Increasing & Improving Community Mental Health Supports in WA

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CENTRE *for* SOCIAL IMPACT

THE UNIVERSITY OF WESTERN AUSTRALIA

WAAMH

Western Australian Association for Mental Health

Acknowledgements

This project has been like steering a ship through a stream. We were ever hopeful we would have the agility to deeply listen, capture and respond to all that was said at each co-design workshop, focus group and interview. However, at times our processes did get in our way. We got busy planning next steps, perfecting instrument design, and the time pressures of getting everything done were ever-present. Sometimes it felt that there was not enough time to reflect in between engagement sessions. The Lived Experience Advisors were instrumental in picking up forgotten pieces, carrying for us the nuances that may have been missed, and keeping our path steady. Regular check-ins with lived experience expertise helped with the delicate steering required when you are trying to hold what a diverse range of people have expressed, and the trust with which people engaged. I would like to thank the advisors, Margaret, Juanita and Amanda, for adding such value to the project, Chelsea for her enabling, authentic leadership throughout, and everyone else who, despite the constraints, helped to make this work.

The Centre for Social Impact, The University of Western Australia

The Centre for Social Impact (CSI) is a collaboration of three universities: The University of Western Australia, University of New South Wales Sydney and Swinburne University of Technology. The purpose of CSI is to catalyse positive social change, and to enable others to achieve social impact. CSI achieves this through transformational research and education that is rigorous and purpose-driven.

The Western Australian Association for Mental Health

The Western Australian Association for Mental Health (WAAMH) is the peak body for the community mental health sector in Western Australia and exists to champion mental wellbeing, recovery and citizenship. WAAMH recognises that a continuum of supports – built on principles of human rights, recovery, co-production, personalisation and choice, social inclusion and cultural connection – are essential to the promotion, protection and restoration of mental wellbeing.

WAAMH's membership comprises community managed organisations providing mental health services, programs or supports and people and families with lived experience of mental health issues and suicide, with whom WAAMH engages in genuine partnership. WAAMH also engages in a wide network of collaborative relationships at a state and national level with individuals, organisations and community members who share its values and objectives.

Foreword

We would like to acknowledge the people with lived experience as individuals, family members and supporters who have gone before us, whose testimonies we honour and, on whose shoulders we stand as we write this foreword.

Since the early 1980s in Western Australia people with lived experience of mental health challenges have been coming together to advocate: "Nothing about us, without us." From then there has been a plethora of reports, frameworks, laws, policies, standards, inquiries and the like which have called for the meaningful inclusion of individuals, families and supporters in the design, delivery and review of services for people experiencing mental health and alcohol and other drug issues.

Individuals, families and supporters consistently assert that what we want, and need is to have someone who can genuinely walk alongside us in times of distress, as well as during better times if required. This is not a simple task and requires different types of workforce willingness, understandings, competencies, and practices as well as more flexible and person-centred models of service.

The work of service design and delivery needs to be solidly grounded in the knowing, not just the belief, that people can come through difficult and complicated life experiences and discover or re-discover ways of becoming participating citizens living their definition of a good life.

A critical disrupting factor in achieving these outcomes (which people with lived experience deserve) is the development of well-supported peer and lived experience consumer and family-supporter workforces and the organisational willingness and readiness which is required to embrace these workforces and embed them into existing and new services.

Our hope is that our systems of support can become more balanced by increasing the development and provision of community mental health supports that are recovery orientated, consumer and family-supporter led, and effective in delivering what consumers and family-supporters say they want and need.

If you are a peak body or service provider reading this document, we invite you to reflect on your current practices and ask how well they reflect the principles outlined in this report. If you readily identify strengths, please continue to build on them. If gaps are identified, please prioritise filling them with the input and expertise of your lived experience community.

If you are part of a funding or commissioning body, we invite you to use your unique position of power to ensure and monitor the requirement that individuals, families and supporters are meaningfully involved in the design, delivery and review of the services which you commission and fund. Yours is a powerful lever for system transformation.

If you are an individual, family member or supporter, we invite you to become active participants in advocating for and creating a service system which better meets our needs.

If we all commit to working together to achieve the principles outlined in this document and consistently put them into practice, we may be in the unique position of achieving transformation in the community supports area.

This is a shift that will change and save lives.

Margaret Doherty, Juanita Koeijers, Amanda Waegeli

Lived Experience Advisors

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Terms used in this report

'**Consumer**' refers to people with a lived experience of mental health distress, challenges or illness, or of using mental health services.

'**Family members, supporters and carers**' refers to people with a lived experience as a carer, family member, friend or other supporter of a consumer. The term acknowledges that not all family members wish to identify as a 'carer', and there may be other important relationships in a consumer's life or recovery process. These terms are used interchangeably in this report.

SECTION 1:

Introduction

1.1 Background

A BALANCED SYSTEM

Community mental health supports can change an individual's life trajectory by enabling them to better understand and manage their own personal recovery, and supporting them to live well in the community and stay out of hospital. Community mental health supports depart from medical models that approach mental health through a clinical lens, and instead work to increase trust and engagement, flatten power differentials, connect, and support an individual to improve their quality of life.

Within the mental health system, these agile, person-centred services often do not get the visibility they deserve. However, increasingly, mental health policy and reform agendas – nationally and worldwide – are calling for the need to expand non-clinical community mental health support. We are understanding more and more that hospital stays, highly qualified clinicians, and medication is not always the answer, or for the COVID-19-related mental health crisis we are potentially facing.

Australian psychiatrist Patrick McGorry has not been the only voice in pointing out that prevention over intervention works best, as a guiding principle in health care systems. Not only do prevention, early intervention and community support contribute significantly to people's emotional and social wellbeing, they also need to be recognised as integral to a financially sustainable health system (McGorry, 2015). The National Mental Health Commission has acknowledged that high rates of emergency department admissions and readmissions to acute psychiatric services is evidence of a 'failure to provide timely and adequate community-based mental health supports' (National Mental Health Commission, 2014).

One of the primary strategic goals of the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan) is to rebalance the system away from hospital-based interventions to more community-based supports. And yet in 2019, community support was still the most under-resourced service type, meeting only 22% of demand in Western Australia (WA) (Mental Health Commission, 2019b).

Investing in community mental health supports is cost effective, and also likely to pay dividends through their potential to cater for population groups that do not access clinical services, and to more flexibly respond to the needs of consumers with multiple needs (such as people experiencing both mental health distress and co-occurring alcohol and other drug use). In addition, a growing body of evidence suggests that community mental health supports do effectively address mental health needs – as both a complement and an alternative to clinical treatment. While a selected sample of published evidence is presented in this report, the main findings presented here have emerged through the lived experience voice – of consumers, family members, supporters and carers, and the perspectives of service providers. Through these perspectives (sometimes very personal), a rich understanding of needs has emerged, as well as another lens through which to view the effectiveness of the mental health system as a whole, and the unique contribution of community-based services.

"I had an excellent Partners in Recovery worker. She offered supports at critical times in my life when other clinical services would not have been interested in helping me. Since Partners in Recovery was defunded, I have not been able to replace her. She had fantastic ethics, understood me and was willing to work flexibly around my needs, rather than asking me to work around her needs. It was the first time I have felt that I received truly person-centred care. She helped me find a place to live when I was facing homelessness. Around the same time I was at significant risk of suicide. She advocated for me to receive clinical services when my GP had tried, failed and given up on trying to get me access to support from my adult community mental health service"
(survey respondent)

PURPOSE OF THIS WORK

Service providers have long been aware of the lack of community mental health supports in WA, particularly those that also address co-occurring alcohol and other drug issues. The Western Australian Association for Mental Health (WAAMH) (WA's peak body for community mental health) has been advocating for increased investment in community mental health supports for decades. However, understandings about the unmet need for community support has, for the large part, been captured anecdotally or informally rather than systematically examined. In particular, there are knowledge gaps around the experiences of consumers, carers or family members. The purpose of this project was to hear directly from consumers, family members and carers, about their experience of community mental health supports. In particular:

- Why are these supports important and effective?

- In what ways could these supports better serve people's needs?

- What models should we consider that improve or expand the available options for community support?

This work brought together co-design and research processes to unpack these questions and examine the need for community mental health supports from a lived experience perspective.

Consumers, family members, supporters and carers, and service providers were invited to share their experiences, and co-design supports that they think will best help them and others in future. Insights from lived experience experts were surfaced through a survey, focus groups and interviews. These insights were analysed and synthesised, then utilised to guide ideation within two facilitated workshops, where models of support were ultimately co-designed.

This report outlines the methods used to inform and design the models, and sketches an outline of the models proposed. Some new and innovative suggestions emerged, however generally the models of support that people have asked for, and components within them, already exist in WA and other jurisdictions, as is highlighted throughout the document. Core components that apply across the models are accompanied by an evidence review based on academic and grey literature.

It is our hope that these models of support will be further refined and adapted to local communities through a second co-design process, and considerations for the implementation phase are also outlined.

This report is structured in four sections. Section 1 outlines the authorising context in which these models are being developed as well as principles that are foundations for this work. Methodology and approach will also be described. Section 2 outlines the models for specific priority groups and describes – in the words of people who participated in the co-design processes – the needs and responses that they consider to be fundamental to their mental health. Section 3 summarises academic and grey literature that underpins some of the core components featured across the models, in order to substantiate their effectiveness or efficiency (including cost effectiveness information). Finally, Section 4 summarises the co-designed ideas and descriptions for how to most effectively implement these models so that the principles – such as safety, choice and empowerment – might be consistently realised at an operational level.

This project was commissioned by WAAMH, with the research led by the Centre for Social Impact, The University of Western Australia (CSI, UWA).

Figure 1: Report structure

SECTION 1	SECTION 2	SECTION 3	SECTION 4
Context, foundational principles and methods	The models and co-design findings	Evidence review of core components	Implementation considerations
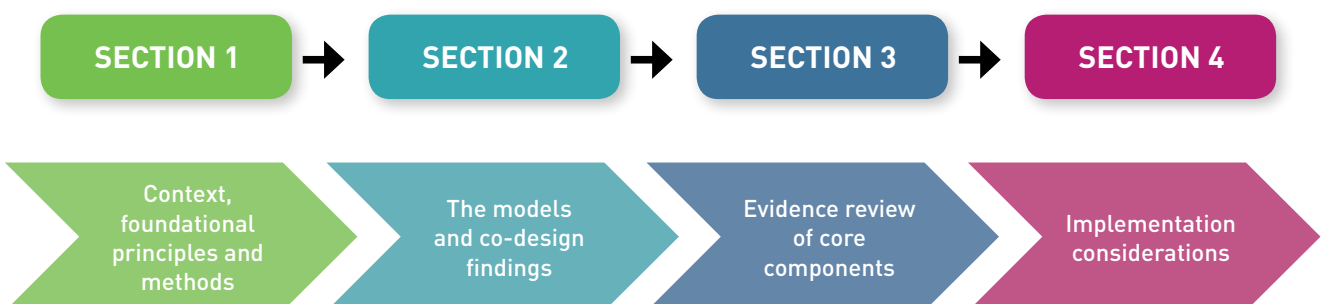
1.2 Needs to address

GREATER INVESTMENT IN COMMUNITY MENTAL HEALTH SUPPORTS

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan) sets out Western Australia's current investment priorities and a road map for reform in the mental health, alcohol and other drugs sector. The Plan highlights the importance of support across a spectrum, with a focus not just on clinical services for acute needs, but also on community-based supports and prevention. For many people, the ability to stay well and healthy in the community depends on regular support that meets their needs holistically and does not require them to reach a certain level of 'crisis' or distress before they can access support.

> "There doesn't seem to be much support out there. And what is out there, you are either not unwell enough, too unwell, or unwell in the wrong way"
>
> (survey respondent)

The Plan Update in 2018 identified a need for 5.8 times as much community support as was available in 2013. The Update called for a 5-fold increase in the community support hours available in WA, and to grow the proportion of community supports from 8% to 19% of the overall service mix (Mental Health Commission, 2019b). While total community support funding has remained largely stable since 2015, between 2015 and 2018 its share of the overall mental health spend has reduced from 8% to 5% due to increased investment in hospital-based services (Office of the Auditor General, 2019).

Government efforts to expand community support thus far has focused primarily on increasing access to supported accommodation services (Government of Western Australia, 2020). WAAMH is not aware of substantial progress towards increasing non-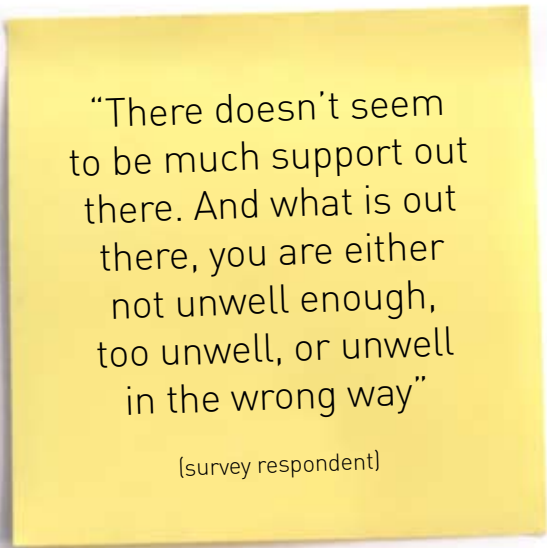accommodation related community support (i.e., increasing community support hours), as outlined in the Plan although the WA Recovery College is an exciting innovative development that will provide recovery-focused education opportunities.

SERVICE GAPS AND PRIORITY POPULATIONS

In scoping this project, WAAMH was guided by some of the priority groups identified in the Plan as most urgently needing new service development. Thus, the project aimed to co-design support model options with the needs of the following groups in mind:

- High school aged young people (aged 12 – 16)
- Young people (aged 16 – 24)
- Family members and carers
- People with high acuity mental health issues and multiple unmet needs (often including co-occurring alcohol and other drug issues)
- People living in rural and remote WA.

More options for supporting the wellbeing of children and young people

The Australian Child and Adolescent Survey of Mental Health and Wellbeing 2015 (Australian Government, 2015) findings show that one fifth of adolescents (19.9%) have very high or high levels of mental health distress. Four fifths (82.4%) reported needing some type of help for emotional or behavioural problems in the previous 12 months. Of these, three quarters (76.8%) had their needs fully or partially met. Barriers to seeking help included stigma and poor mental health literacy.

The forthcoming Young People Priority Framework, expected to be published later in 2020 by the Mental Health Commission, will make recommendations for how young people, aged 12 to 24, can be better supported across both the public health system and non-government services. Vulnerabilities and mental health risks are heightened as young people transition to adulthood, and in these critical years there are a lack of community supports that effectively engage young people. This is especially true for young people who may need support or help with distress, but do not have a formal diagnosis, connection to a clinician nor the ability to access support.

More support just for family members, supporters and carers is needed

The recognition of family members and carers in their role as supporters of consumers is already embedded in many mental health services, and their vital role in helping individuals recover is well evidenced. And yet family members and carers' own need for support is often overlooked (see Price-Robertson, R., Obradovic, A., & Morgan, B, 2017).

A Tuna Blue Report (2019) describes the 'light touch' family and carer involvement that currently exists, noting that 'intensive support models involving families and carers are missing' (Tuna Blue, 2019). Policy makers are starting to look more closely at the family unit that wraps around an individual, and how best to support the whole family. This report also notes that a new model of support that focuses just on carer and family members' own distress, and their own needs would be greatly beneficial to this group "whom we know need more than information provision and self-care opportunities" (Tuna Blue, 2019).

A report into commissioning that consulted widely with service providers in WA uncovered unmet demand for supporting families and carers (Kaleveld, McCorry & McKinney, 2019). The Plan has also mapped this as an area for much-needed investment, and highlights the need to expand carer and family information, increase flexible respite services and better support children who have parents with a mental health or alcohol and other drug problem (the Plan, 2015).

People in regional and remote Western Australia have very little choice in supports available

Better general coverage of community mental health services across the state is urgently needed, especially in rural and remote areas where there is currently a lack of options for consumers to choose from, as well as significant unmet need (Kaleveld, McCorry & McKinney, 2019).

Modelling undertaken for the Plan showed a need to invest signficiantly in community supports in regional, rural and remote WA. It is estimated that 1.2 million hours of community support are needed for regional, rural and remote areas by 2025. That is more than what is in place in 2020 for the entire state. WAAMH advises that there are particularly significant gaps in state-funded mental health services in the Pilbara and Kimberley, as well as in the Goldfields, Mid West and Wheatbelt. In these areas, face-to-face services are extremely thin on the ground (the Plan, 2015).

Increasing support options for people with acute mental health issues and multiple unmet needs including co-occurring alcohol and other drugs

State and federal frameworks and plans frequently recognise the need to improve access to services that have the capacity to address co-occurring mental health and alcohol and other drug needs.

Some people who experience acute mental health issues feel their needs are not adequately met in clinical settings, or they have past negative experiences of services which has left them with a sense of distrust and alienation.

"If the problem is pathologised, then the interventions are pathologised and people feel disempowered or disconnected"

(co-design workshop)

For some people, community mental health supports provide a much-needed alternative or complement to clinical options, that they experience as more suitable and empowering.

"Social interventions may help activate self-agency much more effectively" (co-design workshop)

However, the current lack of community support options leads to problems with supports that are available – i.e., long waitlists, accessibility barriers such as location and rigid eligibility criteria, which further frustrates attempts to get the support needed. Consumers and family members describe the challenges of accessing services not equipped to respond to their multiple unmet needs, and being referred on to other services that also do not have the capacity to engage them or respond to their needs.

1.3 Opportunities for change

IMPACTS OF COVID-19: A CHANGING CONTEXT

While the full impacts of COVID-19 on the mental health of Western Australians are yet to be known, this project has engaged people, during this pandemic, in a discussion about their mental health needs. The changing context brought about by COVID-19 has been part of that discussion.

"COVID-19 has had its benefits in that people are talking much more about mental health [...] I also think there is a desperate need to put funding into mental health promotion, to show people how to look after their mental health" (survey response)

"[COVID-19 restrictions] highlighted the need for socially isolated people to have face-to-face contact with others" (survey response)

As the challenges and uncertainties associated with COVID-19 continue to affect Western Australians on a whole-of-population level, the role of psychosocial supports has become more important in countering the effects of social isolation, supporting resilience and keeping people as mentally healthy as possible.

Operational constraints during the COVID-19 lockdowns have led to service providers gaining a better understanding of the need to offer choice and options in how people access support (and hopefully these insights translate to policy makers too). Survey findings demonstrate the need for caution when making assumptions about people's preferences.

"Online has not had a positive effect. The isolation and lack of personal contact has increased my anxiety levels. The need for face-to-face connection is important. Zoom does not cut it" (survey response)

"My support worker and I were able to do some really good work over the phone, but I wouldn't want to do it long term and I'm not sure how well it would go if I didn't already know the worker. Face-to-face meetings are essential. I felt very alone and isolated having to rely on virtual connections" (survey response)

"Online video/Zoom groups have been extremely beneficial as I can be in the safety of my own home and online support is less exhausting" (survey response)

Going forward, people may be looking for greater choice and flexibility in how services are delivered.

"I think it's shown me that I can use a variety of supports especially when I'm facing challenges" (survey response)

ADVOCACY FOR MORE SUPPORTS

The timing of this work is strategic. Around the mid-point of the Plan's timeframe (2015-2025) is an opportune time to reflect. The Plan (2015) calls for increased community mental health supports before 2025, however the state is not on track to achieve this target, as documented by the Plan Update (Mental Health Commission, 2019b). Service gaps are also apparent, as distilled through WAAMH's numerous consultation processes and findings from other recent and influential reports, such as a 2019 report from the Auditor General (Office of the Auditor General, 2019).

The support models developed through this work will be used by WAAMH to advocate for increasing and improving community mental health support options in general, and especially for the priority groups that these models have been developed for.

As mentioned above, this project has occurred as the impacts of COVID-19 on mental health need and service demand continue to play out. Advocacy opportunities may also include the WA COVID Recovery, state and federal mental health reform, and political processes including the forthcoming 2021 election. These are important opportunities to present to government these community support investment options that are firmly grounded in the needs of priority groups, lived experience of family members, supporters and carers and have been informed by service provider considerations as well. Further to this, these models are relevant to what people have asked for now, and have some evidence-base beyond this that is presented alongside the models.

STRATEGIC DIRECTIONS

Sector reform work, national inquiries, reviews and current state and national policy frameworks highlight the need to develop a balanced suite of services across the spectrum of need. The main concern at this level is to describe how a system should be structured to keep a maximum number of people as well as possible. The following table summarises the current strategic context that supports and authorises the need for increased investment in new community mental health support models, such as those co-designed through this work.

Table 1: Key mental health sector reform directions

Key reform directions	Rationale & supporting evidence	Strategic links & recommendations
A balanced system with the optimal mix and level of services needed for the best outcomes and for reduced reliance on costly and acute services	Prevention, early intervention and community support contributes to emotional and social wellbeing, and to a financially sustainable health system (McGorry, 2015) High rates of emergency department admissions and readmissions to acute psychiatric services is evidence of "failure to provide timely and adequate community-based mental health supports" (National Mental Health Commission, 2014) The current service mix results in people being cared for in the most intensive and higher cost care settings, which is inefficient and often less effective (Office of the Auditor General, 2019)	• The Plan (reform directions) • The WA Mental Health Promotion, Mental Illness and Alcohol and Other Drug Prevention Plan 2018 – 2025 • The Plan (Community Support Actions 21, 22, 23, 101, 145) • Sustainable Health Review (Strategy 2) • Mental Health Portfolio Priorities 2020 - 2024 (Prevention and Community Support stream) • Fifth National Mental Health Plan (Priority Areas 1, 3, 4, 6) • Consumer & Carer Report, Monitoring the Fifth Plan • Vision 2030 (Balanced community based care) • Productivity Commission Draft Report (Sections 4, 7)
Support people in the community to retain or rebuild connection in their lives	The Plan's primary strategic focus is rebalancing services between hospital-based and community-based contexts. It states that the first priority should be to boost investment in community based services Community support is an essential element of an effective and balanced mental health system; it is also the most under-resourced service type, meeting only 22% of demand in WA (Mental Health Commission, 2019b)	• The Plan (Community Support Actions 21, 22, 23, 101, 145) • Sustainable Health Review (Strategies 2, 7) • Fifth Plan (Priority Area 1, 3, 4, 6) • Vision 2030 (Balanced community based care) • WA Peer Support Network Peer Workforce Report • National Mental Health Commission Peer Workforce Development Guidelines (forthcoming)

Table 1: Key mental health sector reform directions (continued)

Key reform directions	Rationale & supporting evidence	Strategic links & recommendations
Contemporary, evidenced-based models of person-centred care	Support models are evidenced-based and meet quality standards, as outlined in the National Standards for Mental Health Services 2010 (Australian Government Department of Health, 2010a) Services provide contemporary, flexible and person-centred approaches that value social connection, warm referrals and individual led recovery and diversity of options (Kaleveld, McCorry, & McKinney, 2019) Services are integrated and support holistic wellbeing	• The Plan (Community Support Actions 21, 22, 23, 101, 145) • Sustainable Health Review (Strategies 2, 7) • Fifth Plan (Priority Area 1, 3, 4, 6, 8) • Productivity Commission Draft Report • WA Peer Support Network Peer Workforce Report • National Mental Health Commission Peer Workforce Development Guidelines (forthcoming) • Consumer & Carer Report, Monitoring the Fifth Plan
Co-design	Consumers should be integral to system and service design, ensuring that models appropriately respond to the real, rather than perceived, client need There should be ongoing opportunities to build the sector's capacity in co-design and co-production through genuine opportunities at all levels of procurement and contracting (Mental Health Commission, 2019b)	• The Plan • Working Together: Mental Health and Alcohol and Other Drug Engagement framework 2018 - 2025 • Productivity Commission Draft report (Section 4, principle of consumer responsiveness) • Sustainable Health Review (patient experience pillar) • Consumer & Carer Report, Monitoring the Fifth Plan
Ensure a variety of demographic groups are catered for	A health system should cater for cultural and ethnic diversity, taking into account the unique needs of certain groups (Mental Health Commission, 2019b)	• The Plan • Fifth Plan (recognising diverse experiences, Priority area 4) • Vision 2030 • Productivity Commission (Section 4)

Table 1: Key mental health sector reform directions (continued)

Key reform directions	Rationale & supporting evidence	Strategic links & recommendations
Enhance the role of peer workers across the system	Peer workers are accepted as a critical component of the workforce and peer support an agreed component of the optimal spectrum of care (Vision, 2030) Peer support can be incorporated into recovery models in different ways; peers can provide informal, naturally occurring support, they can participate in consumer or peer-led programs, and they can be employed as support providers within mental health services (Repper & Carter, 2011)	• Vision 2030 • Productivity Commission Draft Report (Section 11) • Peer Workforce Development Guidelines (forthcoming) • Fifth Plan (Actions 20, 29, 30) • National Mental Health Workforce Strategy (Peer & Lived Experience Workforce priority area) • Consumer & Carer Report, Monitoring the Fifth Plan
Collaboration between health services and non-government organisations	Government-run health services should work together with non-government organisations, ensuring a continuity of care for consumers and a support network that extends beyond the clinical environment (Mental Health Commission, 2019b)	• The Plan (reform chapter) • Fifth Plan (Priority areas 1, 3) • Vision 2030 • Productivity Commission (Section 10) • Consumer & Carer Report, Monitoring the Fifth Plan

The vision outlined in various key sector and policy frameworks not only provides a basis for developing more models of community mental health support, it also justifies the process – in supporting the importance of co-design, and involving consumers and family members and carers in helping to understand their needs and create responses to address these needs.

