

consumers, carers and local communities. For genuine progress, there needs to be strong representative voices for all of these groups, and the co-development of a framework that enables genuine co-design and co-production.

For optimal results, Governments need to take a genuine partnership approach with all the players. We all need to move past an 'us and them' mentality and work together acknowledging our differences but drawing from our respective strengths and experiences.

Community Mental Health

Build consumer and carer architecture - build from this perspective up, rather than top-down

Consumer Representative

Recommendation Three – Consistency between national and state/territory plans

To maximise national mental health policy impact and to minimise policy fragmentation among national, state and territory jurisdictions, the Australian Government should commission and manage an audit/review of all relevant state/territory mental health and suicide prevention plans to ensure their coherence with national mental health and suicide plans.

The issue

The primary concern of national, state and territory authorities with respect to mental health services must be to produce the best possible outcomes for consumers and

The complexities around split of State and National funding makes coordination very difficult

Clinical Psychologist

communities. The Australian Government should facilitate an agreement between all parties to establish consistency in policy alignment, regulatory frameworks and the resources allocations required to implement quality standards. Recognising examples of good practice generated locally can occur

anywhere and Australian Government and state/territory government departments must establish and maintain the structures and processes to identify these good practices and to support their replication nationally.

Thought Leaders were also concerned that funding was often fragmented and there appeared to be insufficient coordination between and among national, state/territory and local government initiatives. Further, funding was often project-based and short-term rather than coordinated through a national program and therefore led to inefficiencies, uncertainty and lacked sustainability.

Fragmentation of funding - funding needs to be coordinated

National Mental Health Commission

Recommendation Four - Dependable and sustainable mental health funding

To ensure quality and sustainability, funding must be allocated within a cohesive long-term national mental health program of funding, not as disparate short-term projects. Each National Mental Health Policy Implementation Plan should be funded centrally as a cohesive national strategy comprising a program of initiatives, each of which:

- i. Contribute to achieving national objectives within the life of the National Mental Health Policy Implementation Plan;
- ii. Can demonstrate a credible scientific evidence-base;
- iii. Meet the criteria for program relevance, effectiveness, efficiency, impact and sustainability²; and
- iv. Does not constitute a 'bucket of funding' for expedient allocations to short-term projects which are not able to secure further funding from other sources or require 'stop-gap' funding to continue.

This should be linked with and informed by the review of services described in the previous recommendation (Three).

The issue

Adequate funding over a sufficient timeframe must be allocated to ensure the quality and sustainability of the national mental health plan implementation. Thought Leaders expressed concerns about short-term expedient policy decisions. In most policy domains, an assured three to five-year funding period is considered the minimum necessary to achieve results, measure outcomes, attract and retain a well-qualified workforce, and ensure program sustainability. The concern was that decisions about mental health services funding were based on political imperatives rather than on reliable evidence of the effectiveness and efficiency of outcomes achieved by those services.

*Resources dictate what can
be achieved: limited resources
= limited outcomes*

Community Mental Health

² These five evaluation criteria from the Development Assistance Committee of the Economic Cooperation and Development (OECD/DAC) have been the most prominent and widely adopted criteria for program design and evaluation globally and have been the foundation of international development programs since 1991. OECD/DAC. Evaluating development co-operation: Summary of key norms and standards. OECD/DAC Network on Development Evaluation. 2010, 3. Chianca T. The OECD/DAC criteria for international development evaluations: An assessment and ideas for improvement. Journal of Multidisciplinary Evaluation. 2008;5(9):41-51..

It was recognised that politicians face obstacles to longer-term planning and policy-making. Sensitivity to opinion polls, high turnover of portfolios, frequent changes in

governments and short time horizons between elections all mean that politicians face strong incentives to maximise short-term gains in office and few incentives to deliver more substantive and enduring public goods over much longer time horizons.

