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Dear Ms Bracher

Review of Adult Mental Health Day Service Model of Care

Thank you for the opportunity to comment on the Adult Mental Health Day Service Model of Care. Health Care Consumers' Association (HCCA) members are eagerly awaiting the University of Canberra Hospital opening, and appreciate the benefits that the purpose-built facility will provide. HCCA invited comments from our members and many took the opportunity to provide feedback. The comments presented here are based on that feedback.

Introductory comments

The AMHDS principles of care include "person and family centred" and "safety and quality" (page 9), two elements that are very important to the Health Care Consumers' Association. These principles are also consistent with the principles of trauma-informed care,[i] the Picker Principles of Patient-Centred Care[ii] and the Australian Charter of Healthcare Rights.[iii]

The AMHDS *Model of care* makes clear that the Service will strive to deliver a "trauma informed system of care" that will "guide all clinical practices and interventions" (page 9, line 17-18). HCCA is entirely supportive of this aim. Unfortunately, we feel that the Model of Care does at present not reflect the principles of trauma-informed care adequately, nor does it provide enough information to reassure consumers that the care provided by AMHDS will offer "opportunities in a safe and supportive environment" (page 5, lines 19-21).

Our key feedback is that the Model of Care should provide more detail about the role of trauma-informed care within the Service and the benefits this approach offers consumers and staff, with a focus on how trauma-informed care will be operationalised in practice.

People with histories of trauma are significantly over-represented among users of mental health services, yet trauma is frequently overlooked as a factor informing presentation at health services including mental health services. This not only hampers the opportunity for recovery from trauma but renders people vulnerable to re-traumatisation as a result of "trauma-blind" health care delivery.[iv] In addition the experience of mental health care can itself be traumatising, particularly for people who have experienced practices such as involuntary admission, seclusion or restraint. Research suggests that a very high proportion of people who use adult public mental health services have experienced trauma, either single incident trauma or complex trauma – that is, trauma occurring as a result of interpersonal violence (such as abuse or neglect) which can have particularly damaging effects when it occurs in childhood. Some evidence suggests that two in every three people attending emergency, inpatient or outpatient mental health services live with complex trauma.[v] In North America, where practice and research on trauma-informed care are most advanced, research suggests that 90 per cent of public mental health service users in that country have experienced multiple traumatic life events.[vi]

Trauma-informed health care is recognised as supporting recovery and contributing to better experiences of care for both consumers and staff. Therefore, we have chosen to respond to the Model of Care according to the core principles of trauma-informed care[vii]

- Safety
- Trustworthiness
- Choice
- Collaboration, and
- Empowerment.

HCCA recognises that a shift toward trauma-informed care is both necessary and challenging for health services as it demands a fundamental reorientation in how care is delivered for most services. It is important for health services to recognise the work involved in moving towards a trauma-informed approach and it is for this reason that HCCA frames our comments on the Model of Care around the principles of trauma-informed care.

Safety

A trauma-informed system of care has client safety as its first priority[viii]. Safety in this context refers to both physical and emotional safety. People who have experienced trauma often have difficulty trusting other people, systems and institutions. This is because trauma affects the way people approach potentially helpful situations and relationships. HCCA is confident that the purpose-built facility at the University of Canberra Hospital has been designed with the physical safety of both staff and consumers in mind. Nonetheless HCCA suggests that practical strategies to protect physical safety are of paramount importance in all health services, and particularly in a

trauma-informed mental health service such as the AMHDS. Recent experiences at the Adult Mental Health Unit, Mental Health Assessment Unit and Brian Hennessy Rehabilitation Centre underscore this point. HCCA would therefore welcome more detail, including in the Model of Care, about practical strategies the service will put in place to ensure consumer and staff physical safety. These strategies might include design features that protect physical safety and staff to patient ratios.

Emotional safety requires a different set of strategies and the current iteration of the Model of Care does not provide evidence of having strategies in place to acknowledge and sensitively address the emotional safety issues of consumers.

It is a priority that a consumer's first experience of contact with the service is welcoming, respectful and engaging.[ix] One way to ensure this is to provide all staff appropriate training in trauma and its implications for their work.[x] This is important because staff need to be attentive to signs of consumer discomfort or unease. Something as simple as the invasion of a consumer's personal space could catalyse negative thoughts and behaviours.