INCREASING FOCUS ON CONSUMER OUTCOMES

The WA Mental Health Commission's (2012) Mental Health Services Outcomes is another essential element of the strategic context surrounding this work. The following outcomes were co-developed in partnership with people with mental health challenges, their families and carers, service providers and community members. They provide an underpinning framework, justification, and perhaps even a call to action to develop more supports that encompass whole-of-life, person-centred, recovery-oriented and community-based approaches.

Figure 2: Mental Health Commission outcome statements

Health, wellbeing and recovery

A home and financial security

Community belonging

Relationships

Rights, respect, choice and control

Recovery, learning and growth

1.4 Methodology and participation

This project employed a mixed methods approach underpinned by co-design principles. This involved a lived experience-led process, supported by research methods, and finally backed up with an evidence review.

The perspectives of people with first-hand experience of mental health issues and accessing supports were critical in designing supports, especially for priority groups, who face increased service access barriers. Critical perspectives were sought from young people, family members or carers of people with mental health or alcohol and other drug issues, adults with lived experience of mental health issues (especially high acuity or co-occurring issues) and community mental health service providers.

Interestingly, some of the gaps that we know exist in the service system – e.g., underrepresentation of service access in young people, men, people from Aboriginal and Torres Strait Islander backgrounds, and the lack of community mental health supports in rural and remote areas – were mirrored in research participation. While the survey was distributed widely through networks, via an open process to achieve the broadest coverage, in the first round of distribution, young people, children, men, people identifying as Aboriginal and people living in rural and remote WA were also underrepresented in the respondent profile.

Throughout each stage of our methodology, the Team was mindful of these gaps and established processes that were more targeted towards the priority groups and groups that are less visible in the mental health sector. Hence, the survey and co-design workshops were complemented by targeted focus groups and service provider interviews. A visual map of the methodology is presented in Figure 3.
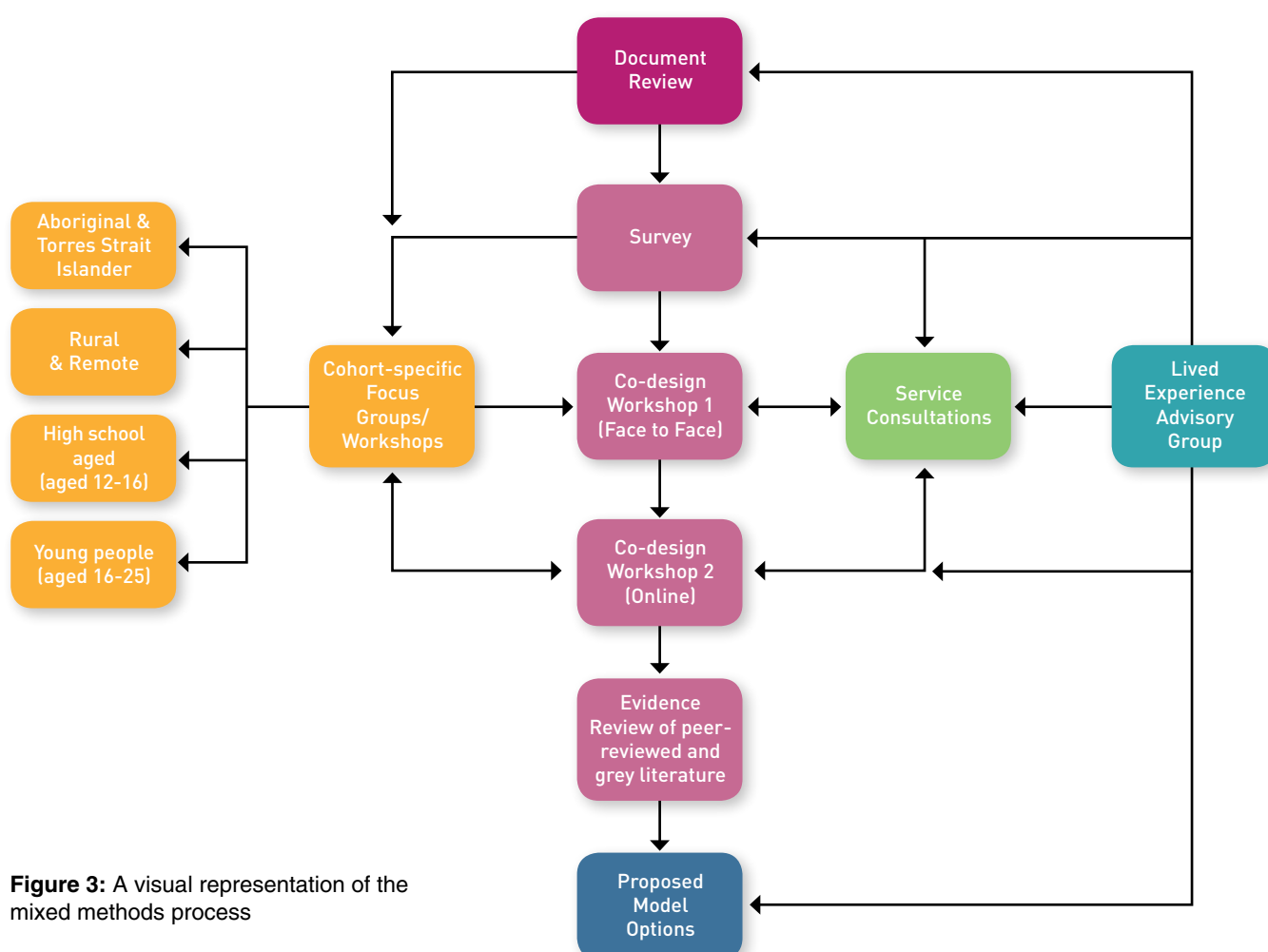
Figure 3: A visual representation of the mixed methods process

OVERVIEW OF METHODS

Document review

For this project, starting co-design with a blank canvas was neither desirable nor feasible. The Lived Experience Advisory Group noted the importance of honouring previous stakeholder consultations, sector reforms, policy and development work. As one advisor stated, "We stand on the shoulders of giants" – a recognition that long before this project began, many used their voice and experience to improve WA's mental health sector.

This project aimed for a 'building on' approach. For example, understandings that consumers want choice, need to exercise personal agency, and will not respond to supports unless they feel safe are well established. These ideas are not just intuitive, they are also reflected in the Commission's Plan, and the policy landscape of the sector – as endorsed by the National Standards for Mental Health Services. The document review aimed to capture this foundational knowledge about what people want and what is needed, that is accepted by policy makers, funders, services and consumers and family members and carers alike. A distillation of this knowledge, in the form of 'broad principles' was then presented in the co-design workshop and described as a foundation from which to build.

The Plan (2015) and a Curtin Community Mental Health Support Review (Martin, Mahoney & Pracilio, 2020) commissioned by WAAMH in 2019 (that reviewed a range of existing non-clinical community support options) were key documents that informed this process.

Lived Experience Advisors

This project was carried out in close collaboration with Lived Experience Advisors, comprised of advocates with diverse experiences of the mental health and alcohol and other drug system. They had significant involvement. They helped to design and review the methodology, provided feedback on draft documents and language, co-facilitated the two co-design workshops and helped make sense of findings. They provided regular support through long and robust meetings (mostly on Zoom calls), and their input and oversight guided the project. Much appreciated was the generous way in which they challenged the researchers' assumptions and understandings along the way.

Service provider consultation

The providers were identified by WAAMH and the research team as important stakeholders with expertise in working with different priority groups.

Service providers were consulted with 30-minute telephone interviews, which were conducted throughout all phases of the project. The purpose of these consultations was to further understand the unmet needs of the community from a service provider perspective, and to explore any effective service models currently in place, or that would be considered valuable. A total of 9 service providers were consulted.

Table 2: Service provider consultation information

Name	Organisation	Cohorts represented
Bridget Harvey	Outcare	Acute mental illness
Jane Chilcott	Linkwest	Rural and regional WA
Paulette Anderson	Mission Australia, Meekatharra	Remote WA
Alison Hilton	Fusion	Rural and regional WA
Katherine Browne	Office of the Commissioner for Children and Young People	Children
Paul Fitzgerald	Wanslea	Children
Lorrae Loud	Lamp	Rural and regional WA
Mason Rothwell	Youth Affairs Council of Western Australia	Young people
Helen McMahon	Mission Australia	Rural and regional WA

Note: of the survey respondents, 46 people (approximately a quarter of total respondents) identified as service provider staff member or peer support worker, so the service provider perspective was also captured this way.

OVERVIEW OF METHODS (continued)

Stakeholder survey

A stakeholder survey captured a diversity of viewpoints from 156 people. Respondents could choose from which perspective they would like to respond, i.e., as a:

1) carer/family member

2) individual with mental health or alcohol or other drug concerns, or

3) service provider.

The perspective selected led to tailored questioning (through a skip logic mechanism). Respondents could also select multiple perspectives, although this meant the survey was longer to complete. While an exhaustive analysis of the survey findings was not possible in the timeframe of this project, targeted analysis was conducted throughout the project to inform the co-design work, and for ensuring that a broader cross-section of the WA community was involved.

Respondents who filled in the survey before a certain date could indicate their interest in attending the co-design workshops. Thus, the survey provided a method through which different voices could be invited into the co-design process (providing a departure from the 'usual faces' or usual recruitment pathways).

A total of 156 respondents gave consent to participate in and complete the survey (in varying degrees of detail). Demographic breakdown totals and the totals for questions will not always add up to 156. This is because most questions were voluntary and respondents may have chosen to skip certain questions.

The survey findings contributed great value to this project by capturing a broader cross section of views than the workshops and focus groups would have allowed on their own.

Survey participants

Gender

Women were over-represented throughout the entire consultation process, and this is particularly evident in the survey where 80.5% of respondents were women.
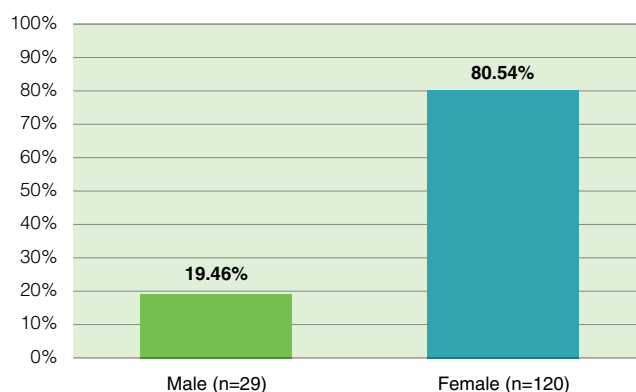
Figure 4: Survey respondents by gender

Geographic region

Approximately three quarters of survey respondents came from metropolitan Perth (75.5%, n=114), 14.5% (n=22) from regional, 8% (n=12) from rural and 2% (n=3) remote. Participants self-defined their rurality classification for this question.
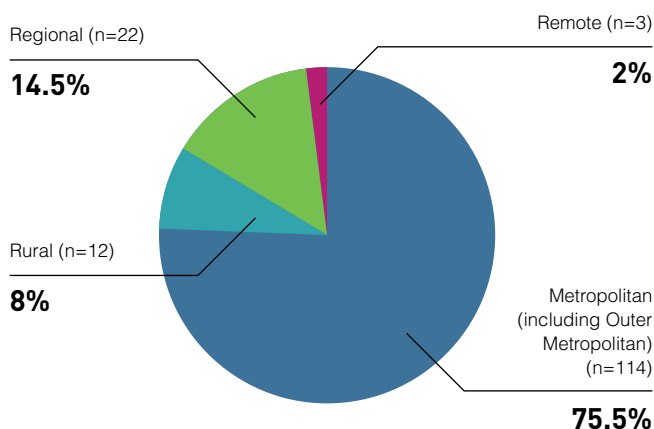
Figure 5: Survey respondents by geographic region

OVERVIEW OF METHODS (continued)

Life experiences and perspectives of respondents

The life experiences and perspective of respondents were diverse. Figure 6 gives a broad overview of the life experiences of the respondents (multiple responses were allowed and so percentages will not add to 100%). 22.73% (n=70) of respondents were living with an acute or co-occurring mental health issue, 5.52% (n=17) of respondents were members of the LGBTIQ+ community, and 8.44% (n=26) were aged over 65 years. Figure 6 also indicates weaknesses in the sampling frame of the survey, including a very low response rate from Aboriginal and Torres Strait Islander people (n=4), young people (n=2) and children (n=2).
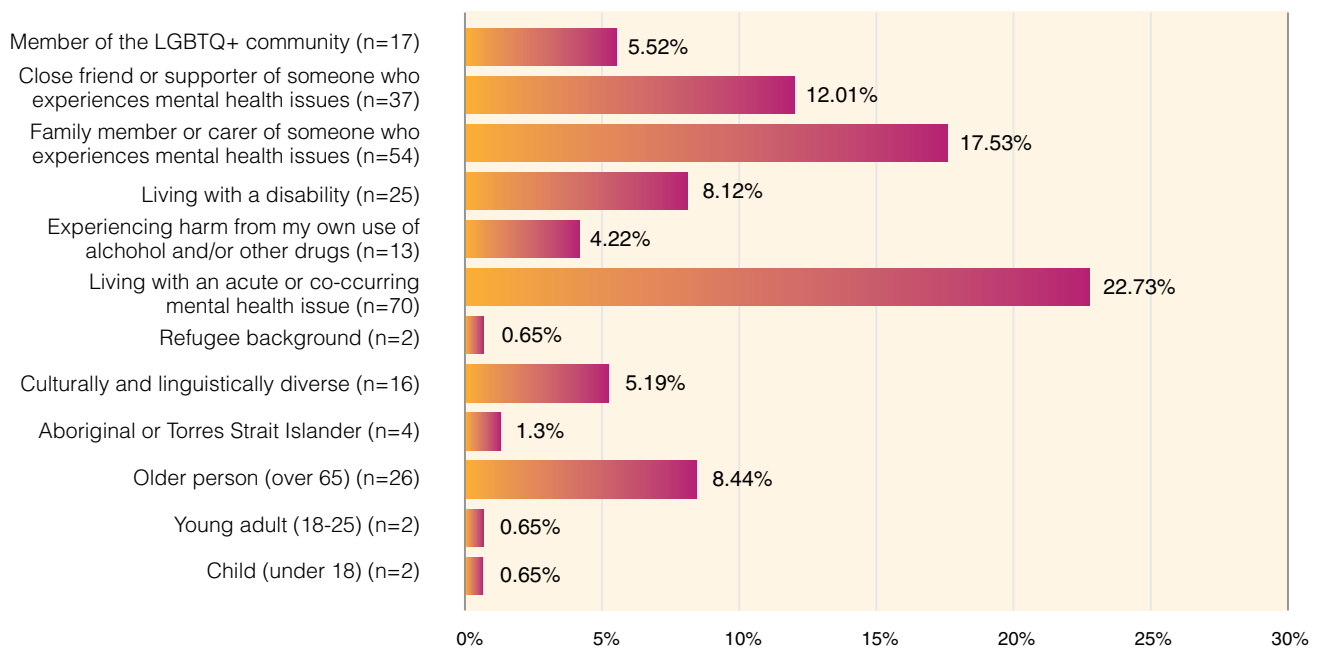
Figure 6: Life experiences and perspectives of respondents

Respondents were able to answer the survey from three distinct perspectives (or any combination thereof):

1) a service provider/staff member/peer support worker or someone who works in the mental health services/support sector

2) a carer, family member or support person of someone with mental health issues

3) someone who has personally experienced mental health issues or harm from alcohol and other drug use, or accessed mental health services
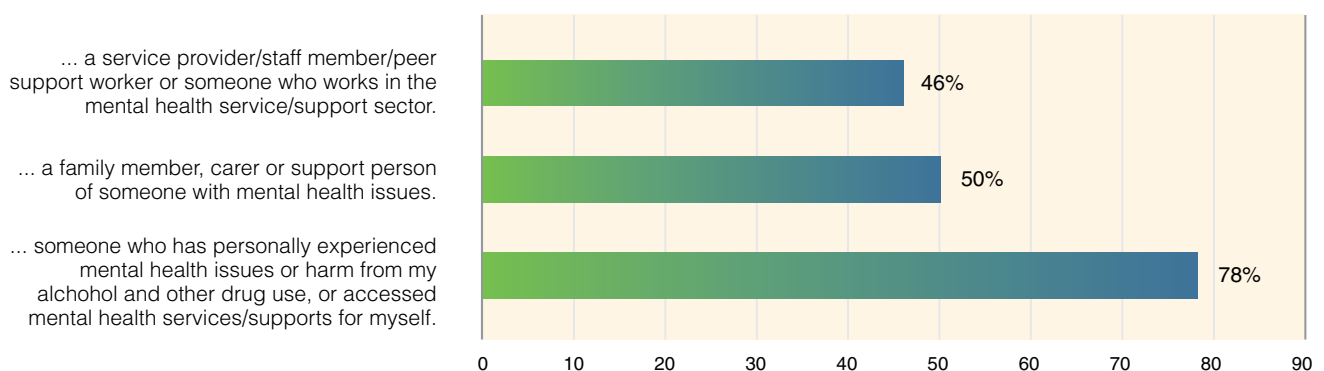
Figure 7: Number of survey respondents identifying with each perspective

OVERVIEW OF METHODS (continued)

There was overlap between these categories – that is, people could respond from the perspective of both a family member and a service provider, for example. The breakdown of these combinations is contained in Table 3.

Table 3: Breakdown of respondent perspectives

Categories (mutually exclusive – exhaustive options)	Number	Percentage
Only family member or carer	29	20.86%
Only service provider	26	18.71%
Only individual with lived experience	55	39.57%
Family member or carer **and** service provider	6	4.32%
Family member or carer **and** individual with lived experience	9	6.47%
Individual with lived experience **and** service provider	8	5.76%
Family member or carer **and** individual with lived experience **and** service provider	6	4.32%
Total responses to this question	139	100

Targeted focus groups for priority groups

Targeted focus groups were conducted to better understand priority groups' needs – particularly where these groups were under-represented in the co-design workshops. Through the focus groups we were able to work closely with groups from a diverse range of backgrounds and develop a nuanced understanding of the needs of specific cohorts. Four focus groups were facilitated, each lasting approximately 1 to 1.5 hours.

1. Aboriginal and Torres Strait Islander Focus Group (online with 5 participants including people from rural and remote areas)

2. Rural and Remote Focus Group (online with 3 participants, all from rural and remote areas)

3. Young people representing high school ages 12 - 16 (face-to-face with 7 participants)

4. Young people representing people under 24 (online with 6 participants)

Co-design workshop 1 (face-to-face)

Seventeen people participated in the initial co-design workshop, held face-to-face . In the workshop we developed a consensus about what community mental health support entailed, and reviewed the foundational principles outlined above. The structures to support designing models were as follows:

1. Bringing the priority groups into the room through empathy mapping/consumer journey process

   a. What really counts to the consumer (of this priority group) at various stages of their journey?

   b. What do they hear and see around them that creates obstacles, fear and/or frustration?

2. A template was provided for developing the responses and core components necessary to meet those needs surfaced in the empathy mapping exercise (see Appendix A for the template)

3. A summary of a sample of the Curtin Literature Review models was provided for participants, and a card sort activity was also provided as an option and way to sort through potential model components. Components were offered (to be sorted) and there were also blank cards

Exercises were offered as options, but groups were told the exercises were not prescriptive and they could work in a more open, emergent way if that better suited them.

Some of the participants for co-design workshop 1

OVERVIEW OF METHODS (continued)

Co-design workshop 2 (online)

The goal of the second workshop was to review the draft models constructed in workshop 1. This online workshop was attended by 16 participants plus 3 Lived Experience Advisors. The majority of participants had attended workshop 1, although a few participants who had not been able to attend the first workshop were invited to workshop 2.

Evidence review

After analysing the findings across the different phases of data collection, several components emerged that applied across the different models along with some model components that were cohort-specific. CSI conducted an evidence review of both peer-reviewed and grey literature to better understand the current evidence base for key components of proposed support models. This review considered randomised control trials and evaluations of programs that had incorporated elements of the co-designed supports in other jurisdictions. This process aimed to complement the lived experience perspective by grounding the co-designed models in best available evidence.

PARTICIPATION SUMMARY

The following table presents all participants in terms of their representation of priority groups, where known. Several people participated in more than one process (especially the co-design workshops) so the total does not represent the total number of individuals, but rather the total number of engagements.

Table 4: Participants in terms of priority groups

	Children (under 18s)	Young people	Families members and carers	People living with acute mental health issues and multiple unmet needs	Rural and remote	TOTAL
Survey respondents (number, and % out of 156 survey participants. Percentages are approximate)	n= 2 (1.28%)	n=2 (1.28%)	n= 50 (32.05%)	n=70 (44.87%)	n=27 (17.37%)	185* (approx. due to different levels of engagement with survey)
Co-design workshop 1 participation	*Unknown – although it was recognised there was an under-representation of men, young people and no children were present, however other priority groups were represented*					17
Co-design workshop 2 participation	*Some participants attended both workshops so the total of 33 participants does not represent discrete individual participants*					16
Focus group participation	8	5			3	16
Service consultation	2	1		1	5	9
	12	8	50	71	35	243

* The stakeholder survey overview has this number at 156, and this represents the number of responses available when much of the survey analysis had begun, however 185 represents the total number of survey participants. Due to time limitations a staggered analytic process was used, thus these numbers do not align.

In addition, six Aboriginal and Torres Strait Islander people with experience working in community mental health were consulted to ensure the models could be as culturally safe as possible.

The focus group for young people involved a Reference Group through the Youth Affairs Council of Western Australia, which included youth representatives for various diverse population groups such as disability, LGBTIQ+ and Aboriginal and Torres Strait Islander.

LIMITATIONS

This project began in May 2020, and engagement processes were conducted in June and July, with the write up completed in August. The tight timeframe put constraints on both the research and co-design processes. Some limitations are described below.

Representation

Co-design workshop 1 lacked representative lived experience participants from some of the priority groups. For example, there were no under 16s co-designing the first model for young people aged 12-16, and also limited young people working on the model for young people aged 16-24. However, people did volunteer to work on these two models and brought to the table insights from their experiences as educators or service providers for children. This initial underrepresentation of young people for this work was mitigated through two targeted focus groups with young people that continued the development work on the models.

While men were slightly underrepresented in all consultation processes (and no opportunity for targeted engagement), their voices were nonetheless present in all processes.

