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**Submission: Review of Model of Care – Adult Inpatient
Mental Health Services**

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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 (consumers¹) 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 Model of Care – Adult Inpatient Mental Health Services (the MoC).

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.

The revised MoC was generally considered to be a significant improvement on previous similar documents. It was noted that a number of sections were clearer and contained more useful information than previous versions. The description of the MoC as a “dynamic document” that can be updated over time was also viewed positively. Consumers also responded positively to the language used in Section 6, *Therapeutic supports*.

A recurring theme across the discussion, however, was that some parts of the MoC remain broad or aspirational. Consumers seek more practical information about what people can expect when accessing inpatient mental health services, how processes work in practice, how consumer choice and consent are protected, and who is accountable for ensuring commitments in the MoC are implemented.

The concerns raised during the discussion are presented below in the order in which they were raised, followed by a summary of the key themes arising from the consultation and a consolidated list of recommendations provided by consumers.

Section 2.1 – CHS vision, role and values

Some of the CHS values are expressed in overly absolute terms. Statements such as “we always do what we say” and “we make everyone feel welcome and safe” (p. 6) were considered difficult to guarantee in practice. Consumers suggested using wording such as “we aim to...” to better reflect these statements as organisational aims rather than outcomes that can always be assured.

Questions were also raised about accountability. It is not clear who is responsible for ensuring that the vision, role and values are implemented in practice or how accountability for these commitments is demonstrated.

Section 3.1 – Adult Acute Mental Health Services

Consumers considered this section to be an improvement, particularly because the descriptions of the different services and the reasons for admission were clearer.

Section 3.5 – Mental Health Consultation Liaison

Consumers request more practical information about how the Mental Health Consultation Liaison (MHCL) service operates from a consumer perspective (p. 10). Queries included

- how an individual consumer can access or speak with the MHCL team;
- whether this contact occurs through a clinician or case worker; and

- how the service works with other people involved in a consumer's support, including NDIS workers and private or independent providers.

These practical relationships and access arrangements could be explained more clearly in the MHCL section.

Section 4.7 – Mental Health Consultation Liaison eligibility criteria

The wording and information in this subsection are considered clearer and improved compared with previous material.

Section 5 – Consumer Journey

Consumers raised several concerns about whether the Consumer Journey section provides enough practical and accessible information about what a person may experience during inpatient care. This concern is elaborated in discussion of specific issues and subsection below.

Consumer Journey illustration

The illustration of the consumer journey is insufficiently detailed and not particularly well designed (p.15). Consumers felt that the images were somewhat repetitive or confusing, and that the presentation could feel as though it was talking down to consumers.

Consumers recommend using more appropriate and selective visual information and providing clearer details about the different stages of the journey.

Section 5.1.1 – Referral and admission pathways

It was noted that the section states that people enter AIMHS through a number of “common pathways” (p. 15). While this suggests that the pathways listed are not exhaustive, consumers are concerned that other referral pathways and circumstances are not sufficiently visible. Examples raised during the discussion included arrival via PACER, other crisis response services, and self-presentation.

Consumers also request more practical information about what happens when someone arrives at the service, including where they enter, whether a designated assessment or waiting space is available, what the admission and assessment process involves, and what to expect while waiting.

Section 5.1.2 – Admission and initial assessment

Consumers seek greater clarity about the belongings check undertaken during admission (p. 16).

The current wording refers to prohibited items and the management of high-risk medications and substances. Information about other potentially risky items, such as shoelaces and belts, should also be clearer so that consumers understand what may be checked, removed or managed, and why.

There was also discussion about the requirement to confirm and explain a person's legal status and provide information about their rights and responsibilities (p. 16). Consumers considered that simply providing or explaining information does not necessarily ensure that a consumer has understood it. The MoC should therefore provide greater clarity about how staff will check or confirm consumers' understanding of information relating to their legal status, rights and responsibilities.

Section 5.1.3 – Care planning, review and continuity

Consumers consider this section too general and that more practical detail is required. This should include but not be limited to information about how frequently care planning and review occur, and what services or supports may be available (p. 16).

Further, peer supports should be explicitly included among the people and services that may contribute to collaborative care planning.

Section 5.1.4 – Therapeutic interventions during inpatient stay

Consumers consider the term “interventions” unclear and recommend that it be explained in more accessible language (p. 16).

There was also discussion about the statement that “Additional assessment and intervention may be offered, such as a cultural assessment by an Aboriginal Liaison Officer or support from Spiritual Support Services” (p. 17). Consumers questioned how access to these supports is ensured in practice, rather than them simply being identified as services that “may be offered”.