HCCA would also value explicit recognition of cultural safety as an important element of trauma-informed care. How will the AMHDS provide a culturally safe environment for service users of diverse cultural backgrounds including Aboriginal and Torres Strait Islander people, people of Non-English Speaking Backgrounds, migrants, and refugees?

The Model of Care includes *Access* as its first *Principle of care* (page 8, lines 16-21). HCCA members felt that this was appropriate, but the description of Access needs to expand, particularly with respect to equity. The sensitive acceptance of different cultures (Page 15, lines 20-34) and sexualities (Page 16, lines 1-4) is covered in the section "Supporting individual needs". However, access may also be affected by one's housing circumstances, transport, financial situation and work. Flexibility also influences one's access. Currently the service's opening hours coincide with the working week and make no allowances for people who are unable or unwilling to attend during these times. Unwillingness, in this case, may arise because consumers wish to avoid explanations as to why they require time off during standard work hours. Furthermore, the Model of Care does not state how the needs of consumers will be addressed outside the service's opening hours. For instance, what arrangements are in place for consumers using the service should they find themselves in crisis? how is medication and its side-effects managed outside of hours?

In describing the *Service user characteristics,* the Model states that consumers must be "willing to engage with services" (page 11, lines 5-6). Taken at face value this seems like a reasonable statement. Yet current understanding of trauma-informed care tells us that engagement with a

service relies on trust. It is likely that building trust will take considerable time and this process should be considered a legitimate component of the Model of Care. Without it, the seemingly reasonable requirement that consumers must be "willing to engage with services" may exclude the majority of consumers who would benefit from the service.

Another safety issue may arise around the *referral pathway*. As presented in the Model of Care (pages 11-13), it does not mention the very individuals the service exists to serve. The AMHDS's own principle of "Person and family centred" care should imbue the Model of Care and be evident in something as crucial as the referral pathway. In contrast, the referral pathway is highly bureaucratic and does not consider how the consumer might experience being referred, assessed and deemed eligible or ineligible. People with a history of betrayal and abandonment are rendered vulnerable to feelings of rejection[xi] and this referral process seems to be setting up – at least some proportion of – potential service users for failure. HCCA would welcome more detail in the referral pathway about how people who are deemed ineligible for the service will be assisted, for example, which alternative services will they be referred to? Finally, it is not clear who is allowed to refer to the AMHDS. For instance, can general practitioners refer directly to the service? HCCA would suggest that general practitioners should be listed as a key referral point, given the importance of general practice in the coordination of care for health care consumers. GP is listed as an acronym in the Model of Care, but general practitioners are not mentioned elsewhere in the document.

An HCCA member has specifically asked whether there is scope within the Model of Care to accept the referral to the service of people who are experiencing homelessness. We believe that the Model of Care should provide assistance that will support people in this situation to stabilise their housing situation.

Entry criteria (page 11, lines 13-25) are clearly necessary for any service without inexhaustible sources of money, staff and resources, but there is no mention of what options are available for people who do not meet the criteria. Presumably people younger than 18 years will be redirected to Child and Mental Health Adolescent Services, and it would be good to see this stated. However, where will consumers over 65 years of age be redirected? It is difficult to locate mental health services for people older than 65 years on ACT Health's mental health services site.[xii] However, we are aware of the Acute Care of the Elderly (ACE) Unit [xiii] and the Older Person's Mental Health Community Team.[xiv] If these are the services to which people over 65 will be referred it would be good to state this. Nonetheless, HCCA members have expressed concern that the services provided by the AMDHS will be denied older residents by virtue of their age, and wonder if this represents discrimination under the *ACT Human Rights Act 2004 - A2017-5*.[xv]

Trustworthiness

Trust nurtures feelings of safety, while its absence undermines one's sense of safety, particularly in someone who has suffered trauma as many mental health consumers have. In the context of a trauma-informed service it is vital to maximise trustworthiness. Consumers should expect and receive timely and appropriate communication about their health care in a way they can understand. Little mention is made of consumer materials in the document. One simple way to improve both trustworthiness and choice is to make the information about program content, functions and aims (page 12, lines 4-7) available to potential consumers, not simply referring clinicians.