Survey sampling

The survey was distributed in an open process through WAAMH and its networks including consumer and carer/family member peak bodies, service providers and advocacy groups who also distributed the survey, with the intention of reaching people who might not normally engage in a co-design process. Thus, the Project Team did not have control over who was invited to participate and what the sampling bias might have been. This is not significantly problematic, as the findings informed the co-design of the models and will not be used for research purposes.

Philosophical bias

During the co-design workshop, an educational presentation was given, so that the foundations of the project could be understood and we were not starting with a blank canvas (which was not viable given the time limits for this project). This may have introduced a philosophical bias into people's thinking – for example the emphasis on personal rather than clinical recovery was highlighted. This may be seen as appropriate given the context and purpose of this work – to design non-clinical, community mental health supports, and the intention not to start with a completely blank canvas.

Time constraints that limited reflection and feedback loops

The other constraints related to the time constraints, which impacted all processes. Ideally, having more time for co-design engagement would have led to more developed models, models that were truer to what people asked for (and also time to develop relationships with participants and for them to express their views more fully and for the Project Team to properly reflect and follow up with any insights). More time would have allowed for deeper synthesis of the survey findings, evidence, interviews, focus groups, with what emerged in the co-design workshops, and a more cohesive and integrated report.

However, these constraints were acknowledged by the commissioning body WAAMH from the beginning. The idea was to see this as a first-round process to sketch out models in time to inform WAAMH's state election campaign asks, which can be developed with more detail if needed.

1.5 Foundations to inform model design

DEFINING COMMUNITY MENTAL HEALTH

The following definition of community mental health was co-designed with consumers and Curtin University researchers (Martin, Mahoney & Pracilio, 2020) during a project commissioned by WAAMH in 2019, and was used to guide this project.

Community mental health support involves formal and informal, funded and unfunded responses, services and options, which respond to mental distress in a non-institutional setting. This may involve grassroots, peer-led and family inclusive options, as well as services offered by not for profit/community managed organisations. Community may involve a geographic location, shared interests, cultural groups or other forms of belonging and connection. The focus may be consumers, families or supporters.

Community mental health support is defined as non-statutory and non-coercive, and does not replicate the processes, practices or principles, which underpin statutory mental health practice found in hospitals, inpatient facilities or outpatient clinics and services.

Those providing community mental health support actively work alongside people to respond to their holistic, contextual and diverse experiences, intersections and needs. Community mental health supports are person-led, working in partnership to offer supports and options that further people's rights and preferences, and that assist to enable people's personal and family recovery, address their social and economic needs, and offer opportunities for the person to connect with/build community connection and citizenship.

Community mental health supports involve paid or voluntary personnel, and expertise by experience is valued as much as educational qualifications.

While this definition is complex and conveys several parallel ideas, it does also embody the range of possibilities, approaches and models that could potentially be considered within the scope of what a community mental health support is.

UNDERSTANDING RECOVERY APPROACHES IN COMMUNITY MENTAL HEALTH

The concept of recovery in community mental health is grounded in a strong theoretical framework. The Community Mental Health Support Review commissioned by WAAMH (Martin, Mahoney & Pracilio, 2020) identified three concepts through which to understand community mental health supports – relational recovery, social determinants of health and recovering citizenship. This project identified personal recovery as also being a foundational concept.

Figure 8: Theoretical framework that applies to understanding recovery in community mental health

Personal recovery

- Understanding of recovery that exists away from the bio-medical lens
- A personal journey focused on building a meaningful, contributing life

Relational recovery

- Recovery is not a purely individual process
- Social connections and relationships form an important part of conceptualising mental health recovery
- Recovery is both an inter- and intra- personal process
- Strong relationships, healthy boundaries and social connection can act as protective factors in mental health and wellbeing

Social determinants of health and wellbeing

- Complex intersection between social factors and disadvantage (such as poverty, homelessness, racism) and mental distress
- The relationship between social factors and mental health is not linear
- Understanding social determinants of mental health moves away from the purely biomedical understanding of disease
- Cumulative exposure to stressors can heighten an individual's risk factors

Recovering citizenship

- Recovery is conceptualised as a 'normal' life involving citizenship and access to services that support recovery
- Citizenship is an expansive concept that involves participation, inclusion, rights, responsibilities, roles, resources and relationships

Personal recovery

The differentiation of 'personal recovery' from 'clinical recovery' is a central foundational concept underpinning community mental health support. Clinical recovery is embedded in the expertise and worldview of mental health professionals, and focusses on alleviating symptoms and restoring social function. Mike Slade (2009) highlights that in contrast, personal recovery has "emerged from the expertise of people with lived experience of mental illness". Anthony (1993) describes personal recovery as:

"...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/ or roles. It is a way of living a satisfying, hopeful and contributing life, even within the limitations caused by illness"

One survey respondent summarised the notion of personal recovery in the following comment:

"It is about engaging people with mental health issues as the central actors in the management of their mental wellbeing, helping them to find meaning in their life experiences, and guiding people on journeys towards a contributing life. This was my experience when I accessed Grow, a national consumer mental health organisation" (survey response)

Relational recovery

"[A]n overemphasis on the 'inner', subjective experiences of people with lived experience of mental ill-health largely obscures the interpersonal contexts of recovery" (Price-Robertson et al., 2017)

The notion of 'recovery' in the mental health sector has garnered significant support, and has been adopted by individuals, grassroots groups, services and policy makers. However, recovery is usually framed as an entirely individual process – that is, as a "deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles" (Anthony, 1993).

"Recovery is said to be 'personal'; it is 'deeply individual'. Why would anyone object to that? Because we are not isolated individuals, to put it bluntly" (Rose, 2014)

Price-Robertson, Obradovic, and Morgan (2017) critique the current lack of focus on the social and relational nature of the process of recovery, arguing that recovery is in fact an "inherently social process". Relational recovery foregrounds social connections and relationships as essential to the conceptualisation of mental health recovery (Price-Robertson et al., 2017; see also Coleman, 2011).

Social determinants of health and wellbeing

"People are made vulnerable to mental ill-health by deep-rooted poverty, social inequality and discrimination" (Allen, Balfour, Bell, & Marmot, 2014)

There is a strong link between mental health and the social determinants of health and wellbeing (Mental Health Innovation Network, 2018). Intersecting factors related to an individuals' social context, such as employment, trauma, housing and experiences with discrimination, can render an individual more vulnerable to mental distress (Allen et al., 2014). Moving away from the dominant biomedical model of illness and pathology, social determinants of mental health align with the bio-psycho-social model of psychiatric care, which recognises consumers' social experiences as integral to mental health. Social determinants of mental health and wellbeing, as identified by Alegría, NeMoyer, Falgàs Bagué, Wang, and Alvarez (2018), include:

- Employment (including unemployment and under employment)
- Income, socio-economic status, material hardship and poverty
- Housing (including insecure housing), homelessness, housing costs and conditions
- Neighbourhood safety and amenities
- Discrimination, stigma, exclusion and marginalisation
- Family and social relationships and supports
- The capacity to participate and enact citizenship
- Trauma and adverse childhood events
- Race
- Gender and gender identity
- Sexuality
- Migration status

UNDERSTANDING RECOVERY APPROACHES IN COMMUNITY MENTAL HEALTH (continued)

Recovering citizenship

Rowe and Davidson (2016) argue that recovery should be conceptualised as a "normal" life involving citizenship and access to services that support recovery – a focus not on eradicating mental illness but rather, living well with a mental health condition. Citizenship involves participation, inclusion, rights, responsibilities, roles, resources and relationships (Rowe & Davidson, 2016). Citizenship-based mental health practices address the material, social, cultural, political and economic context of consumers' lives. Particularly, Rowe and Davidson (2016) advance the importance of comprehensive citizenship, which considers the consumers' role within the broader community and society outside of a specific service or program.

ESTABLISHED PRINCIPLES FOR EFFECTIVELY SUPPORTING MENTAL HEALTH

Through the document review process, the Project Team distilled a list of common themes, ways of working or principles that were important for addressing mental health needs of consumers. Many of the principles were endorsed by the National Standards for Mental Health Services 2010, Principles of Recovery Orientated Mental Health Practice (Australian Government Department of Health, 2010b).

A list from the document review was presented to the Lived Experience Advisors, and then further reviewed in co-design workshop 1. In this process the language was changed slightly, often to be more experiential and based on immediate responses within a service environment – for example 'inclusive' was changed to 'welcoming'.

Table 5: Reviewing Co-design Workshop 1

Principle seen as essential to co-design participants	What this means – as expressed by co-design participants	References (academic, sector-endorsed or policy frameworks)
Safety	Spaces and supports that people feel are safe and welcoming, do no harm, are kind and understanding of the many faces and expressions of trauma. The felt experience is the measure of safety	The Plan (2015)
Flattening power	Power is recognised and addressed, opportunity is shared, different kinds of expertise are embraced and people feel respected	Tuna Blue (2019) Heath (2018)
Belonging	Space and places to belong, connection and connecting are created and experienced	The Plan (2015)
Welcoming and non-discriminatory	People are welcome and welcomed, barriers are reduced – including cultural and accessibility barriers. Everybody has a gentle way in. Services are visible and known	Australian Government Department of Health (2010a) Australian Government Department of Health (2010b) The Plan (2015)

Table 5: Reviewing Co-design Workshop 1 (continued)

Principle seen as essential to co-design participants	What this means - as expressed by co-design participants	References (academic, sector-endorsed or policy frameworks)
Choice and self-determination	The person is at the centre, the support fosters the individual's agency and empowerment. Models show adaptability and responsiveness to individuals, and can hold ambiguity. Supports consider and foster a sense of 'what's next' for that person's life – and that moving on might involve supports outside of mental health, i.e. other supports and opportunities	Kaleveld, McCorry & McKinney (2019) Martin et al. (2020) Australian Government Department of Health (2010b) Tuna Blue (2019) The Plan (2015)
Social context	Recognising that recovery happens in the places and with the people with whom a person shares their life, and is responsive to the social factors that affect people's lived including housing, income, racism and others	Tuna Blue (2019) Martin et al. (2020) The Plan (2015) A Safe Place (2020)
Engagement	Pro-active and person-centred and family-inclusive strategies support engagement, including outreach and working collaboratively with other services and supports	Australian Government Department of Health (2010b) Kaleveld, McCorry & McKinney (2019) Martin et al. (2020) Tuna Blue (2019) Australian Government Department of Health (2010a) The Plan (2015)
Peer developed and peer led	Supports amplify the role of peers. Peer-led and peer-developed options are available	Tuna Blue (2019) Health (2018) Martin et al. (2020)
Collaboration	Services need to liaise with one another, including clinical services	Australian Government Department of Health (2010a) Sustainable Health Review (2019) The Plan (2015)
Evaluation	Focused on the outcomes that matter to people, genuinely responsive to the views and feedback of people who use the services. Qualitative and quantitative feedback is valued. We also need evaluation to build our understanding of evidence-based practice	Australian Government Department of Health (2010b) Mental Health Outcomes Statements (2012) The Plan (2015)

The discussion with co-design participants about this list of principles, and what it might mean for the way supports are designed and structured, was a valuable starting point to launch co-design workshop 1, and the process of understanding what people need to support their mental health and wellbeing.

Community mental health support models designed for priority groups
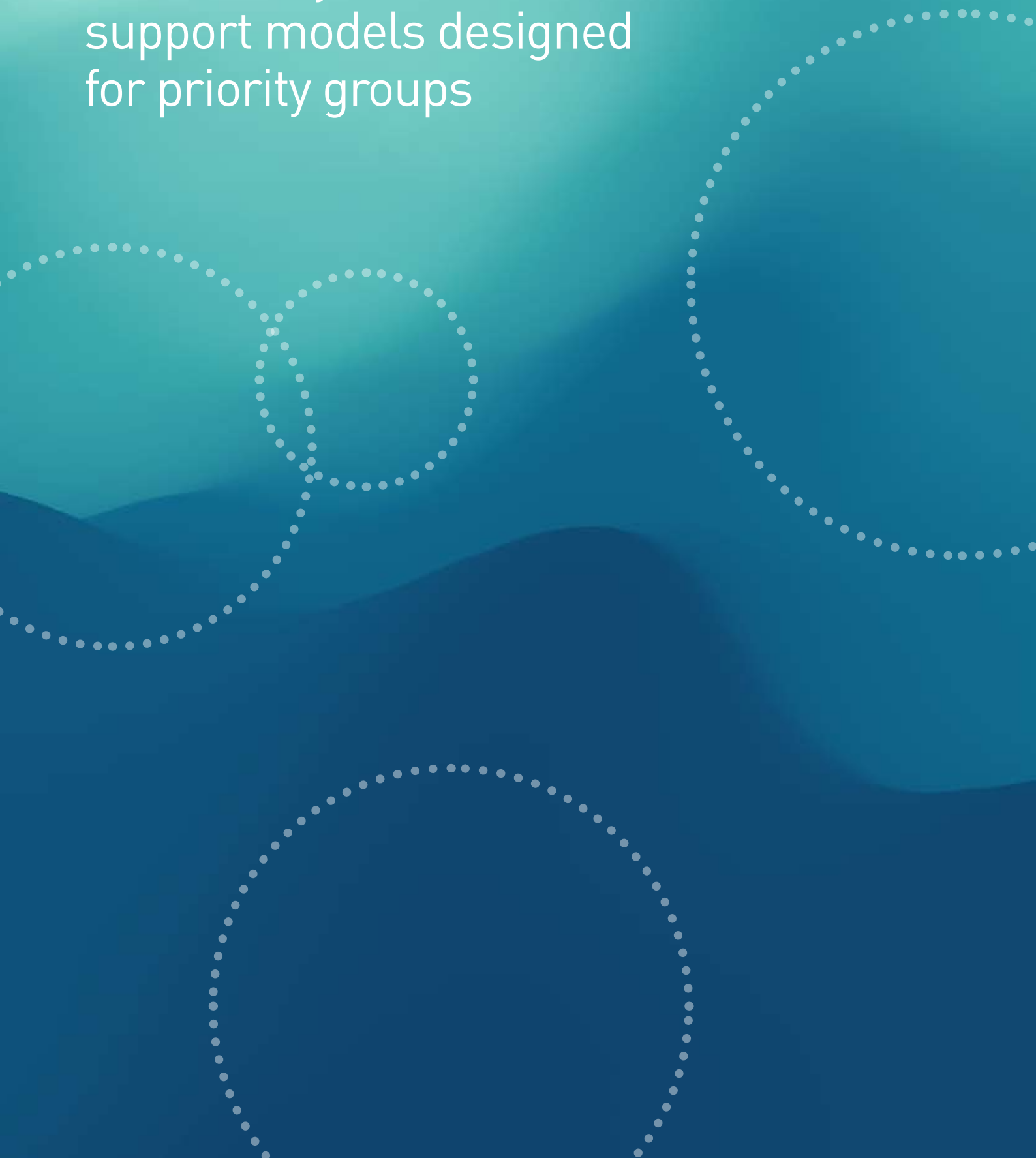
2.1 An early intervention and recovery support for high school aged young people (12-16 years)

What have high school aged young people (12-16 years) asked for?	**An informal drop-in space, near their school or public transport, offering structured group activities (i.e. music, drama, sport and art therapy), and non-pathologising group education to help with social/emotional literacy.** **Qualified, caring adults are available to talk and listen one-on-one anytime. There is a buddy system, and also active outreach within the school and community.**

ACCESS CONSIDERATIONS

My parents might not be there to help me access support for my mental health – I need to be able to get there independently (and maybe go there straight from school) *I want to feel that taking care of my mental health and getting support is normalised in my school*	• Convenient location that is near the school or locally based in an accessible location • Access is facilitated through the school, or there is active outreach into the school and the community through talks or other ways to connect with everyone • This support is promoted as being relevant for everyone (not just for 'at-risk' kids)

RECOVERY SUPPORTS

I need to experience safety within a community of support. I need a space outside of home and school – 'a space just to be' *Adults in my life sometimes fall short. An authentic continuous connection with an adult I can trust and feel safe talking to is important to me* *I need help to understand myself and my experiences, and gain skills and knowledge to navigate things that seem overwhelming* *I need to feel accepted and normal (and understand that nothing is wrong with me)* *I need to connect with other children around shared interests*	• A 'third space' outside of school and home to spend time with friends and trusted adults. Sibling and parent involvement should be limited and only with consent of the young person • Qualified staff who care who can establish a continuous one-on-one relationship with the young person. Someone who has time to talk and listen to the young person (and not tell them what to do) • Opportunities to develop life skills, group education opportunities about difficult topics (such as sexual assault or family conflict) and ideas for taking care of self (using non-pathologising language) • Peer support or mentoring/buddy system • A choice in activities to engage in with others, such as nature walks, music, drama, art therapy, relaxed sports games and video games • Low level brokerage funds to support practical help with transport, phone credit and homework tutoring will help me engage • Phone calls, texting and online chat could be additional supports

MODEL DEVELOPMENT

Bringing in views of young people, and the lived experience perspective

The Plan talks about under 16s as categorised in three groups: infants, children and adolescents. This model was co-designed with young people within the high-school aged cohort (participants were actually aged 12-17) so this model is most appropriate for those defined in the Plan as 'adolescent'.

The first draft of this model was developed in co-design workshop 1, and was described as the children's model. No children attended the workshop. However, the participants who worked on the model had experience working in schools or with children at risk of experiencing mental health issues, or were parents of young children, with lived experience of mental health issues in the family. The empathy mapping exercise focused on primary school aged children (under 12s).

An opportunity was presented to conduct an in-person workshop with 8 young people who were attending the Wanslea Family Services' school holiday program at the time. This included 5 participants who were under 18, and 3 youth workers (under 24) who were supporting the Wanslea program. The focus group involved mapping needs, open questions prompting discussion about gaps in community mental health supports for their age group, and a card sort of potential components that would meet their needs. The group also gave feedback on the model developed in co-design workshop 1.

As a result of this process, the target demographic for this model shifted from primary school aged children to high school aged young people. It was agreed that a support appropriate for teenagers would need to be significantly adapted for children under 12. For example, while teenagers asked for independence and limited involvement of their parents, this might not be appropriate for younger children who may benefit from connections and alignment between their parents, teachers, support staff and/or social workers. Future co-design work focusing on the needs of younger children (under 12s) is recommended.

Descriptions of needs and responses

- **Safe, caring adults who have time to listen**

  One of the strongest themes to emerge from talking with young people was their need for a safe adult in their lives, described as someone who is not stressed, or demanding, and who can listen non-judgmentally; 'non-authoritative adult who is there to listen'. Participants shared that they want 'to feel heard and understood' by someone outside of the school and their family.

  "It's important to know that you have someone to talk to, just in case"

  (high school aged focus group)

  Teachers were described by young people as having a very significant impact on their lives, with the potential to have positive impacts on their self-esteem and mental health. However, the focus group participants spent a long time explaining that while they were looking to the teacher as an alternative adult to support them, ongoing poor interactions with teachers left them feeling judged, unsupported or vulnerable.

  Teachers have demands on their time and are not available to provide the one-on-one attention participants needed. While perhaps beyond the scope of a community mental health support, focus group participants asked for greater training and support for teachers to help them be the safe, supportive adults they are hoping to have in their lives.

  In the proposed support model, 'safe adults' have time for one-on-one chats, listening and guidance. Particularly if young people are facing difficult circumstances at home, there is a strong desire to build trusting relationships with adults outside the family.

MODEL DEVELOPMENT (continued)

Descriptions of needs and responses (continued)

- **A third space away from home or school – and no involvement from family members**

  The setting of the support was a central focus of the workshop discussion. Participants expressed a desire for a 'third space' – separate from school and home settings, and a space that facilitates social connection and a sense of community.

  "We want to interact with people our age, but outside of school and home" (high school aged focus group)

  The safety of this space is paramount, and it needs to be free of the pressures that might exist at school and home.

  "I want a place just to be" (high school aged focus group)

  "A peaceful environment where no judgement occurs or is felt" (high school aged focus group)

  There was a strong consensus that young people did not want their siblings and parents involved in the community support (if they need to be, it must be with the consent of the young person).

  "It is important to have separation from the family" (high school aged focus group)

  Participants explained that having siblings present may bring their home/family problems into their safe space.

  "Teens often have issues at home and need time to themselves or with friends for a break"

  (high school aged focus group)

- **Group support is available, but mainly delivered through shared activities**

  This space would be like a drop-in centre, with the option of structured activities that cater for a variety of interests, for example nature walks, video games or relaxed social sports.

  "A space to hang out with my friends" (high school aged focus group)

  Activities are seen as a useful way for high school aged young people to experience connection and social support indirectly, providing a loose structure for interacting with others, meeting new people, relaxing and "talking about things that are bothering you".

  "I think social interventions rather than mental health interventions are so important for young people – the Backtracks Program in NSW is great example" (co-design workshop 1)

  "I want to feel not-alone" (high school aged focus group)

  "More clubs or teams that aren't just sport" (high school aged focus group)

  "Support from peers is important" (high school aged focus group)

  Other ideas were for nature-based activities.

  "Nature is beneficial for everyone, for getting away from chaos. It's calming, freeing" (high school aged focus group)

  While activities offer informal support, young people also said structured group talks about taking care of yourself and others, and increasing social and emotional literacy will also be beneficial. To complement informal social support they also asked for a regular structured session with an adult support person "[…] so there's time for everyone [to get help]".

MODEL DEVELOPMENT (continued)

Descriptions of needs and responses (continued)

- **Access close to the school and that is facilitated through the school**

  One main concern for young people is how to access support for their mental health. Younger teenagers rely on family and public transport to get around, and may not feel comfortable to talk about their mental health with their parents. There was a strong desire to link the model to the school environment – either through proactive in-reach into the school, or being located at or near the school. Other suggestions included in-school workshops and after-school activities within the school, where kids could then become familiar with the centre and its staff, and 'hang out' there when they wished.

  One participant with a Culturally and Linguistically Diverse (CaLD) background explained that their family would not support or recognise their need for mental health support, due to cultural biases. For this young person, as well as others, physical accessibility was vital. It should be located at school, near public transport or within walking distance from school. After-school times often worked best, but older teenagers expressed a desire for a setting open later in the evening.

  Face-to-face was strongly preferred to online, although the capacity for out-of-hours phone calls, texting and online chat are useful add-ons, and might be important for assisting with young people's mental distress (that can occur any time).

- **Broad engagement strategy to help reduce stigma as an access barrier**

  A crucial element of this support is that it would not be narrowly focused on mental health and mental illness. Young people do not want to be seen as going to a 'mental health program'. Drawing on the social determinants of health, this model would prioritise components that we know keep young people well – while avoiding the stigma that may be attached to a centre targeting 'at-risk' kids (participants stated that they are very aware of any programs for 'at-risk' students and this becomes a barrier). For some young people from CaLD backgrounds, this is especially important.

  A program with strong links to school, offering structured activities and an informal, safe 'hang out space' would allow some young people to access the support without having to announce that they were getting support for their mental health.

- **Practical support with transport, phone credit, homework tutoring, nutrition**

  Some participants asked for help with daily, practical needs that would help them feel more 'on top of' the stress of school and home. While some schools offered homework clubs, there could be some stigma attached to attending these, and having one-on-one tutoring in this support would be more desirable to access.

  "Free one-on-one help with homework, at school or a public place"
  (high school aged focus group)

  Young people can feel isolated if they cannot access phone credit or get around. So having low level brokerage funding for young people without access to financial resources would help young people to stay well, feel included and connected.

  Some participants noted things their school was doing right – for example, a breakfast club which provided both support for physical health and nutrition, but also a relaxed opportunity to check in with adults and friends on a regular basis.

  This was an illustration of where a community mental health support does not need to be complicated. Many of the suggestions came down to simple ways to be together with others in a relaxed way, and ensuring there was enough funding (i.e., "not watered-down milos").

OTHER CONSIDERATIONS FOR SUPPORTING YOUNG PEOPLE

There are two categories of mental health supports for under 16s:

- supporting young people whose families or caregivers are experiencing mental health issues, and

- supporting young people who are experiencing mental health issues themselves.

The service provider consultation with Wanslea Family Services suggested that these needs often co-exist and that ultimately the support for these needs would be quite similar. The specifics of a support would be tailored for the individual child's circumstances anyway. Therefore, the discrepancy between each group would not impact greatly on designing a community mental health support such as the one proposed here.