The wording concerning review of care plans with “the consumer, their carers, families and supporters as appropriate” also raised concerns about privacy, choice and consent (p. 17). Consumers suggested that the document explicitly recognise that involvement of carers, family members and supporters should take account of the consumer's consent and preferences, including circumstances where a

consumer does not want particular people involved or does not want information shared with them. In particular, while consumers strongly support the involvement of carers in the review of care plans and other information sharing, we also acknowledge that not all persons who may claim to be a person's carer are genuinely their carer. For example, in relation to an adult consumer, their parent is not necessarily their carer. Careful consideration must be given to ensuring a consumer's information is not shared inappropriately.

Concerns were also raised about the statement that care planning may be informed by assessment of mental state based on participation in group programs (p. 17). Group programs may not suit every consumer, such as consumers with social anxiety, and some people may choose not to participate. Consumers insist that assessment and care planning should remain individualised. No one should be disadvantaged based on participation in group activities.

Section 5.4.1 – MHCL referrals

Consumers seek greater clarity about referral and presentation pathways involving services such as PACER, related crisis response services and police (p. 18).

The importance of the environment in which mental health assessment and discussion occur was also raised, particularly the availability of an appropriate private space for consumers to discuss sensitive information.

Section 6 – Therapeutic supports

Consumers generally considered the language in this section to be appropriate and an improvement.

Section 6.3 – Peer Support

Consumers recommend that information about Peer Pathways be updated in a timely way as implementation of the service progresses (p. 21).

Questions were also raised about the use of the expression “promote hope” in describing the role of Peer Workers (p. 21). Some consumers suggested reconsidering whether this wording appropriately reflects the role and intent of peer support.

Section 7 – Risk assessment and management

Consumers recommend that the discussion of risk assessment be more comprehensive (p. 22). The document states that AIMHS uses a combination of

clinical assessment and standardised tools and lists the Suicide Vulnerability Assessment Tool, Clinical Risk Assessment and Brøset Violence Checklist. This section should provide greater recognition of other circumstances and forms of risk. Eating disorders were specifically raised as an example that is not addressed within this discussion of risk assessment.

There was also a view that risk assessment should distinguish more clearly between verbal expressions or statements of risk and actual physical behaviour or immediate physical risk.

Accountability within risk assessment and risk management processes was also identified as an area requiring greater clarity.

Section 7.1 – Consumer participation in risk assessment and management

Consumers consider the current description of consumer participation to be too general.

The statement that “open and transparent conversations” between consumers and the multidisciplinary team help individualise assessment does not clearly explain how consumers are actively involved in assessing and managing their own risk (p. 23).

Consumers recommend providing more information about how consumer knowledge is incorporated into risk assessment, including consumer-identified triggers, previous experiences, preferences, strengths and strategies that consumers know may assist them.

Adult eating disorder inpatient service

Specific feedback regarding the adult eating disorder inpatient service was provided. Some consumers question why this service is not included in the service descriptions, noting that the Adult Mental Health Rehabilitation Unit is explicitly described.

At a minimum, the document should briefly identify the eating disorder inpatient service and explain the relevant eligibility and treatment arrangements, even where detailed information is contained in a separate MoC or other document.

Section 13 – Monitoring and Evaluation

Concerns were raised about some of the completion-rate targets listed in the KPI table (p. 32). Some consumers specifically questioned the target of 95% for

consumers undergoing a mental health examination within 72 hours of admission. It was considered that, where people have been admitted for mental health care, this target should be 100%. The target of 80% for consumers having a completed care plan was also considered too low.

Concerns were similarly raised about the staff training targets of 85% completion for mandatory training and 80% completion for required training. In particular, consumers questioned why the completion target for training identified as mandatory is below 100%.

Consumers recommend reviewing these performance targets to ensure they reflect appropriate expectations for inpatient mental health care and workforce capability.

Key themes arising from the consultation

Overall, consumers recognise substantial improvement in the revised MoC while also identifying a need for greater clarity about how the model will operate in practice.

Across different sections, consumers consistently called for:

- clearer and more practical information about what consumers can expect;
- greater specificity about how consumers participate in decisions about their care;
- clearer recognition of consent, privacy, preferences and individual choice;
- greater transparency regarding responsibility and accountability;
- recognition of different pathways and individual circumstances;
- accessible and respectful communication; and
- performance measures that reflect appropriate expectations for inpatient mental health services.

Overall, consumers support the direction of the revised MoC but consider that greater practical detail would make the document more meaningful and useful for people accessing Adult Inpatient Mental Health Services and the staff implementing the Model.