Lack of continuity (i.e., dealing with issues, switching issues as they arise)

Carer peak

These responses were also supported by the Finding the Path policy analysis, which found that there was twice as much information in chronic disease policy on the promotion of consistent financing than there was identified for mental health policy. Strategies for financing chronic disease included describing the benefits of a blended payment system, which was then followed by the inclusion of examples of implementation trials in Australia such as the Diabetes Care Pilot. In contrast, mental health policy literature described intentions for future financing strategies in very general terms.

Recommendation Five – Funding an evolving blend of public and private services

National Mental Health Policy funding should include a blend of allocations to public and private services. These funding allocations should be monitored and adjusted according to well-formulated indicators within an agreed monitoring and evaluation framework.

Structural, financial and administrative barriers should be identified and mitigated so that consumers can move seamlessly between service sectors as they need.

The issue

The private sector plays a key role in the delivery of mental health services. In 2010-11, the sector: provided 20% of total psychiatric beds; engaged or employed approximately 17% of Australia's health professional workforce delivering mental health services; and provided services to eight out of every 10 people who were recorded as receiving mental health specific health services.⁴ Even so, structural and funding administration can at times create duplication and obstruction which hinder service access, the efficient distribution of critical resources and effective integration between private and public areas. Identifying and resolving these impediments is important for ensuring there are sufficient services, improving service access and empowering consumers with a choice of service providers.

Funding, blend of public and private funding – ratios may change as systems mature

Community Mental Health

The policy analysis highlighted the importance of strengthening partnerships to provide innovative care. Overall, chronic disease policy consistently emphasised a strategic focus on strengthened partnerships between government, health and community sectors. Partnership building appeared to form a core component of many policy items (and proposals for policy) and was often addressed in a way that was integrated with the goals of promoting consistent financing and policy integration. However, in mental health policy strengthening partnerships tended to be discussed as a future goal or a guiding principle but not one consistently integrated into current policy design.

Recommendation Six - Priority areas of mental health education and health promotion

Two priority areas for mental health education and health promotion continue to be:

- i. Health education targeting the public, promoting mental wellbeing and reducing stigma. In addition, the importance of support and education for carers/family of the consumer is often overlooked, yet it is essential that people with mental health conditions, their families and carers understand the care options available which will be most helpful to them and how they can best access this assistance.
- ii. Mental health promotion targeting the health and social services workforce, to improve understanding of what mental illness is and what help various care providers offer. The aims of this mental health promotion and education strategy would be to assist all service providers to better identify and provide appropriate mental health assistance and/or refer help-seekers to the most suitable services.

The Australian Government should expand its investment in coordinated and integrated care across programs and services by promoting mental health literacy across a wide spectrum of professions (e.g., police, teachers, etc.)

The issue

There have been good examples of worthwhile mental health promotion campaigns in schools and the community, and government departments have published credible guidance for designing and implementing effective mental health promotion. Yet, evaluations of mental health promotion activities have produced mixed results and consumers frequently describe a widespread lack of understanding and misconceptions about mental health, as well as insufficient comprehension of the types, roles and mandates of available services.

Mental health education is also needed to strengthen a whole-of-health-system approach to mental health promotion and care. In addition to health promotion supporting mental wellbeing, Thought

Leaders described a substantial unmet need for consistent mental health education along with a significant demand for current best practice advice on specific areas of mental health such as suicide prevention, or trauma-informed care. Furthermore, it is critical that all mental health education and health promotion is firmly based upon a careful examination of scientific evidence and is evaluated rigorously for both its intended results and any unintended consequences.

Broader conceptualisation for mental health policy: policy is still about mental illness not mental health

Consumer Representative

Recommendation Seven - Educate and endorse allied health professionals for mental health care plans

Allied health professionals such as social workers, occupational therapists and psychologists should receive nationally accredited education and endorsement to initiate and manage individual mental health care plans. This must include educating providers in other health and community services that care plans must be person-centred, consumer-led, holistic processes focussed on promoting 'mental wellbeing,' not simply responding to episodic acute mental illness. The Australian Government in collaboration with the National Consumer Peak Body (see recommendation two) and the relevant professional groups (e.g. The Australian Health Practitioner Regulation Agency, Australian Psychological Society, Australian Association of Social Workers) should determine the most appropriate education vehicles (e.g. certified professional development, vocational, undergraduate, and/or postgraduate courses), the essential content for such mental health education and the appropriate accredited endorsement processes and supervision/regulatory arrangements to ensure consistent quality standards.