To build trust, the service needs to provide clear information to all consumers about what will be done, by whom, when, why, under what circumstances, at what cost, and with what goals.[xvi] Ideally, HCCA would like to see clear, consistent *communication* added to the AMHDS's Principles of Care. This would bring them in line with both the Picker Principles of Patient-Centred Care[xvii] and the Australian Charter of Healthcare Rights.[xviii]

Choice

HCCA is pleased that the AMHDS will offer a wide range of programs to consumers. While understanding and accepting boundaries is an important part of recovery, it is also vital that consumers do not experience boundaries as punitive.[xix] Boundaries, including access to programs, should be mutually negotiated. Consumers should not perceive the need to "prove" themselves to "earn" services.[xx] As stated above, making information on each program including its content, functions and aims (page 12, lines 4-7) available to consumers is an important start in facilitating consumer choice.

Collaboration

A trauma-informed service leaves a consumer feeling staff really listen to what the consumer wishes to accomplish. True collaboration requires the service and its staff working "with" rather than doing "to" or "for" consumers. [xxi] While the service lists "Collaboration" among its principles, the Model of Care shows little evidence of this. Using the referral pathway, once again, as an example, point 6 states that "each participant's progress and outcomes will be *discussed* individually with them" (page 12, lines 24-26). Choosing to frame communication as a discussion rather than a negotiation suggests a top down model, one which valorises the health professionals' perspective and fails to acknowledge the individual as the expert in their experience.[xxii]

Collaboration also requires that different members of the service to collaborate with each other. This is addressed cursorily under the principle of *multidisciplinary* care (page 9, lines 12-15). However, true collaboration and empowerment extends beyond the physical boundaries of the AMHDS. One of our members suggested that the service link to other ACT based programs such as The Men's Shed, ACT Health's "Living with a chronic condition", and programs at the Belconnen Arts Centre.

HCCA appreciates that the Model of Care provides a definition of collaboration in the Glossary (page 18). However we would urge that this definition should provide more detail on what is involved in this "way of working": this might include recognition that collaboration is based in the principles of consumer partnership and shared decision-making.

Empowerment

In the words of a Mental Health Consumer and Community Worker:

> *People with complex trauma will often respond better to treatment when they are empowered in ways that are unique to them, and the professionals and institutions should not underestimate the patient's ability to be very useful and active in their own treatment.*[xxiii]

A service which empowers consumers is one that recognises that they have strengths and skills as well as challenges and difficulties.[xxiv] This takes more than simply asserting in two places that empowerment happens.

> Group therapy programs – including a broad range of educational and activities based interventions to empower people to take an active role in their recovery (page 7, lines 17-18)
>
> The AMHDS foster a culture of hope and empowerment that values respectful and therapeutic relationships, building on the strengths and resources of the person, their family and their community. (page 8, lines 23-24)

The Model of Care talks about Data Management systems (page 10, lines 13-37), but it does not mention let alone promote consumer access and management of their own records. This would be one way in which to demonstrate the trust that is required for collaboration. HCCA would like the Model of Care to indicate in other concrete ways how it will achieve empowerment. Addressing the following questions would go a long way towards making empowerment a real possibility rather than a slogan:[xxv]

> How are each consumer's strengths and skills recognized in routine service provision?
>
> How does the program communicate a sense of realistic optimism about the capacity of consumers to reach their goals?

How does the service emphasize consumer growth rather than maintenance or stability?

Does the service foster the involvement of consumers in key roles wherever possible (e.g., in planning, implementation, or evaluation of services)?

Given that the Model of Care refers specifically to empowerment, HCCA suggests that a definition of empowerment could also be included in the Glossary.

General comments

The document generally refers to the "Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI)" (page 2, line 11; page 16, lines 1-2), and in the table of contents to "Lesbian, Gay, Bisexual, Transgender and Intersex and Queer (LGBTIQ)" (page 4, line 1). Our understanding is that the community's preference is for Lesbian, Gay, Bisexual, Transgender and Intersex and *Queer* (LGBTIQ).[xxvi]

The Model of Care refers to peer workers (page 9, line 14-15) as members of the AMHDS multidisciplinary team. However there appears to be no further mention of peer workers in the Model of Care. HCCA suggests that if peer workers are to be involved in the delivery of care at the AMHDS considerably more detail should be provided about their role, including the rationale for involving peer workers, the scope of their role, how they will be remunerated, skills required, training and support provided, and how the AMHDS will protect peer workers from vicarious trauma and re-traumatisation.

The Model of Care makes clear that the AMHDS, like all ACT Health facilities, is smoke-free. HCCA appreciates that the Model of Care provides information about smoking cessation support that will be offered to service users. However we would urge that the Model of Care also explicitly recognise that a smoke-free policy is potentially a significant barrier to service access for people who smoke, and describe the strategies the service will put in place to ensure that people who smoke and do not wish to take up the offer of smoking cessation support can nonetheless access the AMHDS.