OTHER CONSIDERATIONS FOR SUPPORTING YOUNG PEOPLE (continued)

In the co-design workshop it was also suggested that the soon-to-be-released National Children's Mental Health and Wellbeing Strategy, and the Commission's Young People Priority Framework would be useful for informing further model development.

A strong partnership with the Department of Education would be recommended for the development and implementation of this proposed model.

In terms of the broader category of children (or under 18s which in the Plan incorporates infants, children and adolescents) one service provider interview stated that under 12s had very limited options for supports that they can access.

"For infants there's a lot of focus on the parent/child relationship, parenting supports and families at risk. Under 12s are very limited in supports they can access. For 12-16 year olds there are some school-based initiatives and targeted supports within the school. For 12-16 year olds there are both school based & federally funded initiatives and programs for students at risk of developing mental illness" (service provider interview)

It is important to recognise that this model does not address the gap for under 12s, and that further development work to look specifically at these needs is recommended.

EVIDENCE AND EXAMPLES OF OTHER SUPPORTS FOR HIGH SCHOOL AGED YOUNG PEOPLE

A focus on de-stigmatisation, and integration with schools

Since 2015, the Australian Government has funded school-based mental health programs – first through KidsMatter Primary and KidsMatter Early Childhood, superseded now by Be You, led by Beyond Blue in partnership with Early Childhood Australia and headspace. These programs aim to provide evidence-based resources, primarily targeted at educators but also staff, families and children, for identifying mental and behavioural problems and promoting general mental wellbeing and resilience. These resources are a combination of online learning and in-person facilitated content.

The aim of Be You and its predecessors is to mitigate the impact of mental health issues on school engagement and educational achievement. Schools are identified as an ideal setting for mental health capacity building because of the role of school and early childhood services as key contexts for development, learning and wellbeing. Further, these contexts enable a whole-of-setting approach, in a protective environment, supported by a cohesive ethos, where a physically and emotionally safe environment for children's social and emotional learning can be developed (Beyond Blue, 2018).

It is difficult to disaggregate evidence on the most effective means of helping children and young people to access mental health support because studies often cross over both cohorts, for instance some studies focus on 0-12-year olds, others 4-17-year olds, some 0-18-year olds, and so forth. Schools and early childhood services are an effective setting for mental health services and learning because of their high attendance, meaning that all or most children have access to them. However, this does not mean that schools should be the only setting. A recent review by Radez et al. (2020) concurred that school is an apt environment for mental health services due to its accessibility, the reduction of logistical barriers such as cost and transport, and the ability to access many members of a child's support network. However, the review also found young people accessing services within schools could experience difficulty expressing emotions verbally and fears about confidentiality. The review suggested that services should also be available that promote children's agency, control and self-determination. To this end, several studies have encouraged the use of digital tools for self-referral and text-based psychological treatments. (This was not supported by our co-design findings, who emphasised face-to-face contact as a priority).

In sum, schools offer several advantages as a mental health service and capacity building setting due to their reach and the potential for immersion of resources across the entire setting, thus creating a positive culture and de-stigmatising mental health issues and help-seeking. However, as always, such an approach is not going to work for everyone, and flexibility in service delivery should be maintained for those whose needs are not met by school-based settings for various reasons.

The model co-designed for this project seems to support these learnings – in that young people asked for a support with strong links to the school, that could be accessed through the school, but that was nonetheless a standalone service not directly connected to the school.

EVIDENCE AND EXAMPLES OF OTHER SUPPORTS FOR HIGH SCHOOL AGED YOUNG PEOPLE (continued)

Drop-in centres for high school aged young people

Youth centres tend to offer a mix of structured and drop-in programs. Documented learnings suggest that structured programs lend themselves to collecting outcome data, whereas the flexible, drop-in nature of some youth centres can make comprehensive evaluations and developing a strong evidence-base a challenge.

In a meta-analysis of after-school programs that seek to enhance the personal and social skills of children and adolescents, Durlak, Weissberg and Pachan (2010) found that when compared to controls, program participants demonstrated significant increases across a broad range of socioemotional outcomes: improved self-perceptions and bonding to school, positive social behaviours, school grades and academic achievement, and significant reductions in problem behaviours. While not specifically analysing the impact of these programs on adolescents' mental health, the positive impact across a broad range of social determinants suggest that after-school programs could have positive effects on feelings of community involvement, social support and, consequently, mental wellbeing.

Chechak, Dunlop and Holosko (2019) undertook a process evaluation of a youth drop-in centre targeted at marginalised teenagers (aged 12-19) in Windsor, Ontario. While their results were quite specific to their program (the evaluation found improvements could be made to make the basketball team more inclusive, for instance), what their research demonstrates is the usefulness of a flexible, temporal systemised evaluation. This involved collecting regular participatory feedback, quantitative data (such as attendance rates) complemented by extensive qualitative data, and translating these responses into timely program changes.

After school programs are found to improve social determinants of health that we know are crucial to helping adolescents stay well. They can help to improve physical activity of young people (Beets et al., 2015); promote healthy identity development and increase academic competencies (Lapalme, Bisset, & Potvin, 2014); provide substance-use education (D'Amico et al., 2012); promote sexual and relationship health (Mathews et al., 2015); and discourage anti-social or delinquent behaviour (Taheri & Welsh, 2016).

The Billy Dower Youth Centre is an after school drop in centre based in Mandurah, WA, and an example of an existing service that incorporates elements of the co-designed model .

The Billy Dower Youth Centre offers a range of activities catering to young people. It is targeted at high school students, and aims to provide a "space to hang out and relax after school. Free WIFI, snacks, sports and arts activities and much more". The centre provides organised activities during school-holidays and during the term, including a low-cost gaming club, and a range of information sessions tailored to the needs of young people.

There are other after-school drop-in centres already in place in WA, often operated through local councils. One approach to offering the model developed through co-design could be to build the mental health capacity of existing drop-in spaces, and to establish new ones where there are gaps.

2.2 A recovery support for young people (16-24 years)

What have young people asked for?	An engagement hub or space to go for immediate support with basic needs, and ongoing one-on-one support with a whole-of-life focus and capacity building. A place to belong with access to a peer network and social opportunities for ongoing support if needed.

ACCESS CONSIDERATIONS

I may be at risk and need urgent support *I may face significant barriers to accessing services, including a lack of transport* *It is likely I will not have a diagnosis and may even fear having a diagnosis*	• Access is offered through immediate contact via various platforms (phone, texting, physical drop-in) and with long service hours – 10am-2am, or 24/7 • Ability to self-refer without the consent of parent/guardian • No diagnosis required • Outreach into schools and communities, opportunities for drop-in as well as centre based appointments

RECOVERY SUPPORTS

I may be looking to leave caregivers for the first time, in order to deal with my distress *While I have traumas to unpack, I often present with a practical need which should be addressed first (e.g. having a shower, food security, a safe home) and have limited knowledge of service options available* *I need help navigating supports and services (Centrelink, employment, housing), maybe as I move out of the family home* *I need to feel a sense of belonging and community connection* *I need to feel heard and validated. I may have experienced discrimination, and do not like to be judged, labeled or misunderstood*	• The young person is the primary client – only involve others if the young person requests • Brokerage funds available to support young people in steps to gain independence • Supported referrals, advocacy and practical help to access clinical and other whole-of-life supports are vital (strong referral pathways). This may include housing, pathways into skills development, life skills and employment opportunities • Staffing includes peer workers plus support from professionally trained adults including youth workers and social workers, with the Youth Work Code of Ethics used as a basis for engagement (e.g. empowering approaches) • Skills and capacity building can be delivered in group format, and include financial skills, self care, being an advocate, taking care of mental health, and peer sex education • Option to drop in and connect with other young people over shared interests (and some structured activities), and including linkage to sobering up spaces if needed, as well as offering safe social spaces without the presence of alcohol and other drugs • Deep listening and allowing the young person to speak about their experiences as equals are useful tools for recovery • A culture that is very inclusive, celebrating diversity, with no discrimination of any group. Youth voice, representation and peer involvement are all built into ongoing service delivery in authentic ways

MODEL DEVELOPMENT

Bringing in young people's views, and the lived experience perspective

Young people were defined as between 16 and 24 years of age . This age group was under-represented in the early stages of co-design processes – with limited participation in both the survey and co-design workshops. To remedy this, the Project Team undertook consultations – a service provider consultation and a focus group with the Youth Steering Committee from Youth Affairs Council of Western Australia.

During the focus group, the models developed in co-design workshop 1 were revised by young people with both lived experience and advocacy experience. The focus group participants represented young people from the LGBTIQA+ community, young Aboriginal and Torres Strait Islanders, young people from Culturally and Linguistically Diverse (CaLD) backgrounds and young people living with disability.

Descriptions of needs and responses

- **Immediate access – as a suicide prevention strategy**

  Given concerns about high suicide risk across the youth cohort, immediate intake was considered a priority.

  "[Immediate access] is important for all groups... but is especially important for young people who, as a group have higher risk of suicide and may be impulsive and not have understandings of other options for assistance" (co-design workshop)

  This means no diagnosis needed, no payment required and no waiting times. The commitment to ensure the service is free should be ongoing, including no gap fees and no private fees, and no fees for non-permanent residents. Long hours are recommended to increase access: either 10am until 2am, 24/7, being available on the weekend, or using a data-based approach (based on need/locality). Once accessed the service should be responsive in providing all supports needed.

  "Then also referral pathways into non-discriminatory health and mental health services (that are 'safe' for young people) and other youth services for CALD, LGBTI+ and disability etc." (youth focus group)

- **No diagnosis needed**

  Young people may not have had the chance to receive a diagnosis or may have changing diagnoses, and fears about being labelled.

  "Definitions and meeting criteria for a diagnosis such what is required to access National Disability Insurance Scheme (NDIS) (e.g. for NDIS it has to be permanent) and many other facets in the application processes are real barriers to accessing and wanting to access services" (youth focus group)

  "Outreach is important to encourage help-seeking, with a strong, clear message that 'you won't be diagnosed, everyone's in'" (co-design workshop)

  "Getting to know someone is an alternative to diagnosis. You can use functional assessment or other instruments so the right supports can be found, if needed" (co-design workshop)

- **The young person is the primary client**

  There was agreement that the involvement of family members or carers should not be assumed.

  "The ability to self-refer without the consent of a parent or guardian is really important" (co-design workshop)

  If the young person expresses the need to reconnect with, heal or strengthen their connection with their family, that should be supported (perhaps through involving their family members and carers). However, it is acknowledged that:

  "For young people sometimes their healing journey cannot begin until they achieve a certain emancipation from their family of origin, and they can see themselves as being able to survive and thrive outside their family system. This is particularly important for young people raised in a home where there was male dominance and/or domestic violence was accepted as normal" (co-design workshop)

  If young people want to reconnect with parents later on, family issues can be addressed then. However, initially it is important to keep the young person as the primary client.

MODEL DEVELOPMENT (continued)

Descriptions of needs and responses (continued)

- **The young person is the primary client (continued)**

  "It has to be their choice, but this can be accommodated with an individualised approach" (co-design workshop)

  "For me, I didn't understand that my family was part of the problem. Some young people need to be educated about their experience within their family, and the model can provide this space to be held..." (co-design workshop)

  The critical need is to understand the context around the young person.

  "Young people can have supportive or non-supportive families – we need to recognise the influence families can have, and that this influence can be damaging" (co-design workshop)

- **Practical support, brokerage funds and help accessing services**

  Young people are likely to need practical and urgent help. The model needs to be responsive to fixing basic, urgent issues that young people might be finding overwhelming.

  "Some young people need the ability to leave violent and unsafe homes quickly and easily" (youth focus group)

  "Young people may present to a service or community support with needs that may need to be met before being able to grapple with mental health concerns" (service provider interview)

  Practical supports include navigating service systems, including Centrelink and mental health services, and finding solutions for addressing food security, stable housing and employment (social determinants of health). If the young person is referred onto other services and supports these need to be physically accessible (i.e., public transport accessibility and disability access considered).

  "Only once basic needs have been addressed, can we focus on belonging" (co-design workshop)

Practical supports needed, identified by the Youth Affairs Council of Western Australia focus group were:

- A universal minimum income or stable income
- Financial support for gender transition
- Affordable education
- Ability to transition genders without medical and legal barriers
- Free tertiary education
- Paid work experience, internships, employment pathways
- Removing parental income assessments for Centrelink
- Removing mutual obligations for Centrelink
- Financial education

The co-design workshop noted that access to a social worker would be beneficial to help with many of these needs, and checking in with the young person about their situation regarding employment, housing and relationships.

"Yes to brokerage funds. The purpose should be to meet the needs of the young person, and then accountability of finances to be reconciled after that need is met" (co-design workshop)

- **A focus on education, skills and employment**

  Many young people may not yet have a clear career trajectory or reliable opportunities for participation in the employment market. Lack of opportunities for employment (especially as the economic effects of COVID-19 are expected to severely limit opportunity for young people for some time), leads to increased risks of social exclusion and flow-on mental health impacts.

  The focus group with Aboriginal and Torres Strait Islander mental health workers brought to light issues of young Aboriginal and Torres Strait Islanders in remote areas of WA who are adversely affected by high rates of youth unemployment, leading to feelings of hopelessness.

  "An employment pathway that involves paid work experience or support in writing applications for internships and jobs could help provide young people with stability, purpose, empowerment and a foundation from which to address mental health distress. Links to TAFE courses or more affordable education can provide young people with a sense of direction, opportunity and hope" (ATSI focus group).

MODEL DEVELOPMENT (continued)

Descriptions of needs and responses (continued)

• **A focus on education, skills and employment (continued)**

In addition, financial education, education about self-care and mental health issues and destigmatised peer sex education was also seen as important.

• **Belonging in a safe community**

The notion of being at ease with one's identity and feeling connected within a safe community was considered vital for young people's ability to stay well.

"Being able to feel at home in a space designed for us is really important" (youth focus group)

Young people we spoke to asked for connection to peers and to culture, and to a supportive group who are accepting of them. There may be times when a specific peer group will need to be formed, to uphold safety and belonging for some people, for example:

"Queer youth spaces that are drug and alcohol free and available to under 18s. Bars and clubs may be the first introduction to Queer community, or the only option, so we need to provide alternative safe spaces" (youth focus group)

Opportunities to connect with other young people socially was considered a need for some young people. A drop-in space that enables young people to interact socially could fulfill this:

"A music/chill out zone to connect with people their own age, people who are going through the same things" (co-design workshop)

However, it was thought that young people also respond well to structured activities and skill development opportunities, to provide a chance to build relationships while doing things – cooking, walking, attending information sessions, arts activities (co-design workshop).

"Young people often will present with some practical issue, but beyond that it can take more than one visit to start getting to underlying issues, so it would be beneficial if there could be activities, groups that will attract them back to the service" (co-design workshop)

• **A non-discriminatory and proactively inclusive setting**

Young people expressed cynicism of services being 'inclusive' without being deeply and authentically welcoming or celebratory of diverse groups. They asked not just for lip service to the idea of diversity, but ways to celebrate "intersectional and diverse identities".

"Inclusion is important but diversity is important too. That is, there's a need to look and see the people represented in a service…then you can ask questions, and see that for example peer development for Culturally and Linguistically Diverse people is really important" (youth focus group)

This could mean services question assumptions of cis-normativity and heteronormativity, have gender-neutral bathrooms, decolonised models of mental health and broader concepts of mental health. Young people do not want supports that shame or stigmatise behaviours (drugs, alcohol, sex work, etc.). This is seen as vital for supporting mental health and recovery (youth focus group).

"We do not want services that say that they're inclusive without hiring any of those people on staff, that don't know how to book or offer interpreters, that force people into models of recovery that are white-centric, ableist, cis/heteronormative" (youth focus group)

"There needs to be an understanding that marginalised young people will assume non-inclusivity as the default and need to be convinced otherwise" (youth focus group)

This needs to extend to services that young people are referred on to, for example, ensuring access to non-discriminatory medical and clinical services.
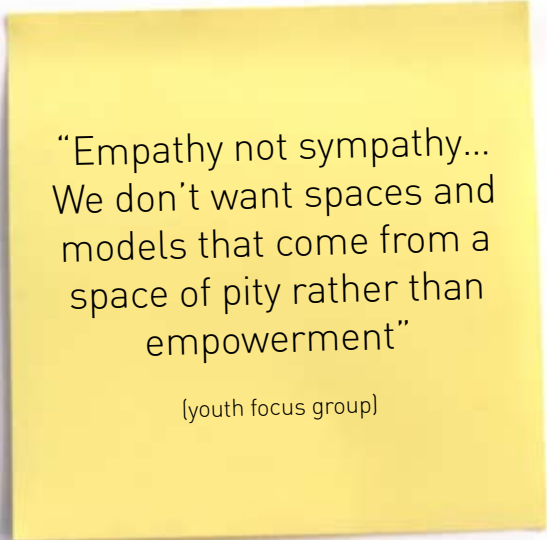
MODEL DEVELOPMENT (continued)

Descriptions of needs and responses (continued)

- **Voice, representation and empowerment built into the service**

  Young people consulted expressed the need to have a voice: a say in how the service is run, and also the "ability to express ourselves without fear". They felt this was directly related to staying mentally healthy. Within a model, this could look like:

  - having youth representation at all levels in the service

  - respect from all older adults

  - the ability for young people to mentor and advocate for peers

  - opportunities to be involved in advocacy work and have a political voice

  - opportunities to be supported to make a meaningful systematic impact, and

  - representation from young Queer people, CALD young people, disabled people and Aboriginal people.

  Plus, in all processes young people are given choices and alternative options spelt out, and empowerment in the way the model is implemented.

> "Empathy not sympathy... We don't want spaces and models that come from a space of pity rather than empowerment"
>
> (youth focus group)

Participants also asked for co-design opportunities and being supported to do advocacy ("which provides relief from distress").

- **Mix of peer workers and other professionals and integration with clinical services**

  Young people asked to be supported by staff with balanced mix of skills – peers who are relatable and also supervised if needed, staff with expertise and a mix of young peers and older adults. Peer support also needs to be complemented by access to clinical support.

  Discussions about the needs of young people highlighted the importance of being able to access a relatable, young person/peer mentor who can "speak their language" or "be hip and cool", which is important for building authentic connections.

> "Young people cannot connect as well with older people sometimes" (co-design workshop)

In addition, young people will benefit from older, skilled or more experienced professionals with the skills to navigate complex family systems (e.g. to intervene appropriately and safely where there is family violence) and skills to advocate for the young person for service access (e.g., arranging housing support through Centrelink).

Access to skilled professionals with mental health expertise is also considered important.

> "Peers also need support in being able to deal with acute mental health distress" (youth focus group)

> "We need upskilling and peer support with possible supervision from psychologists" (youth focus group)

Young people may also actively seek out or be comforted by a safe adult.

> "All needs to be available – professional support such as social workers, plus peers who are cool and relatable to the person. And the young person needs to be empowered by the service to assert themselves if they don't relate to someone" (co-design workshop)

Integration with clinical supports was also important to the young people consulted.

> "Some people want informal support, others need the clinical path as opportunities, but don't separate them. Have a strong referral network" (youth focus group)

MODEL DEVELOPMENT (continued)

Descriptions of needs and responses (continued)

- **Links to facilities where young people can sober up if under the influence of alcohol or other drugs**

  Supports need to recognise alcohol and other drug use in non-stigmatising ways. Young people may not always have a safe home in which to sober up, so this is seen as a need to be met. Other young people expressed the importance of feeling safe away from people under the influence of alcohol or other drugs. A model should be able to accommodate for young people under the influence of alcohol and other drugs through linking them into specialist facilities for sobering up that is separate from where other young people are.

- **Links to facilities where young people can sober up if under the influence of alcohol or other drugs (continued)**

  "Facilities that support de-escalation (e.g. sobering up support in Northbridge that prevent violence rather than calling police)" (youth focus group)

OTHER CONSIDERATIONS FOR SUPPORTING YOUNG PEOPLE

System-level gaps and considerations were raised in the co-design process, and included the following suggestions and ideas:

- The need for postvention support for young people in suicide-affected communities

- More support for children and young people in abusive and difficult situations before child removal

- Group supports for young people who are trauma survivors

- "Funding everything that Tracy Westerman does (i.e. community education)"

- A community-based less formal treatment option for young people in crisis including a respite stay in a supportive (not hospital) environment

- The Department of Education to include Mind Education in the curriculum, alongside Physical Education. To help young people with self-care, destigmatise mental illness and encourage help-seeking.

As with the model for high school aged young people, the Mental Health Commission's Young People Priority Framework (yet to be released at the time of publication) would be useful for informing further model development.

EVIDENCE AND EXAMPLES OF OTHER SUPPORTS FOR YOUNG PEOPLE

Passages is a youth engagement hub, run by St Vincent de Paul Society and the Rotary Club of Perth in the Peel region and Perth area of WA. Passages' objective is to provide services for young people (aged 12 to 25) experiencing homelessness and/or social isolation. The program identifies that many displaced young people experience mental health issues, complex trauma, alcohol and drugs issues and disadvantage. The engagement hubs operate under three main pillars: 1) basic needs including engagement, food and phone access; 2) youth worker support; 3) a network of allied agencies to provide additional support. Passages state youth workers provide person-centred support, mentoring and referrals. Other services provided include engagement with youth workers, information and referral, outreach, medical and legal support, and financial, practical and employment assistance (Martin, R., Mahoney, N., & Pracilio, A, 2020).

Passages is an example of a place for young people experiencing distress, trauma, homelessness or social exclusion. Like the model co-designed in this project, these hubs focus initially on meeting basic needs, provide youth worker support and have strong referral pathways in order to meet many different needs, including mental health.

As a community mental health support this model is very much based on social determinants of health, which seems especially important for young people who are experiencing transitions that make them vulnerable to many social issues that have an effect on their mental health and wellbeing.

2.3 A peer recovery support for family members and carers of people with mental health challenges, including co-occurring alcohol and other drug issues

What have families and carers asked for?	A centre-based, drop-in space to engage informally with peers, plus a structured peer mentoring program and Warm Line.
	The peer mentoring program allows people to be mentored by a peer who is skilled and trained, but is there mainly to offer support through shared lived experience. The Warm Line is a calm place to talk with a peer who understands.
	Within these relationships family members and carers can explore their own recovery, and extra support options, including using the capacity within their existing networks.

ACCESS CONSIDERATIONS

I need access to be convenient and to be able to fit in with everything going on in my life, which might be overwhelming	• Convenient location, accessible (local community focused), child-friendly, home visits offered during school hours, and out of hours support available as well
	• Warm Line offers peer support outside of centre hours

RECOVERY SUPPORTS

The context of my life needs to be understood, and my existing networks can be drawn upon for further support	• A commitment from the service that no-one will fall through the cracks (ongoing, proactive and flexible engagement)
It is especially important for me to feel heard and my experiences validated by peers – especially any difficulties I have faced navigating or feeling excluded from the mental health system	• Ecological approach – understanding the person's needs in context of the networks around them, their culture and other environmental factors
	• The main intervention is deep, empathetic listening; the emphasis is on peers who can provide understanding
At times I need support just for me, that is separate from my caring responsibilities	• Strengths-based approaches are used as they are validating and empowering
	• Capacity building is offered including advocacy and peer support
I may be distressed and need recovery support too	• A formal aftercare plan is put in place – it includes information, advice and referrals to other services

MODEL DEVELOPMENT

Bringing in family members, supporters and carers' views, and the lived experience perspective

People with lived experience as a family member or carer of someone with a mental health challenge worked on this support during co-design workshops 1 and 2. In addition, just over a quarter of survey respondents (26.8%, n=49) identified as a family member, carer or support person for someone with a mental health challenge, so the survey findings were able to provide grounding and confirmation for this model.

Figure 9 presents survey findings that describe family and carer needs. The findings reinforce the idea that existing services for family members and carers tend to focus on the carer's role in supporting someone (e.g. allows me to be involved in the recovery journey of the person I care for/provides good information for carers about mental illness and supporting someone with mental illness). However, supports for family members and carers that focus their own distress or own needs (including social needs), are more limited, with most family members and carers indicating they receive much less opportunity to meet other carers or family members than they would like. Over half (57%) of responses found that their prior experience with community mental health supports provided insufficient information about accessing supports "just for me".