The issue

The timely provision of appropriate mental health care does not rest solely with mental health services or the Department of Health, but is a whole-of-government responsibility. Coordinated support from the collective expertise and capabilities of all government departments is essential to achieving effective outcomes for mental health consumers. Thought Leaders observed that reserving mental health care planning for medical professionals did not cater to holistic social care needs, limited shared decision-making and tended to maintain late/crisis responses rather than early intervention.

Sharing power [is] needed – [there are] cultural and structural issues that lead to dominance of medical/clinical... Need to listen to the individual: this should be the driver of where the plan goes – can include broader care, housing etc. Having the person being the centre of the plan for their own recovery

Consumer Representative

The importance of mental health care plans as tools for recovery was particularly evident in the Finding the Path survey of consumer experiences with care planning. Whilst participants endorsed the current GP mental health plans as a means to access subsidised psychological services that they would otherwise not be able to afford, they also expressed a desire for much greater recovery and management rather than medical focus.

Recommendation Eight - Mental Health Peer Workers

The Australian Government should guide the development of best practice in mental health care and provide the guidance, resources, supervision and support for the establishment of a system of Mental Health Peer Workers to augment the existing mental health workforce. For example, currently, the Certificate IV in Mental Health Peer Work is available under the Australian Qualifications Framework. The Australian Government should assess which course (or courses) should be set as the national minimum requirement for practising as a Mental Health Peer Worker and allocate funding for places in the approved course in sufficient numbers to generate a sustainable peer workforce. This should be done with the active participation of and in partnership with people with lived experience, the National Consumer Peak Body, service providers and a broad range of relevant experts from health, employment and education (e.g. Australian Vocational Education and Training).

The issue

There is a shortage of adequately skilled mental health workers, coupled with staff high turnover and yet the potential contribution of people with lived experience has remained largely underutilised. In addition to the need for more mental health education across a wide spectrum of professions, a sufficient number of Mental Health Peer Workers should be trained, accredited and employed across the range of services accessed by people who want mental health care. This will help to ensure a holistic recovery focus to service provision and care management.

Raising awareness of recovery, using mental health care plans in a more holistic way, the person contributes to their own plan with a peer service

Social Worker

Recommendation Nine - Enhance the GP role in mental health care coordination

A national review should be undertaken to evaluate obstacles to and opportunities for enhancing GP utilisation of existing Medicare Benefits Schedule items for mental health care coordination. For example, the review could examine how their role could be further supported through such approaches as further professional education on mental health, the development of specialist Mental Health GP, Mental Health Nurses, use of appropriate healthcare technology, additional Medicare rebates for case conferencing, secondary consultations, and consultations focussing on primary prevention rather than exclusively on treatment.

The issue

General Practitioners play an important role for mental health consumers and carers to access assessment, care coordination and other services. They can also be a stable presence with whom the consumer can develop a long-term supportive relationship.

Thought Leaders considered that medical practitioners' education involves a greater concentration on diagnosis and prescription rather than care

coordination. In addition, care coordination is not generally well defined in general practice and participants thought GPs could benefit from the involvement of other practitioners such as a consultant-liaison role provided by mental health nurses, and/or others in a multidisciplinary team, including mental health peer workers. In addition, there also appeared to be administrative, structural and funding impediments such as duplicative MBS procedures.

Funding gap – GPs are not currently paid for case-conferencing, if there is no funding for this, it won't happen – this cooperation is not being encouraged.

Clinical Psychologist

Finding the Path analysis of 10 years of the Bettering the Evaluation and Care of Health (BEACH) data indicated that despite the centrality of general practice to the health service system it was under-utilised for both low and high prevalence mental health disorders, particularly for counselling and referral. The consumer experience survey indicated that care planning was often delivered in a perfunctory manner that satisfied requirements of government administrative but not those of the consumers, with comments that the process felt like a "tick box" exercise to satisfy bureaucracy.

