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Submission: Review of Adult Mental Health Rehabilitation Unit (AMHRU) Model of Care

Submitted by email to:

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This submission has been prepared by the ACT Mental Health Consumer Network (the Network) in response to the invitation from the Canberra Health Services (CHS).

Acknowledgment of Country
We wish to acknowledge the Ngunnawal people as traditional custodians of the land upon which we sit and recognise any other people or families with connection to the lands of the ACT and region. We wish to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people may be reading this submission, and we recognise the ongoing contributions of all Indigenous peoples to ACT society and Australia more broadly.

Recognition of lived experience
We wish to recognise people with mental health illness (consumers[1]) whose resilience and work contributes to creating a better mental health system for the Australian Capital Territory (ACT) and a more compassionate society for all.

The ACT Mental Health Consumer Network
The Network is a consumer-led peak organisation representing the interests of mental health consumers in the ACT in policy and decision-making forums. The Network is committed to social justice and the inclusion of people with experience of mental illness. Run by consumers for consumers, our aim is to advocate for services and supports for mental health consumers which better enable them to live fuller, healthier and more valued lives in the community.

General comments
The Network welcomes the opportunity to contribute to the review of the Adult Mental Health Rehabilitation Unit (AMHRU) Model of Care (the MoC). Through

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[1] *We use the term 'consumer' because it is the established and widely understood descriptor across ACT legislation, policy frameworks and advisory structures, ensuring clarity and consistency in our systemic advocacy. At the same time, we recognise that people with lived experience do not all identify with the same language, and that terms such as 'people with lived experience' and 'peer' are increasingly used in contemporary contexts were relevant. Our approach is to retain 'consumer' where required for system engagement, while respecting individuals' right to self-identify in the way that best reflects their experience. This supports inclusion, aligns with national lived experience guidance, and maintains the Network's authority and effectiveness within the mental health system.*

consultation, consumers identified a range of issues across several key areas requiring further consideration.

This submission incorporates both verbal and written feedback from consumers.

Consumers highlighted the following areas of concern:

- Transparency of referral and intake processes;
- Consumer rights, information access, and decision-making;
- Discharge planning and continuity of care;
- Exclusion criteria and rationale;
- Cultural responsiveness and equity of access; and
- Peer workforce integration and consumer involvement.

Each of these matters is discussed in detail below, followed by a consolidated list of recommendations provided by consumers.

Transparency of referral and intake processes

Consumers noted that referral and intake processes are not always clearly explained from a consumer perspective, particularly regarding the information available to consumers before admission.

Section 6 (p. 8) outlines referral pathways, review by an AMHRU Admission Panel, and the intake assessment process. However, it is not always clear what consumers can expect during referral and intake, how admission suitability decisions are communicated, or how they are supported to understand admission expectations. Consumers also questioned whether they are routinely informed about the content of intake assessments and whether opportunities exist to discuss or clarify this information.

It is recommended that this section be strengthened by improving transparency and providing clearer consumer-facing information about referral, intake, assessment, and admission processes.

Consumer rights, information access, and decision-making

Consumers noted that the MoC does not include a clear section outlining consumer rights. A need was identified for clearer information regarding rights during admission, treatment, and discharge, including access to relevant information such as care plans and assessment documentation, as well as complaint and advocacy pathways.

While the MoC describes collaborative care, feedback indicated that decision-making authority remains primarily clinician-led, including decisions relating to admission, continuation of rehabilitation, and discharge planning. Consumers also raised concerns about how disagreement with treatment recommendations or discharge decisions is managed, and whether structured processes exist to support review or escalation.

Consumers suggested that a dedicated consumer rights section be included, along with strengthened processes for managing disagreement, review, and escalation.

Discharge planning and continuity of care

Consumers supported discharge planning beginning at admission; however, concerns were raised regarding the clarity and consistency of discharge processes (p. 10).

It was noted that it is not always clearly explained whether consumers can self-discharge, whether discharge summaries are provided, and how continuity of care is supported following early or unplanned discharge. Consumers also noted that processes for disagreement with discharge decisions are not clearly described, particularly in situations where consumers do not agree they are ready for discharge.

It is recommended that discharge planning processes be clarified, including self-discharge pathways, access to discharge summaries, processes for managing disagreement with discharge decisions, and continuity of care arrangements.

Exclusion criteria and rationale

Consumers noted that while eligibility criteria are clearly defined, there is less clarity regarding exclusion criteria and the rationale for certain diagnostic exclusions (p. 8). In particular, consumers raised questions about exclusions relating to complex post-traumatic stress disorder, personality disorders, intellectual disability, and acquired brain injury. It was also noted that information on alternative pathways or service options for excluded consumers is not provided.

Consumers suggested that exclusion criteria be accompanied by clearer clinical rationale and that alternative service pathways are explicitly described within the MoC.

Cultural responsiveness and equity of access

Cultural responsiveness was identified as a significant gap within the MoC. While Aboriginal Liaison Officers and interpreter services are referenced, it was noted that cultural safety is not clearly embedded as a core component of service delivery.

Consumers highlighted barriers for culturally and linguistically diverse (CALD) consumers and Aboriginal and Torres Strait Islander consumers, particularly in relation to communication, service navigation, and family involvement.

To enhance cultural safety and accessibility, it is recommended that cultural responsiveness be strengthened as a core framework, including clearer interpreter pathways, improved First Nations culturally safe practice approaches, and strengthened system navigation supports.

Peer workforce integration

Consumers identified that peer workforce integration is underdeveloped within the MoC. While future Peer Pathways initiatives are referenced, peer support is not clearly embedded in current service delivery.

They suggested clearer inclusion of peer workers across admission, rehabilitation, and discharge processes, alongside peer-led activities and structured consumer feedback mechanisms such as entry and exit interviews. It is recommended that peer workforce roles be more clearly embedded across the MoC to strengthen consumer involvement and lived experience integration within service delivery.

Recommendations

Recommendation 1

In Section 6 (p. 8), strengthen transparency of referral and intake processes, including plain-language information on assessment, admission decisions, and what consumers can expect during referral and intake.

Recommendation 2

Include a dedicated consumer rights section outlining access to information, participation in decision-making, complaints and advocacy pathways, and processes for managing disagreement.

Recommendation 3

Clarify processes for managing disagreement and escalation in relation to treatment, rehabilitation planning, and discharge decisions (p. 10).

Recommendation 4
Strengthen discharge planning and continuity of care, including self-discharge processes, access to discharge summaries, continuity after unplanned discharge, and disagreement processes (p. 10).

Recommendation 5
In Section 5 (p. 8), clarify exclusion criteria and rationale, including diagnostic exclusions (complex PTSD, personality disorders, intellectual disability, acquired brain injury) and alternative pathways.

Recommendation 6
Strengthen cultural responsiveness and equity of access, including interpreter access, CALD support, First Nations culturally safe practice, and system-level responsiveness.

Recommendation 7
Strengthen peer workforce integration through peer workers in service delivery, peer-led activities, and structured consumer feedback processes.

Conclusion
Consumers welcomed the opportunity to contribute to the review of the AMHRU Model of Care. Feedback highlighted the need for greater clarity and transparency across key areas, including referral and intake processes, consumer rights, discharge planning, exclusion criteria, cultural responsiveness, and peer workforce integration.

These insights aim to support improvements that strengthen consumer understanding, equity of access, and consistency of care across the service.

Consumers value being heard and look forward to seeing how their perspectives are reflected in the final approach.