The community mental health support...

Statement	Much less than I like	Less than I would like	Some but would like more	Almost as much as I would like	As much as I would like
Allows me opportunities to meet other carers or family members for support and friendship (n=17)	29.4%	35.3%	11.8%	5.9%	17.6%
Assists and supports me with any advocacy work (n=19)	31.6%	21.1%	26.3%		21.1%
Provides good information for carers about mental illness, and supporting someone with a mental illness (n=22)	27.3%	35.3%	9.1%	9.1%	36.4%
Sees me as an important part of the recovery journey (n=25)	28%	16%	12%	8%	36%
Gives me information about accessing supports just for me (n=21)	23.8%	33.3%	9.5%	14.3%	19%
Allows me to be involved in the recovery journey of the person I care for (n=24)	12.5%	8.3%	25%	12.5%	41.7%
Show they are understanding and empathetic about the challenges of being a family member/supporter or carer of someone living with a mental illness (n=25)	28%	16%	24%	8%	24%

Figure 9: Family member and carer needs in community mental health support (n=29)
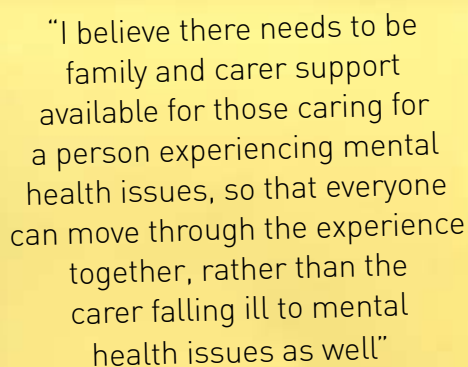
The family members and carers of those who accessed (or may have accessed) community mental health supports rated their satisfaction with the support they received as carers from the community mental health supports. The most highly rated statement was "allows me to be involved in the recovery journey of the person I care for", with 41.7% answering "as much as I would like" and a further 12.5% "almost as much as I would like". Areas in need of improvement include support for advocacy, support for being a carer, and opportunities to connect with other carers.

MODEL DEVELOPMENT (continued)

Description of needs and responses

- **A need to make more visible the distress that family members and carers may be feeling**

  The survey identified that family members and carers were at high risk of experiencing mental distress themselves. As one family member/carer respondent noted:

  "I believe there needs to be family and carer support available for those caring for a person experiencing mental health issues, so that everyone can move through the experience together, rather than the carer falling ill to mental health issues as well"

  (survey respondent)

  Current service models for family members and carers tend to focus on how the carer can better support the individual in their lives facing mental health issues. The emphasis of this model would be addressing the distress that family members or carers feel themselves, and helping them cope with their caring role through supporting their own mental health and their own (or whole-of-family) recovery.

- **Feeling heard and validated**

  For family members and carers, it is a common experience to feel excluded from the care provided to their loved ones, and feel frustrated and ignored within the mental health service system (in both clinical and community settings). There is trauma in not being listened to.

  "[The need] to be listened to… a parent knows more about their child than the medical facility" (survey response)

This support would be sensitive to how family members, supporters and carers are likely to have experienced the mental health system, and provide experiences of validation to counter this.

"Feeling heard, accepted and included in the process, relates to a trauma-informed approach. This might mean staff have training in body language and micro expressions to help them work out the best way to engage with acceptance, empathy, validation and awareness of power imbalances" (co-design workshop)

The power of a support designed around listening only, means it is safe in a way that other non-community based services may not be.

"From my experience working with families and carers, I know some people find it impossible to speak of the violence that happens to them when a person is in a highly agitated and/or intoxicated state and which contributes to the family's ongoing trauma. In peer conversations, they have fed back that they don't believe there is a service space in which they can raise those issues let alone have them responded to sensitively" (co-design workshop)

- **Ecological approach**

  Providing a family member with as much support as possible, in an ongoing way, can be enhanced through an understanding of the person in their context and within their existing social network. This 'ecological approach' is more than a person-centred approach as it takes into consideration the person's family, community, culture and all other social and environmental factors that affect their mental health. It is also a strengths-based approach.

  "Bring in contextual coordination - this means working with the person in context, for example, investigating the capacity of their community networks to provide support and including this in care plans" (co-design workshop)

  "A network that provides additional support may include agencies, family, social and community networks" (co-design workshop)

MODEL DEVELOPMENT (continued)

Description of needs and responses (continued)

- **Whole of the family unit is considered**

  Recognising a 'family in recovery' means that, just as the consumer may need space to take a non-linear recovery path, so too does the family around them (in a dynamic family system). This understanding should be an essential component of a mental health support. For this priority group, recovery needs to be understood as relational, and the family unit considered as a whole.

  "The focus should be on being able to deal with whole of family issues at any time before they escalate" (co-design workshop)

- **Whole of the family unit is considered (continued)**

  "Inclusion of how to support other members of the family" (co-design workshop)

  However, this should be with the consent (for individuals over the age of 18), and also poses some drawbacks. For example, different family members can have opposing ideas about treatment which can lead to conflict and tension.

  "It's vital that everyone is involved – if and where that's appropriate" (co-design workshop)

- **Build access around caring responsibilities**

  Caring responsibilities may be intense and demanding. Support should be offered in either virtual ways or home visits, whatever meets the needs of the family.

  "Location, accessible and close (local community), with out of hours support, or child friendly options (home visits in school hours)" (co-design workshop)

- **Peer mentoring**

  Peer mentoring was a common theme throughout the co-design process. Many carers and families felt that they did not have enough access to people who had been through similar experiences.

  "Sometimes people just want a chat. Not necessarily giving advice. Just giving people space"

  (co-design workshop)

  "Mentoring comes down to peer support... more 'me too' and 'where to from here'... and sometimes all that's needed is a sounding board to bounce ideas off and gain confidence in using your own strengths" (co-design workshop)

- **Practical support**

  This relates to the overwhelming nature – emotionally and physically – of caring for someone with a mental health issue. A practical lens on a family member/carer's needs could include:

  "Help with respite when you are a carer that has depressive or other debilitating health conditions" (co-design workshop)

  "Integration with whole of government services, and not just referral to more clinical services" (co-design workshop)

OTHER CONSIDERATIONS FOR SUPPORTING FAMILY MEMBERS, SUPPORTERS AND CARERS

The needs of young carers (e.g. young children who are caring for parents with mental health issues) are very particular and may need their own model.

A suggestion for a connection/referral system established between Child Victim Witness Services as services for Child Crime Victims do not generally extend to family members and those caring for them.

EVIDENCE AND EXAMPLES OF OTHER SUPPORTS FOR FAMILY MEMBERS AND CARERS

Leggatt and Woodhead (2015) describe a program supporting family members whose young relatives were engaged with an Early Psychosis Prevention and Intervention Centre delivered by Orygen Youth Health in Melbourne. The program is called the Family Peer Support Worker Programme (FPSW), developed in response to feedback from family members who were satisfied with the clinical care their young people were receiving, but felt unsupported emotionally and with regard to psychoeducation. Leggatt and Woodhead (2015) note an extensive body of literature on the effectiveness of including family carers in the treatment of their unwell relative, with several meta-analyses consistently finding, for the consumer:

- reductions in relapse rates
- decreases in hospital admissions
- greater adherence to medications, and
- better coordination of care.

There are various models for including families in mental health care, and the authors state that the evidence advocates for a 'spectrum of family services' to meet the diverse needs of family carers.

The FPSW program involved a family peer support worker initiating a phone call to the families of new admissions to the program. The phone call was not to talk about the young person and the family peer support worker does not ask clinicians for information about the young person (thus maintaining confidentiality). Rather, the phone call is to ask how the family was coping and enquire about the support that they wanted. The FPSW program involved a training program comprised of 7 fortnightly, 90-minute sessions about various aspects of providing support:

- how to use lived experience to help other families,
- providing telephone and face-to-face support,
- coping strategies,
- behaviour management,
- understanding the mental health system,
- managing boundary issues, and
- facilitating a support group.

FPSWs were paid employees, and critical to their success was supervision and support. This involved ongoing consultation with all members of the team in which FPSWs were to be placed, to discuss roles, guidelines, and to establish standards of practice for working together. FPSWs were provided with two hours of training and development per week. The program was ultimately successful and Leggatt and Woodhead (2015) report that the FPSW program is an ongoing part of Orygen Youth Health.

2.4 A crisis and recovery support for people with high acuity mental health issues and multiple unmet needs

What have people with high acuity mental health issues or multiple unmet needs asked for?	A peer-led service that offers various ways to access help and connect with others – including a safe space for drop in, appointments for more structured support, Warm Line, 24/7 crisis response and outreach are available if needed

ACCESS CONSIDERATIONS

| *I may not want to tell my story multiple times and to multiple people. I need one contact person, and the ability to choose this person*

I need a safe service/person who can stay with me while I resolve various life issues in my own time – without risk of fragmenting my own needs to meet bureaucratic requirements

I might have had negative service experiences – I need to build trust and how I feel about the first contact is very important | • Centre-based service supporting drop-in, with long hours and active outreach

• One warm, safe and welcoming contact person (concierge concept) who is a peer, and the consumer can choose who this person is

• Mental health and alcohol and other drug issues can be addressed together – everyone is in and these needs do not need to be fragmented

• The service actively welcomes people who have been excluded from or find it difficult to access other services |

RECOVERY SUPPORTS

| *I need a non-institutionalised environment without stigma, deficit language or bureaucratic rigidities that prevent me from resolving issues*

I need a lot of choice and flexibility to address the multiple issues and barriers I may face, including practical supports

I need something different to clinical approaches

I need highly skilled, trauma informed peer workers | • Peer-led and peer workers provide support (no clinical or non-peer staff on site), although access to clinicians is available when requested. The service has strong integration with off-site clinical supports

• Trauma-informed staff, physical environment, processes and programs from first contact and ongoing

• Brokerage funds to allow a focus of support on basic needs – food security, phone/data access, housing and cleaning

• Support options also include individualised, one-on-one peer support focused on recovery

• Staff can support me with my mental health and alcohol and other drug challenges

• All referrals are warm and some should be hot (with urgency, to respond to acuity); advocacy may also be needed at the referral point |

MODEL DEVELOPMENT

Bringing in the lived experience perspective

This model was co-designed in two workshops, with people with lived experience either as an individual or a carer or family member. Survey findings and interviews with service providers also informed this approach.

Workshop participants noted that the description of 'acute and multiple unmet needs' can be problematic. People can be high functioning in one area, while still having unmet needs in other areas. This idea also emerged in the survey findings.

"For me personally I have a co-occurring mental illness diagnosis with a disability, being that I am also autistic. I have been passed from pillar to post trying to access a suitable community support that encompasses both of my disabilities. I would love there to be more accessible community mental health services for people that also live with a co-occurring disability... I am fed up of being siloed into boxes, with services saying we don't deal with autism or we don't deal with mental health issues" (survey response)

Description of needs and responses

- **Trained peer workers are essential**

  Peer workers are the basis of this model; however, they need qualifications and training. Training may include dialogical training or trauma training, or even supervision to help the peer worker continue to provide quality support.

  "More educated peer to peer group work with good trained supervision occasionally" (survey response)

- **No clinicians on site, however access to clinicians is well integrated**

  Co-design participants with lived experience of persistent or chronic mental health issues described competing needs. Depending on their past experience with hospital or clinical settings, they may be seeking community mental health supports to either complement support from a psychiatrist, psychologist or GP, or as an alternative – perhaps the clinical approach has not benefited them, or may have been a negative experience.

"Adults who have had negative experiences within clinical models might need to know this model is not 'the same' as what they've experienced in the past" (co-design workshop)

It was decided that a model for this priority group should not assume what a person's connection to clinical services should be, and accommodate for all needs.

"We still need to have some clinical expertise. While the focus is on peers, it needs to be people with lived experience who also have certain skills – if the peer is not skilled they can do the opposite [of help]" (co-design workshop)

Careful consideration was given to ensuring the space was 'clinician-free', whilst allowing mechanisms to easily access clinical support where needed, and with the person's consent.

"The idea of 'no clinicians present' is to put a focus on it being a community support service, and to make that distinction that this is not a clinical service. But it's important to have access to clinical expertise, of course. For example, the Men's Shed starts with community support and clinical expertise is added on at a later stage" (co-design workshop)

- **Concierge model**

  Co-design participants asked for ongoing connection with one person (continuity of care) who provides support in all stages of recovery. Although it was emphasised that the consumer needs to have choice about who that person is.

  "Access to the person of choice – service users need to find the person that they are comfortable to be with" (co-design workshop)

- **Flexible and individualised to each consumer**

  The support needs to be adaptable to the individual, and staff need the ability to provide individualised support to each consumer.

  "There also needs to be adaptability for when the person's needs change – and that is sometimes from day to day" (co-design workshop)

MODEL DEVELOPMENT (continued)

Description of needs and responses (continued)

- **Flexible and individualised to each consumer (continued)**

  "Flexibility and creativity in their approach with working with me. I have complex needs and I don't fit into a box. I need responsive care that centres me. What is the point in working in a way that suits the service but does not create sustainable, meaningful change for me?" (survey response)

  "Individuals who experience dissociative episodes may need follow up/check in services as they only present when not dissociating and can lose verbal skills and be unable to make a phone call or attend an appointment when they need the most help" (co-design workshop)

- **An understanding of trauma informs the way support is offered**

  While an understanding of trauma is important across all supports, for this priority group and model it was considered crucial. Staff need to be able to recognise institutionalisation and counter that to support transition. The support will also be mindful of the felt experience – having welcoming staff, and ensuring the consumer is really listened to, seen and understood. Low lighting and soft furnishings will also be a feature of the space. Trauma integration programs such as art, drama, music, writing and therapy will also play a role.

  "Trauma-informed, dissociation-informed and staff have in-depth trauma training" (co-design workshop)

  "Trauma-informed assessment and practice is a must...for assessment – if needed – allow space for voluntary disclosure. This is different to formal assessment – no clipboards. Wait until another day for some questions. Option for the consumer to ask the worker questions, too" (co-design workshop)

  "A lot more training and raising of awareness about PTSD and C-PTSD, including a genuine and deep understanding that PTSD arising from childhood abuse is different from that arising from trauma experienced in adulthood" (survey response)

  A part of this approach is that care is taken to ensure the consumer is informed about all aspects of the service. The staff will make it clear that this support is different – it is not clinical. They are able to understand the service methodology and approach, as well as possibilities and options. They also have access to formal and informal lived experience education.

- **Non-stigmatising service**

  Stigma can be transmitted through the attitudes of staff (behaviours might include asking too many questions (interrogation) or deficit language), as negative stereotypes or discrimination.

  "No posters that label or point out problems – e.g. 'violence will not be tolerated'" (co-design workshop)

  Some co-design participants have found experience in clinical settings stigmatising, and associate clinical language or processes that way.

  "Get away from language and stigmatising ideas from clinical perspectives – 'what's wrong with your brain'" (co-design workshop)

  "Get to know me not my diagnosis" (survey response)

  A non-stigmatising service would make consumers feel valued, through basic customer service skills.

- **Practical supports**

  As with other models, consumers may not be able to address mental health needs unless their practical needs are met.

  "People's basic needs like food vouchers may need to be in place before they can engage" (co-design workshop)

  "Have support to fill in important paperwork (practical support for basics)" (survey response)

MODEL DEVELOPMENT (continued)

Description of needs and responses (continued)

- **Crisis response and immediate help**

  Consumers will need immediate support, and the ability to receive help at any time of day or night. Some individuals suggested out of hours support with overnight staffing or services that can come to the individual. Posters with emergency numbers would be helpful. All referrals should be 'warm' and some should be 'hot' (to respond to urgency).

- **Support is delivered in mixed ways**

  This could involve a safe space with a drop-in setting, providing a calm place to talk one-on-one with support workers or peers and receive further support if needed. This space could also provide activities and operate as a communal setting (a common area) with a focus on social connection where family and friends could also be invited.

- **Referrals into a network of allied agencies, including non-mental health services**

  Referral into different supports was considered essential for meeting unmet needs and providing additional supports.

  Co-design participants raised the need for warm/hot referrals into non mental health services (with consent), for example, life coaching, business development and/or education. A network of allied agencies was recommended, including agencies which focus on physical health and holistic needs. A gradual end to the support was recommended, with regular check-ups to ensure that an individual had not 'fallen through the gaps'. An aftercare plan could be put into place – for example, a Wellness Recovery Action Plan to support self-management (although there was not a consensus on this idea), to allow the individual to softly transition out of support.

  "I think if the services (disability payments, housing, etc.) were more aware of each other and co-existed as a team, a person would be more likely to feel supported and improve" (survey response)

  "Let me decide when I engage and when I want to stop engaging" (survey response)

  Financial incentives for services to integrate and proceed assisted referrals so that people may continue their recovery journey was also proposed.

OTHER CONSIDERATIONS FOR SUPPORTING PEOPLE WITH HIGH ACUITY MENTAL HEALTH ISSUES OR MULTIPLE UNMET NEEDS

The complex interactions between acute mental health issues and other co-occurring conditions such as alcohol and other drug misuse, intellectual or psychosocial disability or complex life circumstances such as experiences of homelessness, family and domestic violence, complex trauma from abuse, and poverty require sophisticated responses and interfaces with other services. Although this is touched on in the model, unpacking how this works in a real-world setting needs further development. Ideally, the safety and assurance offered by this model will be able to be extended into other services that consumers are referred on to.

Dual diagnosis is estimated to affect between 20-80% of people receiving mental health treatment (Padwa et al., 2013). The evidence shows that better outcomes are achieved when services are designed to address both mental health and substance abuse issues in an integrated rather than parallel fashion (Drake et al., 2004). A primary benefit of integrated services is the consistency in the information provided to the consumer, and the development of a coherent, complementary treatment plan. However, there is no consensus about how best to integrate mental health and substance disorder services. In a review of 36 studies, Drake et al. (1998) found that adding dual-disorders groups to traditional services was ineffective, as was intensive integrated treatment in controlled settings, and noted that the most promising results were from comprehensive, integrated outpatient services. Drake et al. (2001) integrate two decades of dual diagnosis service research and identify the following key success factors in treating dual diagnosis:

- A comprehensive, long-term, staged approach to recovery. The fundamental, non-linear stages of the approach are forming a trusting relationship with service providers, building motivation to participate in treatment, skills acquisition for managing conditions and achieving consumer goals, and developing strategies for maintenance of recovery.

- Assertive outreach. Engaging consumers and members of their support system (in line with consumers' wishes) in various settings.

OTHER CONSIDERATIONS FOR SUPPORTING PEOPLE WITH HIGH ACUITY MENTAL HEALTH ISSUES OR MULTIPLE UNMET NEEDS (continued)

- Motivational interventions. Helping consumers to identify their goals and providing information and education towards realistic understanding of how not managing their treatment interferes with their achievement of goals.

- Capacity building towards consumer goals. This typically involves counselling aimed at promoting cognitive and behavioural skills, social support interventions that leverage social networks to support recovery, comprehensive support (e.g. housing, vocational rehabilitation and medical management, all tailored for those with dual diagnosis), and community-based supports.

- Cultural sensitivity and competence. Tailoring services to particular group characteristics leads to higher engagement.

EVIDENCE AND EXAMPLES OF OTHER SUPPORTS FOR THOSE WITH HIGH ACUITY AND MULTIPLE UNMET NEEDS

Flourish Australia (formerly RichmondPRA) is a rapidly expanding, peer-led service, with over half of the service's staff having lived experience. Headquartered in New South Wales, Flourish has sites throughout NSW and Queensland. Flourish offers an array of services and integrates many of the principles that arose through the co-design processes of this current project. The first is a low barrier to entry; Flourish Australia specifies that no referral is necessary in order to contact them and receive some level of support (even if it is a warm referral to another service).

Second is peer leadership. Peers are involved across all of Flourish's services, and Flourish runs place-based warm lines and support programs run by peers.

Third is the idea of a 'one stop shop'. Flourish offers mental health support, National Disability Insurance Scheme (NDIS) support, and support for carers, consumers and professionals. Services vary by region, but the integration and awareness of services provide the consumer with confidence that their varying needs can be addressed, further lowering barriers to help seeking.

The following case study, taken from Flourish Australia's Inspiring Stories page, indicates the benefit of some of the services available.

Tamar, an adult mental health consumer

When I walked in off the street to Flourish Australia I was warmly welcomed and felt I'd been wrapped in a cocoon after battling on alone for years.

I've always been self-reliant. Feeling supported by life affirming people at Flourish Australia is a new experience for me. I feel renewed by the kind words and understanding of the peer workers when they talk about their lived experience.

My marriage broke down after my son was born with a disability and my husband's mental health suffered following unexpected deaths in our family. I was studying teaching but put this on hold because I cried every day for months.

I never imagined we'd separate. When it happened it was traumatic. I experienced a mental fog, not knowing what to do. When I stumbled on Flourish Australia I was invited to try art and painted a cocoon because I felt I'd come into a safe place and became hopeful.

So much of what I know about early childhood learning applies to mental health recovery - like valuing each individual and encouraging them in their unique way of growing. Recognising this was an important shift for me. I wanted to get back to teaching. I'm now achieving high distinctions at TAFE and feel I'm reclaiming a part of myself.

In just 12 months my life has turned around completely. My self-esteem and confidence keep growing. I've developed new life skills, worry less, communicate better with my husband and have learned ways to support my son. I feel everyone is on my side and everything is going my way.

I've never let go of the love of art I discovered that first day. My dream now is to paint my life journey.

2.5 An early intervention and recovery support for people living in regional and remote WA

<table>
<tr>
<td>What have people living in regional and remote WA asked for?</td>
<td>A place-based neighbourhood centre where everyone is welcome to drop in and socially connect in a welcoming space, and through shared activities.

For remote areas, a focus on practical support is offered to help a person feel unburdened before emotional needs are addressed. And then, for Aboriginal people, opportunities to heal on Country may be considered.

Skilled, locally trained staff and peer workers, and in some areas, Aboriginal Health Workers, are needed.</td>
</tr>
</table>

ACCESS CONSIDERATIONS

I may be hesitant to seek help directly for my mental health *I need it to not be just a mental health service, because of stigma*	• A local centre based and face-to-face service that offers social connection and support with other things, not just mental health, and building on what is already available in local communities • No diagnosis required and people can self-refer • The service can cater for people with co-occurring alcohol and other drug issues in an integrated way • Build on existing capacity – community resource centres and neighbourhood centres

RECOVERY SUPPORTS

If I have had mental health issues in a small community I may need help to recover and to shake the label *There are times when living in remote areas is stressful and expensive. I need help making things work – sorting out Telstra, my water bills, balancing cultural and employment obligations and finding ways to go back to Country* *I may need help with trauma or other complex issues* *I need strength based approaches that understand and connect with local issues and supports*	• Community based social, education and outreach activities help normalise mental health and wellbeing, build community connection and resilience and connect people to supports • Opportunities for social connection and engaging with others 'shoulder to shoulder' while busy with activities that are not explicitly promoted as mental health events • Staff are actively non-stigmatising and recovery focused. Approaches around recovering citizenship – looking at positive integration in the community • Brokerage funds to assist with making someone's life function better, and unburdening a person are immediate needs to be addressed. This may include petrol money to travel for cultural reasons, which supports mental health • Help to initiate peer support groups and train local peer workers • For Aboriginal people, especially living in remote WA, a Traditional Healer or Aboriginal Mental Health Worker can then provide social and emotional support, or support for a person to heal on Country • One-on-one, individualised support with skilled staff is available

MODEL DEVELOPMENT

Bringing in the views of people living in rural and remote areas

At least one participant representing regional WA was present at both Co-design Workshops. Three service provider consultations with services in regional and remote WA were conducted. A focus group of three consumers living in regional areas was also arranged. The focus group of six Aboriginal participants with experience working in mental health also informed the development of this model. The survey findings brought in a broader range of views. Throughout these processes, three distinct needs were understood:

- The needs of people living in rural WA
- The needs of people living in remote regions of WA
- Aboriginal people living in rural and remote WA

If further development work is initiated, creating three models adapted to each of these slightly different priority groups would be recommended. Or, at minimum these distinct needs should be considered (where relevant) in the process of adapting this model to any specific local context.