Acronyms are used extensively in the Model of Care. HCCA appreciates inclusion of an Abbreviations list (page 2). Thought could be given to spelling out names of services in full at points in the document (e.g. AMHDS, MHJHADS) for ease of understanding of readers not familiar with the array of health services referred to in the document. The acronyms ECR (Electronic Clinical Record) and NRT are used in the document (pages 10 and 17 respectively) and should be included in the Abbreviations list on page 2.

HCCA welcomes inclusion of art therapy (page 8, lines 7-8; page 14, line 11) and sensory modulation therapies (page 8, lines 7-8; page 14, line 10-11) in the Model of Care. Evidence consistently demonstrates that participation in art projects can assist in recovery. Our members

would like to know whether art therapy will include a variety of modalities not limited to painting, craft and sculpture – for example, song and dance? A variety of creative activities will provide more opportunity for services users to discover activities that they enjoy and which aid their recovery.

Summary

HCCA supports the principles of care and would like to see communication added to them. We would also like to see more tangible descriptions of these principles in action. In particular HCCA would welcome more detail on how the AMHDS's stated aim of delivering trauma-informed care will be achieved, particularly with regard to how the key principles of trauma-informed care will be operationalised in the service. HCCA feels that the current AMHDS Model of Care represents a medical approach to mental health care, and would welcome a more explicit discussion of trauma-informed care to be provided by this Service. It may also assist to articulate how the Service will acknowledge the social aspects of mental health and fully incorporate these into a recovery-oriented approach to care. We look forward to seeing how our feedback is incorporated in a future version of the Model of Care.

Yours sincerely

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[i] Kezelman CA and Stavropoulos PA. 2012. *The last frontier: Practice guidelines for treatment of complex trauma and trauma informed care and service delivery,* Adults Surviving Child Abuse found at https://www.blueknot.org.au/ABOUT-US/Our-Documents/Publications/Practice-Guidelines (Accessed 16 May 2018)

[ii] http://www.picker.org/about-us/principles-of-patient-centred-care/

[iii] https://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/

[iv] Mental Health Coordinating Council (MHCC) 2013, *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction,* Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, Authors: Bateman, J & Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA)

[v] Hussain & Chapel, 1983; Emslie & Rosenfeld, 1983; Mills et al., 1984; Bryer et al., 1987; Jacobson & Richardson, 1987; Craine et al. 1988; Swett et al., 1990 in Mental Health Coordinating Council 2013 see note iv

[vi] Dunne, M, Purdie, D, Boyle, F & Coxeter, P, 2005. see note iv

[vii] Kezelman 2012 (see note i)

[viii] Kezelman 2012 (see note i)

[ix] Fallot, RD & Harris, M. "Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol." in (Eds.) *Using trauma theory to design service systems. New directions for mental health services*. San Fancisco: Jossey-Bass. 2009 (p7)

[x] Fallot 2009 (see note ix, p15)

[xi] Kezelman 2012 (see note i, p9)

[xii] http://health.act.gov.au/our-services/mental-health/mental-health-services

[xiii] http://health.act.gov.au/our-services/rehabilitation-aged-and-community-care/acute-care-elderly-ace-unit

[xiv] https://www.mycommunitydirectory.com.au/Australian_Capital_Territory/Canberra/Ageing_Services/General_Ageing_Services/20767/151140/Older_Persons_Mental_Health_Community_Team

[xv] http://hrc.act.gov.au/discrimination/

[xvi] Fallot 2009 (see note ix, p7)

[xvii] http://www.picker.org/about-us/principles-of-patient-centred-care/

[xviii] https://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/

[xix] Kezelman 2012 (see note I, p8)

[xx] Fallot 2009 (see note ix, p8)

[xxi] Kezelman 2012 (see note I, p26)

[xxii] Fallot 2009 (see note ix (p9)

[xxiii] Kezelman 2012 (see note I, p7)

[xxiv] Fallot 2009 (see note ix, p17)

[xxv] Fallot 2009 (see note ix, p9)

[xxvi] A guide to LGBTIQ-inclusive data collection https://www.aidsaction.org.au/images/resource-library/LGBTIQ%20Inclusive%20Data%20Collection%20-%20a%20Guide.pdf