Recommendation Ten - Identify and adopt good practice examples of mental healthcare technology

At national, state/territory and local service provider levels, developments in healthcare technology should be continually monitored to promote better access, efficiencies and efficacy in mental health service provision. People with lived experience and industry experts should assess the practical and ethical considerations of the inclusion of new healthcare technology and ensure infrastructure to support its use, especially in remote areas. An essential strategy to support the use of technology for mental health is to educate the public so that they are better able to choose the most appropriate online service for themselves or to support the person for they are caring to do so.

The issue

E-mental health services such as online counselling, web-based self-help and support services, electronic health records and video chat applications are effective for people experiencing mild to moderate symptoms of mental illness, especially for people experiencing anxiety or depression. E-mental health services can facilitate access, augment existing mental health services, reduce costs, offer convenience and protect anonymity. They also can be particularly helpful for people who have transport problems, or who live in rural and remote locations. There are now a variety of options for direct consumer access as well as platforms such as eMHPrac which deliver practitioner mental health training and support.⁵ Potential areas of development include assisting those who have limited access to or confidence with information technology and increased availability to health professionals of technologies which facilitate care planning, management, monitoring and coordination.

Technological innovations may occur at any level of policy implementation and/or service provision and may often occur in isolation as pragmatic a response to a local issue. It is important that such developments are identified and where appropriate adapted, adopted and replicated nationally to improve the quality, effectiveness and efficiency of achieving better practice and better outcomes in mental health services.

Stop looking at mental health in isolation – e.g., access to online health records – issues around stigma, insurance, privacy/confidentiality

Community Mental Health

Recommendation Eleven - Timely care focusing on primary, secondary and tertiary prevention

Service provision must not be conditional upon a person being in crisis but rather care interventions should be planned and offered in order to prevent the person from reaching crisis. Mental health policy and service planning should focus on early prevention and timely intervention to prevent the occurrence, recurrence and/or progression of an illness. In particular, service provision should not be determined by a specific diagnosis but on a comprehensive assessment of the person's current functionality and their own account of their needs. Government departments at all levels and service providers (government and non-government organisations) should educate people with mental health conditions, their families, and their carers about all care options available to them, which would be the most helpful to them at any given time, and how they can most easily access that assistance.

The issue

Mental health policy and service planning should have the focus and capacity to facilitate long-term wellbeing outcomes rather than short-term responses to acute illness. A service system which can respond to people only when they are in crisis is a system that is itself in crisis. Mental health policy and service planning should increase their focus on timely service provision (primary, secondary, tertiary prevention) to ensure a good quality of life and to prevent the exacerbation of and complications associated with chronic mental health conditions.

In addition, the importance of support and education for carers/family of the consumer is often overlooked, yet it is essential that people with mental health conditions, their families and carers understand the care options available, which will be most helpful to them at any given time and how they can best access assistance.

Gatekeeper role can cut people out, how people fit into diagnostic categories dictates care.

Consumer Representative

We need to ensure that current policies, regulations and funding processes do not create perverse incentives. Preventive medicine and psychological services are generally time intensive when compared with ordering a diagnostic test or reviewing medication. Relatively high Medicare reimbursement rates for treatments and diagnostic tests in contrast to relatively low reimbursement rates for time spent talking with patients will act as a disincentive to spend time with health consumers on prevention, education and counselling. This is also the case where the performance of individual practitioners or organisations are measured and rewarded based on diagnostic or treatment criteria rather than health education and preventive services.

Recommendation Twelve - Care based on a person's functionality, not their diagnosis

The type and intensity of mental health care that mental health specialists and allied health practitioners provide should be based on a comprehensive assessment of the consumer's functionality, and therefore appropriate to the level of need the consumer is experiencing at that specific point in their recovery journey, rather than based on their diagnosis. For example, as a system of stepped care is rolled out by Primary Health Networks, it is important to avoid the association of specific steps with example diagnoses, focussing instead on the presenting limitations to health and quality of life for which each step is most appropriate.