Descriptions of needs and responses

- **People living in regional WA need more options**

    The co-design process uncovered what we already know – there is a lack of community mental health supports in regional WA, and both services and consumers are aware of this.

    "Community mental health in the Goldfields region needs a real good look at" (survey response)

    This was also emphasised by the service provider interviews who described multiple, compounding gaps. Lack of effective NDIS-focused initiatives means that supports available to all are even more vital. The lack of services is across the board – Cognitive Based Therapies and talk therapies are hard to access (and people cannot afford it) and "in Geraldton there are also not many peer support groups" (focus group).

"There's a lack of services, and a lack of options in the services that are available. People have difficulties accessing NDIS, even if they have a plan. They might be eligible for a 'recovery coach' for example, but there are none in Geraldton" (service provider interview)

For consumers, having no services locally available is a significant access barrier.

"Because there are no community mental health supports available in our town, the nearest major town with these services is more than an hour by road away with no public transport. Because all the services are in major cities or towns, it's easy to ignore tiny towns like mine" (survey response)

Even when there are supports they are often under-funded and less able to be responsive.

"The bigger 'business' agencies like Anglicare, Baptistcare and the like get most of the extra funding available, leaving little or nothing for small grass roots organisations like small family/neighbourhood centres" (survey response)

"Better funding needed for programs and services in regional areas" (survey response)

"Services don't reach out to small towns in the Central Wheatbelt. A school psychologist can take weeks to get an appointment with" (survey response)

This co-design process confirmed that telehealth alone is not the answer to meeting needs of people in rural and remote WA.

"Zoom is not the answer...the models that get overlooked are those that are on the ground at the coal face, meeting with people locally – which is incredibly important, and it works" (service provider interview)

MODEL DEVELOPMENT (continued)

Descriptions of needs and responses (continued)

- **People living in regional WA need more options (continued)**

The impact of lack of services in regional areas is that people are unsupported. People from specific priority groups are especially vulnerable due to difficulties accessing peer group support.

"For LGBTI+ and rainbow folk, in addition to sexuality issues, there is also the stigma, still present in many rural communities, that make the coming out process more difficult. There are few or no support groups in rural areas, and particularly for young people, no public transport available so they can get to ones in bigger towns without their parents' help in getting there. Loneliness, feeling like you're the only one, fears about changed relationships with peers and the wider community, bullying in schools... where do I start? It's not just a gap in services; it's a dangerous abyss" (survey response)

"Emphasis on diversity of support for different demographics e.g. I think there needs to be more diverse and creative approaches to supports, particularly in regards to social groups. I am a male in my 30s and most social support groups are predominately accessed by older women. This results in me never making any meaningful connections and friendships through these support groups" (survey respondent)
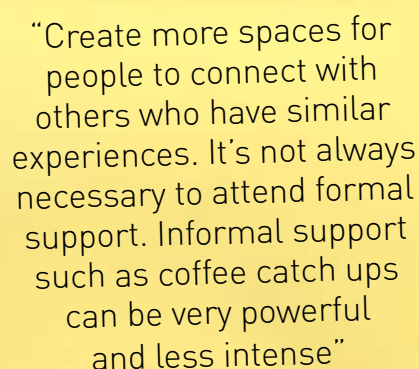
- **Need for well-resourced universal services (neighbourhood centre model/day community centre)**

Universal services mean they are open to everyone – there is no target group and can involve a range of initiatives including family and domestic violence responses, digital literacy sessions for seniors, playgroups, community legal centres, Grow Groups, etc. These models are 'gap fillers' and by moving away from models based on specialisation, such centres can be the glue that smaller towns need.

"If there is an issue in the community, these centres are the first to know, and to know how to respond to individual need or how to develop a community response. For example, they can work with the Shire to develop a local drug and alcohol plan. Then for example, local drug action groups that run out of them are really successful" (service provider interview)

"Bring back the models that were really working... such as neighbourhood houses. More of a community and village feel. Less clinical spaces that do not stigmatise the visitor" (survey response)

These service models can also provide the social connection needed, for people living in isolated areas.

"Create more spaces for people to connect with others who have similar experiences. It's not always necessary to attend formal support. Informal support such as coffee catch ups can be very powerful and less intense"

(survey response)

"We need services where you can choose to participate in or not, was probably the best I have been to, because it is socially focussed providing people opportunities to participate in activity or conversation or just hang around and be part of. No pressure, no judgement, safe, access to food and hot drinks, comfortable, low key, peer led staffing. Things that take you away from 'solving your problem' but lead you into health and wellbeing such as health education, connecting, sharing stories, just hanging around with each other, creating art or something" (survey response)

MODEL DEVELOPMENT (continued)

Descriptions of needs and responses (continued)

- **A focus on a variety of non-mental health engagement, non-mental health activities and destigmatisation**

    Rural and remote communities are more likely to struggle with stigma attached to mental health challenges, therefore approaches should be led by local workers who are sensitive to this context.

    "From a remote view I feel a safe space and one that is not just labelled 'mental health' support as people don't need to know what I might be doing in that building. We have only a few businesses operating in our remote community and all essential services are volunteer, so having somewhere like our local Community Resource Centre, who do lots of community stuff as well as provide an opportunity to connect, relax and feel part of community is really important to me as it does not brand me as a 'mental health' consumer" (survey response)

Destigmatising activities could include activity-based opportunities for sharing, and mental health awareness community seminars.

"Many of the interventions can be about positive experiences, shared connection and learning… plus more focused seminars on suicide prevention for example" (service provider interview)

"We are activity based, which is what people want – and they also don't want to go to mainstream services (like Men's Shed). We have a Work Bench where people can take risks, and we have qualified staff here to help them have a go at new things. This works really well for this cohort" (service provider interview)

- **Local leadership and opportunities to train local people**

    Supports in rural and remote areas need to engage local workers and leaders. There is a lack of trained peer workers.

"Regional barriers: infrastructure, lack of services and qualified and experienced staff" (survey response)

A service provider from a remote community pointed out that some Aboriginal people need to stay on Country to receive care and to heal, so more Aboriginal workers are needed (although family linkages can be a barrier, as they will not be able to work with everyone).

"We have such a small pool of people to work with. If there are family or friendship connections, which there often is in a small community, this makes it really hard too because often there is stigma about mental health in these communities" (service provider interview)

- **Practical assistance to address the burdens of living remote**

    People living in remote WA are likely to face additional burdens – with limited access to employment and communications. Living costs are high and sometimes the last thing you can think about is your own mental health. These needs apply especially to Aboriginal and Torres Strait Islander people who also may be dealing with the burden of living in two cultures/code switching, and trying to navigate complicated systems and services.

"Our service approach is, what can I help you with right now that would make your day easier?"

(remote service provider interview)

MODEL DEVELOPMENT (continued)

Descriptions of needs and responses (continued)

- **Sensitivity needed to address mental illness stigma and shame within small communities**

  For people in small communities, a service that focuses on practical help (for their shop window) is also beneficial in helping to de-stigmatise help seeking that might be associated with experiencing mental health issues.

  "When you live in a remote community you think you are the only person with mental health issues, and you fear talking to others in town as everyone will know...We need easy access to remote services that understand the limitations of small communities and the environment I live in. A few years ago, I rang a help line and the person said they understood remote living, but really they just understood regional living which was very different. So I hung up feeling quite lost as I could not make them understand that accessing services even if 40 km away was hard as I had no public transport and did not want to ask someone locally as I was embarrassed about my illness" (survey response)

- **Due to a lack of services, integration needs to be done well**

  In small towns and regional areas, a relative lack of services means that service integration and collaboration is critically important.

  "For rural remote, use existing well tested and proven community services and encourage all service support providers to work in collaboration with these local place-based services" (survey response)

  "Generally, agencies play well and there's a good mental health network. This needs to happen because overall there's a lack of support" (service provider interview)

OTHER CONSIDERATIONS FOR SUPPORTING PEOPLE IN RURAL AND REMOTE AREAS

System-level gaps and considerations were also raised in the co-design process, and are summarised here.

- Difficulties accessing NDIS support even for people who are eligible for a plan (but supports not available). At the same time, there are a lot of people not eligible for a plan (about one third of service users according to one service provider interview), who still rely on psychosocial supports to keep them well. The Australian Government estimated that nationwide 424,000 people with mental illness would require some kind of community support, not covered by the NDIS (Australian Government Actuary 2012), which equates to about 42,400 people in Western Australia, based on population estimates. Rural and remote areas need block funded, stand-alone models outside of the NDIS.

  "More understanding of challenges in the provision of NDIS in rural areas and adjustments to hourly rates to cover rural differences" (survey response)

- Difficulties recruiting and retaining qualified staff in rural and remote areas. Mental health training and recovery-based training and understanding is needed in these areas (usually not offered locally)

- Instability of funding is an issue because of the lack of options, people come to rely on programs and the relationships developed through them

"Many impacted by mental illness in Aboriginal and Torres Strait Islander communities are of the view that 'it is what it is' [...]. Many Aboriginal and Torres Strait Islander mental health clients are not adequately assessed or aware of their mental health needs, so can and will never be adequately serviced or supported."

(co-design workshop)

OTHER CONSIDERATIONS FOR SUPPORTING PEOPLE IN RURAL AND REMOTE AREAS (continued)

- One survey respondent proposed a trauma-based centre model for regional WA:

  "Trauma based centres located in each regional area that will cater to the needs of the communities within that region. These centres will have all specialised services under one roof, which will allow the clients to have a more spiritual, natural, trauma informed model of care at their fingertips. This would stop the unnecessary anxiety of going to multiple services located at different areas of town and being given multiple different instructions to follow which can cause disconnection for the person" (survey response)

EVIDENCE AND EXAMPLES OF OTHER SUPPORTS FOR PEOPLE LIVING IN RURAL AND REMOTE AREAS

Issues in rural mental healthcare are well-documented – geographic and social isolation can increase the prevalence of mental health issues, the external factors that can trigger distress differ from those in urban areas, and the availability of formal supports is poor relative to urban centres (Lifeline, 2020). These factors, in combination, lead to an increased reliance on social and community-based supports (Letvak, 2002). A key problem in developing local community initiatives has been the assignment of responsibility for analysing the needs of a community to external agencies, generally leading to ignorance of the community's strengths (Kretzmann & McKnight, 1996). In response to this, Boyd, Hayes, Wilson and Bearsley-Smith (2008) advocate for an asset-based community development approach to rural mental health.

The need for community integration of mental health services is well-established. The leverage of existing community assets – physical, financial, and tacit – is useful for cost efficiency, higher community uptake, and better service provision. The ABC's coverage of rural community-based mental health resource service *Are You Bogged Mate?* provides an insight into the need for such initiatives.

The SA Centre for Economic Studies (SACES) (2013) undertook a comprehensive evaluation of the social and economic impacts of community and neighbourhood centres in South Australia. While not explicitly focused on mental health outcomes, these centres were found to provide an array of improvements in public health, local community development and addressing the multi-factors that lead to social exclusion. The community centres provided an example of an asset-based community development approach to rural mental health, which considers the specific local context and community; strengthening assets or groups that may already be evident and responding to the real needs of the community.

The key focus of a place-based approach is to contribute to the strengthening of local assets – physical, human, financial and social – and especially human capital, which is "the single most important factor in enhancing local development and growth" (SACES, 2013). In Re-thinking Social Policy: Place-Shaped as Well as People-Focussed (Walsh & O'Neil, 2013), the failure of many social and economic policies to achieve re-engagement of people and families into the broader local community was in part because "government and their agencies have not yet given communities the degree of ownership and control over the design and implementation of strategies that would increase the prospects of achieving maximal effectiveness" (Walsh & O'Neil, 2013, p.3).

Health promotion programs were run by 82% of community centres, and 90% of centres offered skills and personal development programs, physical activities, special activities and programs and self-help, mutual and social support programs. Neighbourhood centres could respond flexibly to the needs of the communities, with some centres offering life skills programs, counselling, community gardens, cafes, woodworking and home and community care (SACES, 2013).

In a review of the literature relating to the effects of neighbourhood centres on children, families and communities, the Social Policy Research Centre NSW (2009) reported that neighbourhood centres:

- Provide an effective and cost effective method for engaging vulnerable members of the community and to providing them with a range of non-stigmatising preventive services.

- Act as a conduit for other services which many vulnerable families are otherwise unlikely to access.

- Help to foster greater levels of social capital in the community, providing the potential for greater productivity, higher levels of participation and decreased use of services.

EVIDENCE AND EXAMPLES OF OTHER SUPPORTS FOR PEOPLE LIVING IN RURAL AND REMOTE AREAS (continued)

There is clear evidence that neighbourhood centres provide a cost effective way of delivering support to the most vulnerable families in the community. Their unit costs are far lower than other equivalent service providers, and they tend to rely on volunteers and other committed staff members" (Ismir, Katz & Bruce, 2009).

Neighbourhood Drop-In Centre Model

Example: Community Centres SA is the peak body for 107 community and neighbourhood centres throughout South Australia

Community or neighbourhood centres are developed in close collaboration with local communities and can provide an array of practical and social support. This could include life skills, education, gardening or craft workshops, along with more traditional types of mental health support like counselling or support groups.

Milang Old School House Community Centre (MOSHCC)

Milang is a rural community in the Alexandrina council area in South Australia, with a much older population profile than South Australia and Australia. 38.9% of households in Milang have a gross weekly income of less than $600, likely reflecting the aged population receiving an aged pension. 400 people access the services provided by MOSHCC, delivered by eleven staff (two full time) and 70 volunteers who contribute around 5,000 hours of time a year. As of the 2011 Census, there were 883 people living in the community of Milang, and nearly 8% of the community volunteer at the community centre.

Activities and services:

- Adult Community Education Foundation Skills
- Home and Community Care (HACC)
- Community transport program
- A youth group
- A men's group
- A women's group
- A crèche
- Referral and an information service
- Emergency assistance
- Meals on Wheels deliveries in the local area
- "Friday Feast": a low-cost meal program offered by the centre where participants receive a two course meal prepared by volunteers. It provides an opportunity for socialisation and participation in post-lunch activities, contribution to community wellbeing through minimising social isolation.

The Adult Community Education programs provided by MOSHCC had excellent outcomes. The Foundation Skills ACE enabled 14 participants in 2012 to move onto further accredited training, and over 100 people have gained Certificate III and IV qualifications. Community centres can act as a pathway for those who may have become disengaged, or who may find accessing a community centre more viable than attending TAFE.

There are also established Community Resource Centres in Western Australia. Many of these small, community managed centres have been entrenched in their communities for 30 years or more, building on the strengths and assets that already exist within their communities. Building the mental health support capacity of these existing centres would be an ideal way to implement this model, with evaluation relevant to the local context.

2.6 A Warm Line to support multiple priority groups

What have people across multiple priority groups asked for?	A Warm Line is a calm place to talk with a trained peer who understands, without needing to be in crisis. Within this relationship, they can explore extra support options if needed, but mainly this is a place to talk.

ACCESS CONSIDERATIONS

I need access to be convenient and to be able to fit in with everything going on in my life	• Warm Line is accessible 24/7, 365 days a year
I need somewhere I can get immediate support anytime, even if I am not at crisis-point	• Very low barrier to entry – do not need to be at crisis point to access the Warm Line. Privacy and confidentiality are assured
I might prefer to text, or to talk	• Accessible to people across the state
	• Consider development for specific population groups once established
	• Options to engage by phone, text or messaging apps

RECOVERY SUPPORTS

Sometimes, all I need is a chat and for somebody to listen	• Emphasis on trained and skilled peers who can provide understanding and unburdening through listening
I need a place I can go to talk, where I don't need to be in a crisis and where I know I won't be referred	• Confidential service
I need someone to hear my distress or loneliness	• Peers may discuss extra supports or referral to further services, but only if the caller expresses that this is what they need
	• Consumer peers and family member peers are available

MODEL DEVELOPMENT

Bringing in views from lived experience

The Warm Line was explored in various co-design sessions and was seen to meet the needs of:

- Family members and carers,
- People living with acute or co-occurring mental health issues, and
- People living in rural or remote areas.

There was a general consensus during the workshops of the need for immediate help and for the opportunity to feel heard, and that this model would most effectively meet those needs for the maximum number of people.

Co-design sessions for family members and carers, and people living with acute or co-occurring mental health issues independently came up with this as an idea, and it was reflected in the survey as well. For people living in rural and remote areas, this was seen as directly meeting some of the needs described, including access issues, and overcoming stigma and sensitivities around speaking about mental health issues with local workers who live in small communities.
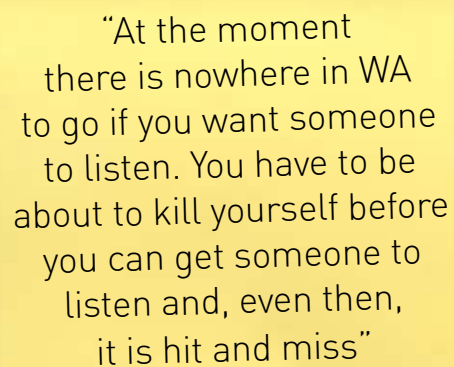
Descriptions of needs and responses

- **The need for a phone line that provides support anytime without the need to be in a crisis**

  Co-design participants expressed the desire for this service in WA. The 24/7 access that a Warm Line can provide is considered a critical benefit of this model. Many participants pointed out that a mental health crisis does not happen during business hours, and at night sometimes loneliness is overwhelming.

  "Perth does not have a Warm Line like they do in other places. We desperately need 24/7 access to such a service before things get to crisis point" (survey response)

  "Increase availability during the 24 hour day. My partner always has acute events at 11:00pm" (survey response)

"At the moment there is nowhere in WA to go if you want someone to listen. You have to be about to kill yourself before you can get someone to listen and, even then, it is hit and miss"

(survey response)

"My mental health issues do not stop at the end of the traditional working day. Weekends and evenings are the times I feel most isolated and at risk, it would be good to have more supports and services operating in these times" (survey response)

- **The need for immediate help and the opportunity to feel heard as ways to manage mental health in community**

The survey provided a foundation in identifying core needs to be met by community mental health supports. These include a need for immediate help, the opportunity to feel heard and the recognition that mental health is not confined to business hours.

A Warm Line that was available 24/7 with a focus on listening is a solution that addresses these needs.

"A Warm Line is a must for Australia. There needs to be a well-funded and supported peer workforce" (survey response)

MODEL DEVELOPMENT (continued)

Descriptions of needs and responses (continued)

- **The potential to have targeted Warm Lines to better meet needs**

  The Warm Line has been included as a stand-alone model not linked to the specific needs of any priority group. However, it was recognised that with further development, Warm Lines could be targeted to specific vulnerabilities or experiences – for example, the elderly or carers.

  "A few years ago, I rang a help line and the person said they understood remote living, but really they just understood regional living which was very different. So I hung up feeling quite lost as I could not make them understand that accessing services even 40 km away was hard as I had no public transport and did not want to ask someone locally as I was embarrassed about my illness" (survey response)

  A more focused Warm Line model would allow for recruitment of peers with specific lived experience that would allow them to connect with targeted group, a deeper and more nuanced training of staff, leading to a better more effective service for consumers.

- **Differing views about the role of referral**

  Differing views that emerged from the co-design process were related to the final stages engagement with a Warm Line. While it was agreed that the Warm Line was there to provide immediate support for an individual experiencing mental distress – or at risk of experiencing mental distress – there was a lack of consensus about the 'next steps'.

  One view is that the purpose of the Warm Line should be to provide a casual, anonymous chat with someone who was there to listen – and there is no integration with clinical services.

  "Sometimes people just want a chat which is not necessarily about giving or receiving advice – it's just about giving people space"
  (co-design workshop)

The second view is that the Warm Line should be integrated with whole-of-government services.

"We don't want a Warm Line that leads to nowhere" (co-design workshop)

In this proposed model, we have tried to resolve these two perspectives by enabling the peer workers to be knowledgeable and trained about options for additional supports and referral pathways, however the ways in which this knowledge would be applied is nuanced. They would only suggest the referral if the caller requests further support, and it would be in the hands of the caller to pursue this referral, with help from the peer only if requested.

This difference of view would need to be resolved when the model is further developed, perhaps through further co-design processes.

EVIDENCE AND EXAMPLES OF WARM LINES

Warm Lines, that is, phone or text services that offer emotional support and/or early intervention to prevent crisis, have been present in the mental health care system around the world for the last two decades. The workers at the end of the Warm Line are typically volunteers with lived experience of mental health issues although some also use paid peer workers.

An article by Pudlinski (2004) compares different models of Warm Lines – a beeper service where the Warm Line worker gets notified of a call and gets a page/text message, a team-based in-person call centre, and a call forwarding service where calls get forwarded to the worker's home phone. The beeper service was observed to be the best model from the perspective of the workers, as it mitigated transport issues and allowed for flexibility. The call forwarding system was not recommended due to the inability for workers to distinguish Warm Line from ordinary calls ahead of time. The impact of the Warm Line on callers was not assessed. As technology has addressed many of the issues that Pudlinski (2004) found with the different Warm Line models, this article serves more to illustrate the longstanding place that Warm Lines have in mental health service delivery than to advocate for a particular implementation. In the US, Warm Lines operate in about 30 states, and the California State Government has recently provided substantial funding (USD10.8m) to expand a San Francisco-based Warm Line to the cover the whole state (Stephens, 2019).

Dalgin, Dalgin and Metzger (2018) undertook a longitudinal evaluation of a peer-run Warm Line service in the US. Though they found no significant difference in Recovery Assessment Scores over time, Dalgin et al. (2018) found significantly increased visits to GPs, leisure and recreation activities, and social activities. It is important to note that Dalgin and colleagues (2018) were only able to follow 48 callers longitudinally. In addition, Dalgin et al. (2018) note the importance of training for Warm Line operators.

Community Counselling Solutions in Oregon, US take a novel approach to ascertaining the potential cost savings of their Warm Line (as described in the Community Counselling Solutions website). At the end of each call, they ask the caller what they would've done if they had not been able to connect to the Warm Line. They then record and categorise the responses and multiply the frequency of a response by the cost of the Warm Line alternative (e.g. 1000 people said they would have gone to the emergency department, each emergency department visit costs $700 on average. 1000 * $700 = $700,000 cost savings). The Community Counselling Solutions website lists their cost savings from Quarter 2 2017 as $526,985. In Stephens (2019), Community Counselling Solutions refer to a cost-savings report on the evaluation that found a Warm Line call costs $10, versus $100 for a 911 call or $700 for an ER trip. The same report estimates the cost savings of direct referrals provided by the Warm Line, in addition to the avoidance of police and emergency and other crisis use, as USD4.8m per year. This service only covers one state in the US.

Warm Lines in Australia

Mental health phone services in Australia are primarily crisis lines, however, there are several examples of peer-led Warm Lines.

Brook Red Warm Line

Brook Red in Queensland offers a peer-staffed phone line from 5pm to 9pm on weekdays for people in recovery. The peer line is open to anyone (with a number listed on the website), though the overall service aims to provide local support, given that the local system is what the peer workers are familiar with.

Mind Australia Carer Warm Line

Mind Australia is based in Victoria but operates a Warm Line that appears to operate via referral across jurisdictions. The Warm Line provides peer-to-peer support, information and education for carers of people with mental health issues. Mind Australia indicates that outreach to carers is a large function of the Warm Line, suggesting that it is a more local service despite not listing a geographic catchment area.

Being-Mental Health Consumer Advisory Group Warm Line

In May 2020, the NSW Mental Health Commission announced $800,000 in funding for a peer-led Warm Line to provide additional mental health support. The funding was provided in light of the increased anxiety and stress caused by COVID-19. It appears that the Warm Line will be state-wide, with an aim to provide services to those in rural and remote locations. The Warm Line will operate from 10am-4pm and 6pm-10pm, 7 days per week.