Recommendations

Recommendation 1

Review the wording of the CHS values to avoid overly absolute statements and consider language such as “we aim to” where appropriate, and clarify responsibility

and accountability for implementing the vision, role and values in practice (Section 2.1, p. 6).

Recommendation 2

Provide clearer practical information about how consumers can access and communicate with the Mental Health Consultation Liaison (MHCL) team, including the role of clinicians or case workers and how MHCL works with NDIS workers, private clinicians and other independent or external support providers (Section 3.5, p. 10).

Recommendation 3

Review the Consumer Journey illustration to provide clearer, more meaningful and appropriate information, reduce repetitive or confusing visual content, and better explain the different stages of the inpatient journey (Section 5.1, p. 15).

Recommendation 4

Expand the information on referral and admission pathways to acknowledge other pathways and circumstances raised by consumers, including PACER and other crisis response services, self-presentation and police involvement (Section 5.1.1, p. 15).

Recommendation 5

Provide more practical information about what consumers can expect when arriving at an inpatient service, including where they enter, the availability of designated assessment or waiting spaces, the admission and assessment process, and what to expect while waiting (Section 5.1.1, p. 15).

Recommendation 6

Provide clearer information about belongings checks during admission, including potentially restricted or high-risk items such as shoelaces and belts, how these items may be checked, removed or managed, and why (Section 5.1.2, p. 16).

Recommendation 7

Include processes for checking and confirming that consumers understand information about their legal status, rights and responsibilities, rather than relying solely on providing or explaining this information (Section 5.1.2, p. 16).

Recommendation 8

Provide more practical detail about care planning and review, including how frequently reviews occur, what services and supports may be available, and explicitly recognise peer support as a service that may contribute to collaborative care planning (Section 5.1.3, p. 16).

Recommendation 9

Review the term “interventions” and provide clearer, more accessible explanations of therapeutic interventions, including how consumers are offered and supported to access cultural, spiritual and other identified supports in practice (Section 5.1.4, pp. 16–17).

Recommendation 10

Strengthen the wording relating to the involvement of carers, families and supporters in care planning and review to explicitly recognise consumer consent, privacy, preferences and choice about who is involved and what information is shared (Section 5.1.4, p. 17).

Recommendation 11

Ensure that assessment and care planning remain individualised and that consumers are not disadvantaged where participation in group programs is unsuitable or not preferred (Section 5.1.4, p. 17).

Recommendation 12

Provide clearer information about referral and presentation pathways involving PACER, related crisis response services and police, and ensure consumers have access to an appropriate private environment for sensitive mental health assessment and discussion (Section 5.4.1, p. 18).

Recommendation 13

Ensure information about Peer Pathways is reviewed and updated in a timely way as implementation progresses, and review the use of the expression “promote hope” to ensure the language appropriately reflects the role and intent of peer support (Section 6.3, p. 21).

Recommendation 14

Expand the discussion of risk assessment to recognise a broader range of circumstances and forms of risk, including presentations such as eating disorders, and clarify distinctions between verbal expressions or statements of risk and actual physical behaviour or immediate physical risk (Section 7, p. 22).

Recommendation 15

Clarify accountability and responsibility within risk assessment and risk management processes (Section 7, p. 22).

Recommendation 16

Strengthen the description of consumer participation in risk assessment and management, including how consumer-identified triggers, previous experiences, preferences, strengths and strategies are incorporated into assessment and decision-making (Section 7.1, p. 23).

Recommendation 17

Include information about the adult eating disorder inpatient service, including its role, eligibility and relevant treatment arrangements, with reference to a separate Model of Care or other relevant document where more detailed information is available (Sections 3–4, pp. 7–13).

Recommendation 18

Review the 95% completion target for mental health examinations within 72 hours of admission, including consideration of whether a 100% target is more appropriate for consumers admitted for mental health care (Section 13, p. 32).

Recommendation 19

Review the 80% completion target for consumer care plans to ensure it reflects appropriate expectations for inpatient mental health care (Section 13, p. 32).

Recommendation 20

Review the staff training completion targets, particularly the 85% target for mandatory training and 80% target for required training, including consideration of whether mandatory training should have a 100% completion target (Section 13, p. 32).

Conclusion

Consumers expressed strong support for the direction of the revised MoC and recognised it as a significant improvement on previous versions. The recommendations in this report are intended to strengthen the document by providing greater practical detail, clarity and transparency, ensuring it is meaningful and useful for people accessing Adult Inpatient Mental Health Services and the staff who will be implementing the Model.

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