The issue

The type and intensity of care provided should be appropriate to the level of need the consumer is experiencing at any specific point in their recovery journey. As described in recommendation 11, Thought Leaders were concerned that too much care was driven by diagnostic labels rather than ongoing assessment of current needs, and was reactive rather than preventive and recovery-focused. The introduction of stepped care was seen as a positive step, but is reliant on a comprehensive assessment system, availability of appropriate services and the capability to manage smooth transitions between steps according to consumers' changing needs.

Making sure services are accessed in a timely way - Getting people into care based on functionality rather than diagnostics

Social Worker

Participants in the Finding the Path consumer experience of care planning survey made

What people need are high quality ongoing medical and allied services. The plans do not enable adequate, let alone high quality, mental health services to arise from the ether. Until such services are created the plans remain a bureaucratic exercise for many, probably for most with significant mental illness.

Survey Participant 15

similar observations. They saw the important role for care planning, including comprehensive assessments of needs, but most did not feel that the plans were used in this way. One critical issue identified in the survey was that systems of assessment and management could not operate effectively in the absence of sufficient and connected quality services.

Recommendation Thirteen – Consumers have choice and control in their care planning

A sufficient number of adequately trained mental health staff must be allocated enough time and the appropriate resources to ensure mental health care plans are jointly planned and monitored in a process led by the consumer and guided by the health service provider. Consistent with recommendations seven and eight, providers involved in this shared decision-making process should be expanded to include allied health professionals and peer workers. Emphasis should be on consumer control of their recovery and the treatment and other actions taken to progress their goals.

The issue

The development of a mental health care plan should be a collaborative process in which the consumer has enough information and time to make informed decisions about their physical, psychological and social wellbeing, including assessing their mental health needs, identifying their recovery goals and monitoring their progress. A key function of mental health care plans is to facilitate goal-setting and a focus on recovery, but many plans are created with the minimum information needed to satisfy requirements for subsidised psychological care.

Choice and control facilitation for person to feel that they can own what they need, and empower the agency of the person to be more effective

Consumer Representative

Thought Leaders and participants in the consumer experience survey suggested that shared decision-making was one of the poorest aspects of the current system, often putting most control in the hands of service providers and leaving consumers out of planning their recovery.

Recommendation Fourteen – Mental health care plans are holistic, incorporating psychosocial issues and supports

Mental health service providers involved in care planning should be provided with education and guidance to ensure that mental health care plans include but are not dominated by medical/clinical concerns and are holistic, incorporating relevant psychosocial issues, supports and services as required by the consumer. Mental health care plans should support individuals to maintain and enhance their connection to their local community and to community-based service providers as appropriate.

The issue

There was a consensus among the broad range of stakeholders at the Thought Leaders' Forum that the aim of a mental health care plan should be to keep people living in their communities and out of a hospital, yet they observed that often this was not the case. Care plans should focus on continuing recovery and maintaining the quality of their life rather than episodic acute interventions.

The only way to get care is 'to be really sick'

National Mental Health Commission

A mental health care plan can be an important tool to assist consumers and health professionals to maintain a person's quality of life and to prevent exacerbation or relapses of their condition, however, the practical value of such a plan is contingent on it being a 'living document' that is regularly monitored to ensure its continued relevance and utility for the individual. Finding the Path BEACH analyses concluded that the rates for the reviews of GP care plans were commensurate with their creation for diabetes, but not for mental disorders. Findings suggest that care plans are underutilised for people with low prevalence mental disorders, and while they offer financial benefits to consumers by assisting access a limited number of allied health consultations, they may not result in ongoing collaborative care.

Appendix 1 - Questions and topics from the Thought Leaders' Forum

Questions used to facilitate the Thought Leaders' Forum

1. What are some specific strategies that you think you might improve mental health policy on the key macro and meso level building blocks in the ICCC model?
2. What do you think might explain the lack of change/progress in successive mental health plans and how might this be improved?
3. What do you see as the core role of general practice for serious mental illness care and what is needed at a system level to support this?
4. What strategies do you suggest are needed to improve the use of mental health care plans to support care coordination and long-term management?