Evidence underpinning model designs
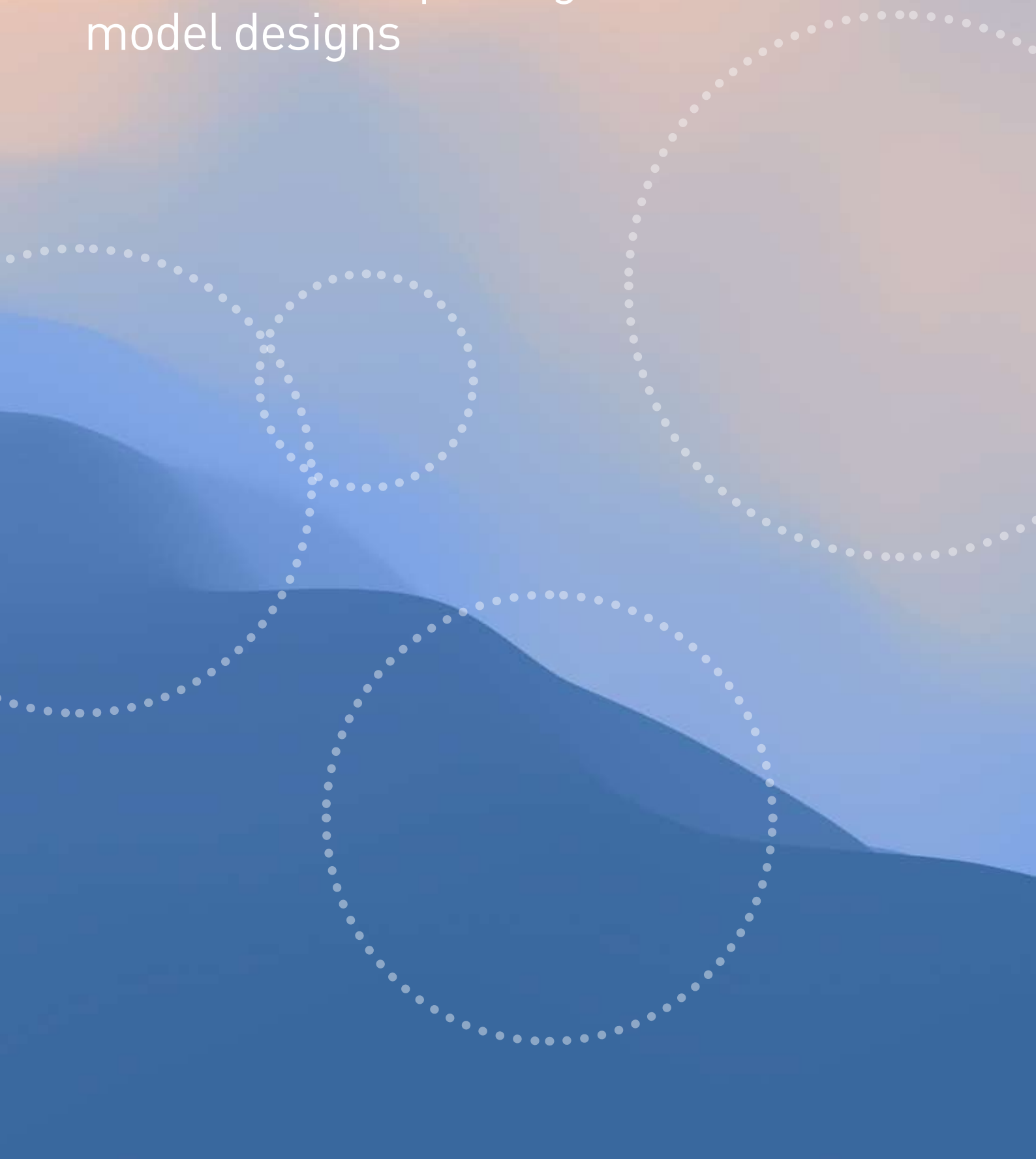
Purpose of the evidence review

This section reviews available evidence about the service elements that were preferred by the different cohorts of consumers and family members (who participated in the co-design processes and/or responded to the survey), and that applied to several or many of the models.

Across the models, we identified four key elements that people commonly asked for in the model design:

1. peer workers/peer support,
2. brokerage funds to support practical assistance with basic needs,
3. engagement without the need to have a diagnosis, and
4. general support approach

A general support approach involves the positioning of the support as providing general support in conjunction with some specific mental health focus. For example, people are welcome to come just for chats and being listened to, or other activities and opportunities to be with others are also provided so you do not need to engage in dedicated 'emotional disclosure'/'talk therapy' based sessions, if not your preference.

These components and the priority group models they apply to are summarised below.

Model\component	Use of peer workers	Need for brokerage funds	No requirement for diagnosis	General support approach
Children - Under 18s	–	✔	✔✔✔✔✔	✔✔✔✔✔
Young people – 16-24	✔✔✔✔✔	✔✔✔✔✔	✔✔✔✔✔	✔
Family members and carers	✔✔✔✔✔	✔✔✔	✔✔✔✔✔	–
People with acute mental health issues and multiple unmet needs	✔✔✔✔✔	✔✔✔✔✔	✔✔✔	–
Rural and remote	✔✔✔	✔✔✔✔✔	✔✔✔✔✔	✔✔✔✔✔
Warm Line	✔✔✔✔✔	–	✔✔✔✔✔	✔✔✔

KEY

– Did not emerge in co-design process as a component	✔ Nice to have	✔✔✔ Recommended	✔✔✔✔✔ Essential to the model

Table 12: Service delivery components and models

The evidence review focuses on these core threads, presenting evidence from academic and grey literature – in particular generalisable findings published in peer reviewed academic journals, or otherwise published findings of systematic evaluations or research – for example randomised controlled trials. The evidence presented includes evidence for effectiveness, cost savings, implementation considerations and examples of implementation in other jurisdictions. Cohort-specific evidence is presented where available.

3.1 Peer workers

GENERAL EVIDENCE

Peer support has been part of the mental health care system of Western countries for decades, and is widely recognised as an important component of recovery-oriented (rather than traditional medical) models of mental health care. Strategic work is underway at state, national and international levels to advance and strengthen peer work as an essential component of contemporary mental health systems e.g., New Zealand Government (2018) report into mental health and addiction contains loud, clear calls for increasing the peer workforce. In Australia, the forthcoming Western Australian Workforce Strategy, and the forthcoming National Mental Health Commission's Peer Workforce Development Guidelines do the same.

Many studies find that peer support leads to greater feelings of empowerment and independence, for the consumer as well as the peer worker (Corrigan, 2006; Resnick & Rosenheck, 2008). Peer support has been found to improve social wellbeing, with clients who receive peer support reporting greater engagement in meaningful activities (Nelson et al., 2006) and a greater number of friends (Ochocka et al., 2006) than those who did not receive peer support. It is proposed that increased empowerment and social wellbeing is facilitated by peer support as they normalise feelings and responses that are typically problematised in traditional health care, which supports clients' development of an identity that is separate to 'mental patient' (Repper & Carter, 2011). For the peer worker also, increased stability is experienced through their work (economic participation and training opportunities) (Ochocka et al., 2006).

A Cochrane systematic review of 11 randomised control trials examining the effectiveness of peer support workers (termed 'consumer-providers' by the authors) found that peer and clinical support was equally effective (i.e., no significant differences) (Pitt et al., 2013). Five studies examined programs that employed peer workers and professionals in similar roles and compared the outcomes of clients placed with a peer worker versus those placed with a professional.

There were no significant differences between clients with a peer worker and clients with a professional in terms of:

- self-reported quality of life
- depression
- general mental health symptoms
- client satisfaction with treatment
- use of mental health services
- hospital admissions
- length of hospital stay, or
- program attrition.

In other words, among 5 randomised control trials, peer workers performed equally as well as their professional counterparts when employed in similar roles. Clients with peer workers recorded a small reduction in crisis and emergency services, likely attributable to the greater amount of face-to-face time that peer workers spent with clients (Pitt et al., 2013).

The remaining 6 randomised control trials compared services that had peer workers versus those that did not. No significant differences were found between programs with or without peer workers in terms of psychosocial outcomes, client satisfaction, attendance, hospital admissions, length of hospital stay, or program attrition. One study found higher client and staff ratings of clients' needs having been met among programs with peer workers relative to those without. Importantly, no studies found any adverse client or cost impacts associated with the involvement of peer support workers (Pitt et al., 2013).

Peer support can be incorporated into the mental health workforce in different ways. Peers can provide informal, naturally occurring support in all settings, they can participate in consumer or peer-led programs, and they can be employed as support providers within mental health services (Repper & Carter, 2011). The different models of peer support and the inconsistent collection of evidence mean that there is not a comprehensive or cohesive evidence base as to the outcomes achieved using peer support, nor an unquestionable best practice model of how peers should be incorporated into mental health care. However, there is some good quality effectiveness evidence regarding implementation of peer support.

Brook RED

Location: Queensland

Brook RED is peer-led, grassroots organisation governed, managed and operated entirely by individuals with lived experience of mental health recovery. Utilising the "unique perspective and knowledge" from their lived experience of recovery as the foundation for all the group's work (Brook RED, 2019), Brook RED's core values include: 1) connection and empathy for meaningful relationships; 2) hope for better futures; 3); self-determination of individuals to know what is best for them; 4) courage to maintain reflective work; 5) lived experiences informing all practices.

Brook RED run an array of peer-led services including: residential spaces for people working toward recovery goals, suicide prevention programs, an LGBTIQA+ inclusive group, National Disability Insurance Scheme (NDIS) services, and peer support training.

Source: Martin, R., Mahoney, N., & Pracilio, A. (2020)

COHORT-SPECIFIC EVIDENCE

Family members

In a New York study, caregivers (n=1231) of children with a mental health issue that had access to a family advocate reported significantly higher social functioning than those that did not have access to a family advocate, including:

- greater participation in social activities,

- higher likelihood of having someone who would help in a crisis,

- increased ability to handle stress, and

- higher levels of support of others (Radigan, Wang, Chen & Xiang, 2014).

They also reported that their young people were happier, better able to make friends, and better able to get along as a family.

Hargreaves et al. (2008) describe the Paying Attention to Self (PATS) program for adolescents who have a parent with mental health issues, often placing them in a caring role. The program involved weekly, hour-long, small group (4-8 young people) sessions for 8 weeks, facilitated by a health professional and a peer leader. The sessions aim to decrease stigma and increase knowledge about mental illness, resources available, and healthy coping behaviours. While they do not report outcomes, Hargreaves et al. (2008) report some anecdotes that indicate increased ability to cope:

Her school was much more understanding, her father put less pressure on her ... She knew the places to call if she needed help or if her mother had an episode.

Even though it was still hard, things felt like they had been lifted off her shoulders. Most importantly, she stopped blaming herself and stopped getting so upset with her mother, because she knew her mother's illness was not her mother's fault and that she was not insane.

I came to the realisation that I wasn't the only one out there and having someone to talk to that fully understood what I was on about really helped. I made some really good friends and we had a ball catching up each week and sharing our stories and just having a laugh.

I went to PATS and they helped me to understand what mental illness is and how it affects people like my Dad.

Consumers with acute and/or chronic mental illness

In a randomised control trial study in the United States, Sells et al. (2006) evaluated the outcomes of employing and training peer workers to provide community-based services in parallel with intensive case management for people with mental health conditions so severe that they would be eligible for mandatory outpatient treatment. The rationale of incorporating peer workers into the care model was that those with chronic conditions can be difficult to engage in treatment, and the hope was that peer workers would encourage participation in treatment, increase hope, and model problem-solving behaviours. Those who were assigned to a peer specialist and who were most unengaged at baseline significantly increased their contacts with providers in the first six months, while those without a peer worker decreased their contacts.

COHORT-SPECIFIC EVIDENCE (continued)

Consumers with acute and/or chronic mental illness (continued)

Interestingly, mirroring the results of other studies (on general adult mental health services), those with a peer worker reported feeling more understood and accepted at the 6-month mark but these effects disappeared at the 12-month mark. It is suggested that this means that peer workers facilitate earlier engagement with treatment and therefore may help people with mental health issues get on the path to recovery more quickly than treatment teams without a peer worker (Davidson et al. 2006).

Young people

A peer support program at Headspace Gosford, NSW, involved peer workers welcoming clients to the service and assessing clients' needs before clients see the clinical Youth Access Team. The model was intended to support shared decision making, with peer workers aiming to help the young people understand their options, the possible benefits and harms associated with their options, and the likelihood of each of those benefits and harms. An evaluation by Simmons et al. (2017) found that, relative to clients that did not work with a peer worker, clients with peer workers had significantly higher perceptions of shared decision making which, in conjunction with lower decisional conflict (levels of feeling conflicted about decisions one has to make), was significantly associated with client satisfaction.

While this does not speak to outcomes, satisfaction and a sense of self-determination in the decision making process can be key to retention in and engagement with a program and, therefore, ultimate outcomes. The Ontario Centre of Excellence for Child and Youth Mental Health (2016) posits that, because of young people's high level of investment in same-age peer relationships, peer workers may reduce young people's hesitance to access services and may facilitate reduction of young people's self-stigma.

Children

In a large scale survey of children (n=768, aged 9-18) who had accessed mental health support and their caregivers in New York, Radigan et al. (2014) found that access to family advocates was positively associated with children's and caregiver's satisfaction with services, the appropriateness of their services, and their participation in services. Young people with access to a peer advocate were better able than those without a peer advocate to understand medications, such that they were significantly more likely to report that

medications were explained in an understandable way, that they knew what side effects to watch out for, that they felt they had choices about taking medications, and felt comfortable taking medications. Youth with peer advocates also reported that they felt better equipped to face challenges and make friends.

REQUIREMENTS FOR SUCCESSFUL IMPLEMENTATION

There are several common barriers to the effective implementation of peer support (Vandewalle et al. 2016). Peer workers often report feelings of role ambiguity (Asad & Chreim, 2015; Cabral et al. 2014) and a lack of supervision and professional development (Cabral et al. 2014; Chinman, 2008). This can lead to a lack of credibility of the peer worker role, which is reinforced and compounded by the negative attitude of many professionals that peer workers work alongside (Ahmed et al. 2015; Simpson et al. 2014). These barriers are often attributable to the inadequate integration of recovery-oriented practice, such that peer workers are added into the mix of roles and skills without education of the peer workers and their fellow staff, and also without changes to organisational policy and practice required to shift from medical to recovery practice. The lack of seamless integration of peer and other non-clinical supports into mental health services can be argued to be driven by government policy and funding models that, despite purporting to support a recovery-oriented and consumer-led approach, require clinical assessment to determine client eligibility for services and measure the effectiveness of services based upon clinical outcomes (Gray, Davies, & Butcher, 2014).

The South Australian Peer Work Project addressed barriers to peer worker implementation through a formalised training program at Certificate III level, though the peer workers suggested increasing it to Certificate IV to make it more challenging and bring the qualification in line with other qualifications in the industry. The training course covered principles of recovery, dealing with stigma, mental health (services, acronyms, jargon, and resources), workplace communication and culture, sharing your experience in a professional manner, workplace mentoring, and debriefing (Franke, Paton, & Gassner, 2010). The training course increased feelings of preparedness and interest among potential peer workers. Once employed, the Peer Work Project model provided peer workers with organisational support in the form of supervision and staff meetings, and individual and group mentoring. Overall, the Peer Work Project resulted in positive employment outcomes for peer workers and a positive experience of employment (Franke, Paton, & Gassner, 2010).

REQUIREMENTS FOR SUCCESSFUL IMPLEMENTATION (continued)

It is important to note that there are extensive resources for the effective development and implementation of the peer workforce in Australia, as a result of peer work being recognised as important to mental health outcomes in National Mental Health Plans as early as 2003. Action 20 of the fifth National Mental Health and Suicide Prevention Plan is to develop the Peer Workforce Development Guidelines, and is due to be completed mid-2021. The Australian Government's Primary Health Networks released a brief report regarding the role of the peer workforce role in mental health and suicide prevention with a list of additional resources for peer workers and organisations seeking to introduce/develop peer workers (see Section 4 in the discussion of workforce).

Orygen's report 'Side by Side: Supporting youth peer work in mental health services' (Fava, Simmons, Anderson, Zbukvic & Baker, 2020), outlines the current state of youth mental health peer work in Australia, including a review of the evidence. The report makes ten recommendations for policy and practice development to support its successful implementation. It found peer work is effective in improving outcomes, although more high quality research is needed.

COST SAVINGS EVIDENCE

Two studies of Australian peer-led services have provided preliminary support for the ability of peer-led mental health services to deliver cost savings. Lawn, Smith and Hunter (2008) evaluated a peer-led support service delivered to adult mental health consumers in South Australia, aimed at providing hospital avoidance and early discharge support. All peer workers had prior experience of providing support, formal training of Certificate III level or above along with a 6-week peer worker course, and formal organisational induction (confidentiality, occupational health and safety, medical, police and licence checks). Estimates of hospital bed days saved for each client as a result of the service were gathered from the referrer, peer and consumer. The mean of these three estimates was used to estimate bed days saved. From 49 support packages provided over three months, an estimated saving of 300 bed days was attributed to the service, equating to cost savings of AUD93,150 after taking into account the project's AUD19,850 of set up costs. Only 17% of consumers required more than 8 hours of support and,

compared to an expected 30% readmission to hospital rate, only 17% of referrals to the peer-led program were readmitted to hospital following their support period. Qualitative feedback from all stakeholders – consumers, peers, GPs, referrers and staff – was generally very positive.

The cost benefits of peer work, has also been noted in a Orygen report published this year, which refers to Australian work by KPMG and Mental Health Australia that estimates a return on investment of approximately $3.50 per dollar spent (Fava, Simmons, Anderson, Zbukvic & Baker, 2020).

Social Ventures Australia (SVA) completed a Social Return on Investment (SROI) analysis on a peer-operated mental health service run by Flourish Australia (previously RichmondPRA) in Queensland. The service comprises a resource centre, available 9am-5pm for one-on-one support, group activities or drop in, a Warm Line accessible to everyone and outside of business hours and on weekends, and a 3-bedroom rest and recovery house. Based on one year of outcomes, SVA calculated that for every $1 invested in the service, $3.27 of social and economic value was created. This was primarily in the form of positive outcomes for the peers, but also through reduced use of surrounding services (e.g. earlier discharge from inpatient facilities due to the existence of support), as well as benefits accrued by the peer workers and volunteers themselves.

SUMMARY OF THE EFFECTIVENESS OF ENGAGING PEER WORKERS

There is evidence on the effectiveness of peer support workers for all diverse groups of mental health consumers and family members. The impact on client outcomes of peer support is, at minimum, equivalent to the impact of support offered by other skilled staff. There is also consistent evidence of increased satisfaction with services among clients and their families who interact with peer workers, as well as greater self-reported hope, feelings of acceptance and of being understood. These outcomes are well-aligned with a recovery-oriented model of mental health and, importantly, may also contribute to increased participation in engagement with all services. The rapid uptake at state and federal levels of actions to advance and strengthen peer work indicates support at all policy levels.

3.2 Use of brokerage funding

GENERAL EVIDENCE

The use of brokerage funds in community services is relatively commonplace, though it is often not formalised, nor well defined (Queensland Government Department of Housing and Public Works, 2018). Brokerage involves the acquisition of goods or services to enable clients to meet their goals, usually because they indirectly affect the person's presenting problem and/or impede the intervention(s) to address the problem. Most often these goods and services cannot be provided by the primary service provider. A parent with mental health issues may, for example, access brokerage funds to pay for their child's school uniforms so as to alleviate that stressor and enable the parent to focus on recovery.

Developing evidence for the effectiveness of brokerage funds is quite difficult, as brokerage funds comprise only a small part of a broader service delivery model. Accordingly, attributing outcomes specifically to brokerage funds is difficult. However, the inclusion of brokerage funds in contemporary government-funded programs to address the mental health concerns of particular cohorts (as elaborated below) is recognition of the usefulness of brokerage funds to complement service delivery. In the context of homelessness, Costello, Thomson and Jones (2013) found that case management without access to brokerage funds was ineffective in terms of alleviating housing stress and sustaining tenancies. In this context, brokerage funds were used for a wide array of purposes, from paying utilities, purchasing food, paying for rehabilitation programs, and other ad-hoc goods and services. A key recommendation of the report was utilisation of brokerage funds due to their demonstrated ability to stabilise people's circumstances.

Similarly, the Doorway program in Victoria provides integrated housing and recovery support for people experiencing persistent mental ill health who are homeless or at risk of experiencing homelessness. The program subsidises private market rent for up to 18 months and provides case management through housing and recovery workers. An independent evaluation identified brokerage and collaboration between landlords, hospitals, housing providers, and mental health service providers as critical success factors (Dunt et al., 2017).

Cook, Russell, Grey and Jonikas (2008) evaluated a general adult mental health service called Florida Self-Directed Care. This model involved consumer-directed brokerage; participants were allocated a budget and were responsible for determining their own recovery management plan. The plans and budgets had to be approved by a senior quality advocate. There was a requirement for 48% of the budget to be allocated to traditional services such as medication management and psychotherapy, but aside from that, the participants could choose the services that they believed would facilitate their recovery. Evaluation at the 1-year mark showed clear linkages between the services participants chose to acquire and their stated goals. In addition to traditional clinical recovery, 29% of people's budget was spent on goods and services to enhance community integration (e.g. food and clothing), 13% was spent on non-clinical support (e.g. peer support and exercise programs), 5% on dental, 3% on optometry and ophthalmology, and 3% on transportation. Evaluation at the 2-year mark revealed, relative to the year prior to joining the program, participants spent significantly fewer days in inpatient facilities and recorded significantly higher global functioning scores. High rates of education and employment were also recorded, and only 16% of participants were hospitalised for psychiatric reasons and even fewer (5%) involuntarily so.

Hammond (2012) describes a similar program in the UK called Signpost. Signpost employs and accredits independent social care support brokers, half as peer brokers, to support consumers who are eligible for a personal budget. The brokers inform consumers of the service options available to them, help them to decide which best suit their needs, and facilitate the procurement process. Integral to the program has been quality assurance and the involvement of lived experience at all stages. Program staff regularly engage with both brokers and consumers to prevent misuse of funds. Signpost has a website, designed in conjunction with people with lived experience, guides individuals to finding a broker.

These examples are somewhat similar to the NDIS approach to personal budgets, however, it is important to note some differences. These examples offer a more flexible approach to the types of goods or services that can be purchased, and the use of brokerage funds in the proposed models would support a different population to NDIS participants.

COHORT-SPECIFIC EVIDENCE

Acute and/or chronic mental illness

The Victorian Government Department of Health and Human Services include brokerage funds as an essential component of their Adult Intensive Complex Care Packages (ACCPs). They acknowledge that brokerage funds "can enable consumers to address an extraordinary or pressing need and/or the prevention of a critical situation" (p4). Brokerage funds of up to $5,000 per consumer per year are available for needs that cannot be readily met by the provider or alternative available service. Under the ACCP, brokerage is to be used as a last resort, the decision to use brokerage funds and how these funds are used must be made in conjunction with the consumer, and brokerage must be used as a brief intervention. Service providers are also subject to substantial accountability requirements, including the development of policy for use of brokerage funds and safeguards to prevent misuse.

While it is important to note that brokerage funds are only one part of the service delivery model – integrated clinical and recovery-oriented support, assertive outreach, intensive case management, out-of-hours service, and active engagement of consumers and their carers are also critical components – and brokerage funds sit alongside these core components. The ACCPs aim to improve consumer outcomes, including symptom stability, functional ability, physical health, compliance with treatment, housing security, justice system interaction (as victim and perpetrator), substance misuse, suicide and self-harm, and social and economic participation. At the service system-level, the ACCPs should achieve a reduction in inpatient stays, unplanned re-admissions, reduction in police and ambulance callouts and emergency department presentations, and reduced incarceration.