Addendum: What should we do with this information/our recommendations?

Topics for thematic analysis of responses from the Thought Leaders' Forum

Topic 1: Improving mental health policy at the macro level

Topic 2: Improving mental health at the meso level (organisation & community)

Topic 3: Micro level - mental health consumer interaction with service provider

Topic 3.1: Improving use of mental health care plans for care coordination & management

Topic 3.2: Role of GP for serious mental illness care

Appendix 2 - Thought Leaders' Forum findings

Topic 1: Improving mental health policy at the macro level

Co-Design:

1. Integration and person-focused – look at the person's journey {Community Mental Health}
2. Perception vs. Reality e.g., in terms of quality, safety, effectiveness, need to value the consumer perspective {Mental Health Consumer Peak}
3. Build consumer and carer architecture - build from this perspective up, rather than top-down {Consumer Representative}
4. Still in phase of experts telling people what they want – for policy, a blend is required from person-driven perspective that also utilises expertise that has been collected over time {Community Mental Health}
5. Clarity on what is being used e.g., co-design vs. consultation etc. {Community Mental Health}
6. A shared or common plan (Group)

Funding:

7. Funding, doing! {Community Mental Health}
8. Ongoing investment in mental health services and reform (Federal Health Policy)
9. Funding, blend of public and private funding – ratios may change as systems mature {Community Mental Health}

Government Policy & Strategy:

10. Policy based on older/incomplete or fragmented data, a national approach to national data is needed {Mental Health Consumer Peak}
11. Long term goals, with short-term goals {Community Mental Health}

Political & Government Stability:

12. Overall framework is stable {National Health Consumer Peak}

Prevention & Early Intervention:

13. Focus more on promotion, prevention, early intervention {State/Territory Health Policy}

Private MH Care\Considerations

14. Also important to recognise the role of private health care within the system {National Health Consumer Peak}

Right Care (Type, Time, Intensity):

15. Titrating services to need {National Health Consumer Peak}

Using an Evidence Base:

16. Policy based on older/incomplete or fragmented data, a national approach to national data is needed {Mental Health Consumer Peak}
17. Evidence-based policy and decision making, recognising the importance of data and research (Federal Health Policy)

Whole Service System:

18. Lack of understanding of what mental illness is, and what providers are offering that exists between different health care providers {Clinical Psychologist}

Workforce Development:

19. More mental health education across a wide spectrum of qualifications, ensure literacy (e.g., police, teachers, etc.) {Community Mental Health}

Topic 2: Improving mental health at the meso level (organisation & community)

Co-Design:

20. Build consumer and carer architecture - build from this perspective up, rather than top-down {Consumer Representative}
21. Integration and person-focused – look at the person's journey {Community Mental Health}
22. Perception vs. Reality e.g., in terms of quality, safety, effectiveness, need to value the consumer perspective {Mental Health Consumer Peak}
23. Still in phase of experts telling people what they want – for policy, a blend is required from person-driven perspective that also utilises expertise that has been collected over time {Community Mental Health}
24. Clarity on what is being used e.g., co-design vs. consultation etc. {Community Mental Health}

Funding:

25. Lack of understanding of what mental illness is, and what providers are offering that exists between different health care providers {Clinical Psychologist}

Right Care (Type, Time, Intensity):

26. Focus more on promotion, prevention, early intervention {State/Territory Health Policy}
27. Titrating services to need {National Health Consumer Peak}

Technology for MH Care:

28. Stop looking at mental health in isolation – e.g., access to online health records – issues around stigma, insurance, privacy/confidentiality {Community Mental Health}

Using an Evidence Base:

29. Evidence-based policy and decision making, recognising the importance of data and research (Federal Health Policy)

Workforce Development:

30. More mental health education across a wide spectrum of qualifications, ensure literacy (e.g., police, teachers, etc.) {Community Mental Health}

Topic 3: Micro level - mental health consumer interaction with service provider

Topic 3.1: Improving use of mental health care plans for care coordination & management

Co-Design:

31. Raising awareness of recovery, using mental health care plans in a more holistic way, the person contributes to their own plan with a peer service {Social Worker}
32. What does it look like? Walk with the person, recovery path, person-directed care {Community Mental Health}
33. Addressing SR's Q: Accurately assessing the individual's need – isn't the best person to do this, the person themselves? {Community Mental Health}
34. Choice and control facilitation for person to feel that they can own what they need, and empower the agency of the person to be more effective {Consumer Representative}
35. Sharing power needed- cultural and structural issues that lead to dominance of medical/clinical {Consumer Representative}

Right Care (Type, Time, Intensity):

36. Making sure services are accessed in a timely way - Getting people into care based on functionality rather than diagnostics {Social Worker}
37. What does it look like? Walk with the person, recovery path, person-directed care {Community Mental Health}

Whole Service System:

38. General population literacy can assist e.g., what to ask, how to talk about it {Community Mental Health}
39. Raising awareness of recovery, using mental health care plans in a more holistic way, the person contributes to their own plan with a peer service {Social Worker}
40. Bringing services to people, especially in the beginning when people are at the beginning of their mental illness journey (early, rather than waiting for them to get more unwell), unable to leave home to access services {Community Mental Health}
41. Accessing mental health services within other areas, e.g., 'accessing MH services, without accessing MH services' {State/Territory Health Policy}
42. Addressing SR's Q: Accurately assessing the individual's need – isn't the best person to do this, the person themselves? {Community Mental Health}

Topic 3.2: Role of GP for serious mental illness care

Care Coordination:

43. Choice and control facilitation for person to feel that they can own what they need, and empower the agency of the person to be more effective {Consumer Representative}
44. A shared or common plan (Group)

Access & Availability:

45. Bringing services to people, especially in the beginning when people are at the beginning of their mental illness journey (early, rather than waiting for them to get more unwell), unable to leave home to access services {Community Mental Health}

Co-Design:

46. 'Informed decision-making' – how do you include the person in this discussion about their care {Community Mental Health}
47. Need to listen to the individual, this should be the driver of where the plan goes – can include broader care, housing etc. Having the person being the centre of the plan for their own recovery {Consumer Representative}

Multi-Disciplinary Approach:

48. Perhaps other health care practitioners can also create/manage mental health care plans {Community Mental Health}

Right Care (Type, Time, Intensity):

49. 'Informed decision-making' – how do you include the person in this discussion about their care {Community Mental Health}
50. Important to note that clinical psychologists aren't limited to CBT, there are other therapy options that can be used for sessions {Clinical Psychologist}
51. Research predominantly based on CBT, in trials usually use manuals – what works for people is broader {Clinical Psychologist}
52. Need to listen to the individual, this should be the driver of where the plan goes – can include broader care, housing etc. Having the person being the centre of the plan for their own recovery {Consumer Representative}
53. Bringing services to people, especially in the beginning when people are at the beginning of their mental illness journey (early, rather than waiting for them to get more unwell), unable to leave home to access services {Community Mental Health}
54. Sharing power needed- cultural and structural issues that lead to dominance of medical/clinical {Consumer Representative}

Service System Capacity Building:

55. Accessing mental health services within other areas, e.g., 'accessing MH services, without accessing MH services' {State/Territory Health Policy}
56. Slower reform would be useful, working towards long term goals, with certainty, a plan and steps and leadership, for example the Button plan of car tariff reduction, and the way that agricultural tariffs were reduced in Australia. Predictable, and gave people time to adapt and change {Community Mental Health}
57. National MH Plan could be refocused to bring about long term change {Community Mental Health}
58. Plan where it is going, step by step approach, not be related to political cycles {Community Mental Health}

Workforce Development:

59. Perhaps other health care practitioners can also create/manage mental health care plans {Community Mental Health}

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