Children

The Victorian Government Department of Health and Human Services also includes brokerage funding as a component of their Families where a Parent has a Mental Illness (FaPMI) program. Relative to the brokerage scheme described in the above-mentioned ACCPs, the FaPMI brokerage guidelines are less prescriptive, although the program is funded at a substantially lower level than ACCPs. As with the ACCPs, FaPMI brokerage funds must only be used to meet a need or avert a crisis that the service provider cannot readily address. Examples cited include food and clothing, transport, recreational programs, childcare and school support.

Again, brokerage funding forms just one part of the service model, with the provision of family-inclusive interventions, education, and referrals at the core of the model. However, the outcomes the model seeks to achieve include improved mental health outcomes for the parent experiencing mental health issues, recognition of dependent children's support needs, increased safety, improved family cohesion, and improved mental health outcomes for children.

Co-occurring mental health and substance use

First Step in St. Kilda, Victoria is a wraparound addiction and mental health service with a fully integrated legal service. One of their services is Flexible Funding Brokerage, aimed at building individual capacity and providing short-term support. In addition to geographic catchment requirements, consumers must have a Health Care Card and/or not be able to afford similar services, and have a diagnosed mental illness including Substance Use Disorder, and not be eligible for NDIS. First Step provides three examples on their website and how and why brokerage funds were used, and what they helped to facilitate.

First Step St. Kilda Flexible Funding Brokerage examples:

Example 1:

Frederika* was referred to First Step St Kilda by her GP. Frederika was recovering from a substance use disorder. As part of her treatment plan to build resilience and to introduce her to positive peer groups, she engaged with VOSS (Voices of the South Side) to participate in a course titled 'Speaking Out'. This 10 week course was (is) designed to provide an opportunity to learn how to speak confidently in public, to advocate, to become more aware of one's own communication style and to gain the confidence and ability to clearly articulate ideas.

On her own Frederika was not able to afford the course - however through Flexible Funding Brokerage, Frederika secured the necessary funds to complete the course, resulting in a marked increase in confidence and further engagement with a new creative writing course and local choir.

Example 2:

Fred* has been engaged with the Mental Health Integrated Complex Care team for around 6 months.One of Fred's challenges was dealing with the voices in his head. Fred's mental health team felt that many of his treatment goals would be facilitated if the voices in his head could be better managed.

Many options were reviewed before it was settled on the purchase of a radio/cd player as a method for quieting the voices. This simple solution had the ability to provide a dramatic change to the quality of Fred's life. With background noise (like that provided by the radio) Fred was able to concentrate on his own thoughts rather than the incessant chattering in his head. His concentration improved which also improved his ability to interact and relate to others. This encouraged his participation in other activities like Art Therapy.

*pseudonyms.

Source: https://www.firststep.org.au/ffb_examples

COST SAVINGS EVIDENCE

It is difficult to attribute outcomes and therefore cost savings to brokerage funds specifically. Dunt and colleagues' (2017) evaluation of Doorway in NSW identified cost savings of $1,149 to $19,837 per individual based on reduced usage of bed-based clinical service and reduced hospital admissions. While brokerage funds were but one component of the service delivery model, they were identified as a key success factor. Supporting this, Costello et al. (2013) in an evaluation of a homelessness program found that intensive case management without brokerage was ineffective.

Cook and colleagues' (2008) evaluation at the two-year mark of Florida Self-Directed Service revealed that participants spent, on average, less than a third of the funds that had been allocated to them. Given that the amount allocated was based on the average cost of services in the financial year before, this represents a significant cost saving, particularly in light of the outcomes achieved (fewer days as an inpatient and higher global functioning).

SUMMARY OF THE EFFECTIVENESS OF USING BROKERAGE FUNDING

Brokerage is an integral part of some mental health service systems. While intensive case management approaches typically advocate for less brokerage and more direct service provision, the use of flexible brokerage funds as a complement to clinical and recovery-oriented supports is well-established. While outcomes are hard to attribute specifically to brokerage funds, it follows logically that removal of the indirect barriers that impede consumers from focusing on and effectively participating in their recovery will lead to better outcomes. Case study and anecdotal evidence supports the positive impacts of brokerage, and evaluation of a consumer-led, solely brokerage-based service delivery model reveals substantial potential cost savings and positive outcomes relative to traditional treatment models.

3.3 Non-reliance on diagnosis

GENERAL EVIDENCE

Mental health assessment is used in clinical settings to facilitate decision making about recovery pathways. It is useful for ensuring that physical health issues are not causing symptoms or intervening with treatment, and can lead to a diagnosis which many people struggling with mental health issues find helpful (Perkins et al. 2018). Given this typically central role of assessment in mental health services, there were no examples in academic literature where services did not have diagnosis as part of their service model. This is not to say that such services do not exist, nor that participation in every service is contingent on diagnosis. Rather, an environmental scan indicates that diagnosis is embedded in many service delivery models. However, clinical mental health services are also more likely to be formally evaluated and academically reviewed than community mental health supports, and the foundation of clinical models are based on the diagnosis followed by treatment pathway (and therefore diagnosis is an eligibility criterion for service access). Thus, there is an evidence gap in this sense. Evidence presented in this section will therefore focus on why requiring diagnosis in order to receive services may impede the achievement of positive outcomes.

The Black Dog Institute (2020) reports that 45% of Australians will experience a mental illness in their lifetime, and more than 1 in 5 young people (18-24-year olds) meet the criteria for probable serious mental illness. These figures are drawn from analysis of survey data against diagnostic guidelines; Sanderson & Andrews (2002) found that 23% of Australian National Survey of Mental Health and Wellbeing respondents who did not meet the DSM-IV criteria for any mental disorder nonetheless experienced limitations to their usual activities due to mental health symptoms. Meadows et al. (2002) found that 3.9% of the Australian population had a perceived need for mental health services but did not meet diagnostic criteria for a mental health disorder. Therefore, there is evidence that meeting diagnostic criteria does not necessarily reflect need for support, nor the potential benefit that could be achieved through provision of support.

In other jurisdictions concerns have been raised about consumers without a diagnosis or a mental health need using mental health services, and this constituting a misallocation of resources. In the US, Druss and colleagues (2007) found that only 5.6% of services were delivered to people with no or low indication of need, and that a very small proportion of these services were specialty or medical services and instead were more likely to be human services and complementary/alternative medicine. Therefore, there is minimal evidence that mental health system resources are misallocated towards people without need.

Further, the Black Dog Institute (2020) reports that 54% of people with a diagnosable mental health disorder do not access treatment – possibly, as reported by Sweeney, Gillard, Wykes & Rose (2015), due to factors such as general fear or fear of stigma or discrimination. These fears are often linked to diagnosis and, consumers who access services while fear is central are less likely to trust staff and less likely to participate actively in their recovery (Sweeney et al. 2015). Accordingly, measures that reduce fear, such as a reduced emphasis on clinical diagnosis, may encourage help-seeking and accessing support earlier, and may increase the effectiveness of services through more active consumer participation.

In their review, Perkins et al. (2018) identified several factors across studies that determined whether diagnosis was positive for the consumer. First and foremost was whether it was driven by consumer need. Service users often felt that diagnoses were more beneficial for the service – driven by interests of power, control, and resource allocation. Diagnosis for diagnosis's sake was perceived by consumers as meaningless, and often removed support and evoked prejudice in their treatment. In order for diagnosis to be useful in achieving consumer outcomes, it should serve as a guide to care and must be considered with consumers' preferences and previous experience.

It is also important to acknowledge that other studies point to negative impacts related to diagnosis. In a systematic review of qualitative literature, O'Connor et al. (2018) found the experience of receiving a psychiatric diagnosis could be both helpful and harmful for young people. They highlight the complexity of experiencing diagnosis, and the potential for a psychiatric diagnosis to threaten a young person's sense of self and social relationships. For others, a diagnosis can feel invalidating, and rob an individual's personal agency through harmful social and psychological effects (Forgione, 2018).

PERSONAL EXPERIENCES AND VOICES OF RESPONDENTS

From this co-design work, a wealth of feedback has emerged regarding people's personal encounters with mental health services. Sitting alongside the evidence review are reflections from participants and survey responses about the difficulties faced with accessing supports. Specifically, the discussion around diagnosis was complex. Interestingly, 96 respondents to the survey stated that they have lived experience of mental health issues, but only 67 respondents stated they had a diagnosis.

There was a general consensus that accessing a community support should not be dependent on having a formal diagnosis:

"Without a diagnosis, it is difficult to access many services. Mental health happens to everyone. Many services are only accessible if you have been hospitalised or have a diagnosis. In my experience there is little or no support for the everyday mental health issues that are faced within a family setting" (survey response)

"I think the one thing we all need is to be accepted for who we are and to be viewed as 'people' – not as what we have been labelled 'as' in clinical mental health diagnostic terms"

(survey response)

Some participants spoke of the difficulty they faced when they were turned away from services. In some instances, they were told "my circumstances were too complex or not complex enough" (survey response). Others were "not severe enough" for support – and some may have been suffering more than their initial presentation may suggest:

"I feel that I wasn't believed when expressing how I was feeling and what I had been experiencing recently. I didn't 'appear' unwell aesthetically, whether this contributed to the situation or not I am unsure. Supports could realise that even articulate/educated and well dressed/presented consumers may still experience mental health problems" (survey response)

"Because I am high functioning, sometimes my needs aren't recognised as important. I am working, I am relativity intelligent, I know about a variety of services, and I can 'pass' as not being mentally unwell so services can judge me as not needing support. I would like services that don't just cater to people on Disability Support Pension or NDIS. What about the rest of us? We are invisible in lots of ways" (survey response)

COHORT-SPECIFIC EVIDENCE

Young people

As noted in the peer worker section, young people place a strong emphasis on same-age relationships. Accordingly, young people with mental health issues are concerned about how these issues may affect their relationships. Lawrence et al. (2015) found that 62.9% of Australian children and young people with major depressive disorders cited worries about what people would think as the reason they did not seek help or receive more help. Overwhelmingly the most common reason for young people presenting to mental health services is their feelings, and more than two-thirds of young people do not meet the threshold for mental health diagnosis (Rickwood et al. 2014). Therefore, there is evidence that diagnosis is a particularly poor indicator of need among young people, and that a requirement for diagnosis (and thus the stigma that diagnosis may carry for the young person) may discourage service access. Further, young people may have less independent access to mainstream health services to receive mental health assessment (e.g., going to the GP alone), thus in addition to an emotional barrier, a requirement for diagnosis may present a significant logistical or financial barrier to treatment.

COST SAVINGS LOGIC

People with untreated mental health issues have higher usage of crisis and emergency services (Niedzwiecki et al. 2018). Looking at the prevalence of mental health issues among service users (rather than prevalence of service use among those with mental health issues), Downey, Zun and Burke (2002) found that 45% of people presenting to emergency departments in US hospitals met the criteria for undiagnosed mental illness. This evidence may indicate that many people with mental health issues use high-cost crisis and emergency services in lieu of more effective and cost-effective mental health services (Vos et al. 2005). Therefore, lowering the barriers to mental health treatment will likely result in offsets to the costs of mental health treatment through reduced use of crisis and emergency services.

SUMMARY

The requirement for consumers to have a diagnosis to access a service, the emphasis on diagnosis in treatment (irrespective of the consumer's wishes), and the fear or reluctance of consumers to get a diagnosis, are all significant barriers for a good portion of the population to receiving mental health support. While recognising that importance of a diagnosis as the operational basis for some services (and it being of value for some consumers too), offering the option for some services to not require a diagnosis has many benefits across the service system. It may help to engage some consumers who would not otherwise reach out to get help, result in increased uptake of services and greater participation and retention in services and, therefore, improved mental health outcomes across the population and reduced use of high-cost crisis and emergency services.

Diagnosis is an important part of the mental health journey for some people. However, for others the stigma, fear and structural barriers created by the need for a diagnosis creates barriers to accessing services or the diagnosis itself can be a negative experience. Further, there is ample evidence that consumers are well positioned to determine their own need for mental health supports, and evidence confirms that generally people without need do not access mental health supports. Therefore, when analysed from several angles the evidence-base suggests that having mental health supports available that provide the option to offer support without needing a diagnosis is an important part of the service-mix of the mental health sector.

3.4 General support approach

GENERAL EVIDENCE

The final core theme that emerged through the co-design processes was the need for more general supports or engagement activities to be provided alongside (or for some individuals as an alternative to) mental health specialist support. For models this might mean that people are welcome to come just for chats and to be listened to. A model might provide opportunities for people to participate in structured activities and spend time with others, if that is the limit of what they need at that time, or if they are not yet ready to engage deeply with mental health issues. To align this idea to a trauma-informed approach, an individual may first want a chance to develop trust and familiarity with staff before they engage in dedicated 'emotional disclosure' or 'talk therapy' based sessions.

As co-design participants describe, support can be provided (or experienced) while engaging in activities such as hiking, art, music, fixing things or social sports. Not only do these activities have positive effects on wellbeing in themselves – when delivered in a supportive, non-competitive environment – they also allow informal support opportunities and interactions with peers, with peer support workers or skilled staff. Research by Conradson (2003) highlights the significance of establishing informal and safe community spaces that encourage 'everyday encounters' between individuals, stating that this alone can facilitate or promote health and well-being.

"I think social interventions rather than mental health interventions are so important for young people – the Backtracks Program in NSW is a great example" (co-design workshop 1)

Although this would not be a core component for all models, it is important to highlight because it can also be useful when thinking about ways to adapt models to other populations (such as people with CaLD backgrounds).

Take A Hike

Take A Hike gives youth the opportunity to experience nature through a group hiking programme. Youth are taken to a different location and hiking trail each week by facilitators who are also trained in outdoor and survival skills. Youth learn about the value of experiencing nature mixed with physical activity as a method for coping with life stressors while also receiving wilderness training in addition to first aid and CPR training. Youth hike through unique and challenging trails that involve beautiful summit views, canoeing and even wading through water and caves. While hiking, facilitators talk with the youth about different issues that they may be dealing with. This gives the youth the opportunity to vent about their problems as well as receive support and advice from peers and facilitators (Davidson, Manion & Brandon, 2006).

Although most models asked for elements of this approach as an option provided alongside mental health support, this idea of general supports emerged strongly in the core of the models for high school aged young people and rural and remote communities. Interestingly, highly stigmatising attitudes to mental health issues are also strongly associated with rural communities (Smalley and Warren, 2012), and young people (Chandra and Minkovitz, 2007).

The insights of co-design participants representing CaLD communities suggested a prevalence of stigmatising attitudes to seeking mental health support within CaLD communities, a finding that can be confirmed in academic literature (Prasad-Ildes and Ramirez, 2006). Thus, potentially this kind of model design may also be important for accommodating CaLD communities where there are also barriers to openly seeking mental health supports. Men may also benefit from or be more successfully engaged through the provision of general supports – as has been found in the success of Men's Sheds. For instance, research indicates that men respond poorly to interventions that are perceived as emotionally intrusive (Rochlen & Hoyer, 2005) and may need more 'shoulder to shoulder' ways of accessing support (as also suggested by service provider interviews with community mental health supports in rural and remote Western Australia).

Men's Sheds

The success of the Men's Shed model for supporting men's social and emotional well-being is well documented. Many older, retired men, or unemployed men have limited social networks and the resulting social isolation can lead to diminished social and emotional well-being and reduced mental health. The simple model of a place to come together with other men in a shed environment is shown to promote friendship and social support, which is associated with better mental and physical outcomes (Misan and Sergeant, 2009).

Although the mental health of most people would be improved by emotional sharing Holloway, Seager & Barry (2018) propose that some people need alternative 'ports of entry' to emotional sharing than the more traditional clinical, therapeutic or emotional disclosure models of support.

Table 7: Evidence that activities have benefits to mental health recovery

Activities	Relevant findings	References
Art therapy	A review of 15 randomised controlled trials (RCTs) n = 777 compared effectiveness of verbal therapy and art therapy. While verbal therapy was more cost-effective than art therapy, the authors stated that there was a "sizeable probability" that art therapy was more clinically effective.	Uttley et al. (2015)
Social sports	A systematic review of mental health effects of sport uncovered different psychological and social health benefits reported, with the most commonly being wellbeing and reduced distress and stress, with social sports showing greater improvements.	Eime, Young, Harvey, Charity & Payne (2013)
Group hiking	Young people who hiked every week, with facilitators who were trained to speak with them about mental health concerns, were found to have enduring positive effects on their mental health.	Davidson, Manion & Brandon (2006)
Men's Shed type activities (e.g., restoring furniture, fixing lawn mowers, repairing bicycles for children or making cubby houses)	Men's Sheds provide men with 'passive mental health benefits' through an opportunity to engage with others about their concerns, in a non-pathologising and partnership mode. This has practical implications in the areas of social connectedness, mental health and suicide prevention.	Cavanagh, Southcombe & Bartram (2014) Morgan, Hayes, Williamson & Ford. (2007)

Table 8: Populations that may benefit from alternatives to 'emotional disclosure' models of support

Population	Relevant finding	Reference
Men	Men may be put off seeking help because of reluctance to engage in interventions in which the focus is on emotional disclosure.	Holloway, Seager & Barry (2018)
Aboriginal & Torres Strait Islander	"Aboriginal people in this community would find no benefit at all sitting down and talking to a counsellor…which is a Westernised model of support."	Service provider interview for this project
Children	A systematic review of children's mental health research strengthens the evidence for the efficacy of practices such as play, leisure, work, social participation, activities of daily living, instrumental activities of daily living, and sleep and rest, within a variety of environments. For example the effectiveness of occupation and activity-based programs to improve social behavior and self-management is supported for children with Autism Spectrum Disorder and for children and adolescents with diagnosed mental illness or serious behavior disorders.	Arbesman, Bazyk & Nochajski (2013)
Culturally & Linguistically Diverse populations	Consumers from CaLD backgrounds reported that "they had problems seeking and receiving help due to stigma, cultural beliefs that one must be always strong and cope and have control over one's own emotions and thoughts".	Prasad-Ildes & Ramirez (2006)
Rural & remote	Mental health stigma is one of the most common reasons for unmet mental health needs in rural areas. For example, residents in rural communities report fear of taking psychotropic medications and that seeking treatment for mental health might adversely impact their employment.	Alang, S. M. (2015) Snell-Rood, Hauenstein, Leukefeld, Feltner, Marcum & Schoenberg (2017) Crowe, A., Averett, P., Janeé, R., Harris, A., Crumb, L. & Littlewood, K (2019)

GENERAL EVIDENCE (continued)

Demonstrating the success of these approaches in addressing mental health needs is challenging as programs are diverse and often operate in small organisations with limited resources (and therefore are not evaluated). It is also difficult to understand whether positive outcomes are a result of the mental health support provided whilst engaging in the activity, or the result of intermediary factors such as increased social support or engagement in extracurricular activities (Byrne, Barry, & Sheridan, 2004). None the less, this very cursory and limited scan of evidence, plus the high prevalence of mental health issues in the population, suggests that including more general supports and activities within a mental health support model would be highly valuable for supporting and engaging individuals:

- who may feel discomfort engaging directly, or straight away, with therapeutic interventions,

- engaging individuals who have stigmatised beliefs about seeking mental health support or are members of communities that may hold such beliefs,

- engaging individuals who might otherwise not seek help, and

- engaging individuals for whom other models of support provision are not effective.

Mental health supports are often founded on historic psychiatric models involving emotional disclosure, but a review of evidence suggests that some people might find healing through processes very removed from this model – or at least they may need a 'portal' into this type of engagement. People may find healing on Country, doing craft with others, hiking in nature and during deep engagement in activity with others; 'demonstrating the unity of head and hand, thinking and doing, reflection and action, culture and nature' (Cavanagh, Southcombe & Bartram, 2014)

Providing supports that incorporate some of these 'portals' and healing opportunities, alongside specialist mental health support from skilled staff, is a powerful combination and an important addition for a service mix that can address a diverse population.

SECTION 4:

Implementation considerations

4.1 What do principles look and feel like in practice?

The co-design process captured rich ideas for how the mental health sector can more effectively meet consumer needs. Some of this information was broader than model design – for example ensuring psychological safety.

During the co-design process (especially the workshops), whenever a participant spoke fervently about belonging or choice or any other important idea, we tried to follow up with the question: what does this look like in practice?

We have created this section because understanding these principles and what they look (and feel) like in practice should underpin this work, and will become more relevant when the models are further developed and implemented. And while this section is by no means a comprehensive examination of issues such

as trauma-informed service provision or inclusion, we did not want to lose the opportunity to capture the ideas that emerged from this co-design process.

Co-design participants pointed out that many of these principles are about the feel of a service, and while that may seem intangible the impacts are nonetheless quite concrete. As we heard from consumers, if a service does not feel right, it is not going to be effective at all in supporting recovery. For example, if a staff member fails to create psychological safety for a consumer, all the model components that were carefully designed in will just lose their power and meaning.

In this section we revisit the principles outlined in Section 1 that were based on the document review and are summarised here:

Figure 10:
Principles for an effective recovery support

A broad summary of how the co-design participants in workshop 1 and 2 described these principles, is outlined in Table 13 which are captured in a consumer journey structure – based on the template used in co-design workshop 1. These suggestions remain as close to the original language of participants as possible.

Table 9: Summary of how to ensure principles are put into practice and are part of the 'felt experience' of a support.

FIRST STEP	PARTICIPATION	NEXT STEPS
Welcoming... - Reassurance and acceptance of accessing help - Non-pathologising choices including other choices beyond medicine or clinical approach - Feeling welcomed and listened to. "Hospitality in healthcare" - Soft entry which is simple and accessible - Low lighting environment and soft furnishings **Accessible...** - Accessibility – easy to get to, transport available, low or no eligibility criteria - Self-referral possible. No diagnosis needed - Voluntary engagement - Access to interpreters etc. - No waiting times **Respectful processes...** - Do not have to tell your story "a thousand times" - Staff should have training in body language and microaggressions - Basic customer service focus - Privacy respected - Non-invasive assessment and person-centred (no lists of 20 questions) - Language that is not limiting - Being met where they are at - Message of hope – recovery is possible - Trauma informed approach	**Safety...** - Continuity of care – the same person walks with you throughout your time at the support (you can choose this person) - Additional training for staff/ support workers - Address holistic needs - Non-compulsory attendance - Trauma informed care - Ensuring cultural safety and appropriateness - looks like both cultural and religious - Cultural safety – recognition and respect for cultural diversity. Feeds back into consumer choice and safety. **Whole of person...** - If the individual would like their family or social network to be involved, this is supported - Understanding that peoples' needs may not be confined to specifically "mental health" but could involve social, practical, financial, housing needs. Stronger ties between these social determinants of health and the support. - Emphasis on social connection **Flexibility and choice...** - Variety of service delivery options dependent on your situation and preference - Holistic, adaptable and flexible - Option for immediate help, even out of hours. Recognition that mental health is not confined to a 9-5 schedule - Flexibility with the delivery of the service	**Gradual...** - If you need or want to re-engage with a support, you should not be at the bottom of the list - Provision for clients to step right back into the service without having to restart the process - this ties in with continuity of care and having a single point of contact through the recovery process - Safety net – ability to come back - Need to know where the next step is **Connected and practical...** - Supportive of lasting, healthy relationships - Supportive community - Integration with other services and supports. Services should collaborate, rather than be "siloed" - An on-request referral to other services so you are not left in the lurch - Individuals' social network is included in health decisions (on the request of the individual) - Warm and hot referrals - Have support to fill in important paperwork (practical support for basics) **Safe...** - Human check to ensure people haven't fallen through the gaps - Independent evaluation mechanism of the support, which includes lived experience

4.2 What works to safeguard the principles

DEVELOPING AND SUPPORTING THE MENTAL HEALTH SECTOR WORKFORCE

The human-to-human interface is the key to everything in mental health – an authentic, caring interaction unlocks engagement, trust, recovery, empowerment and healing. It is unsurprising, therefore, that the workforce emerged as the most significant contributor to positive and negative outcomes for consumers.

Overall respondents were positive about community mental health support, but the significant workforce challenges that apply across the mental health sector also apply to community mental health. These challenges are around accessing skilled staff (especially in regional WA), ensuring ongoing training opportunities and adequate supervision and finding the right level of support for staff working in difficult environments. Unexpectedly, survey findings threw up many workforce issues, although the survey did not ask directly about this.

Enabling services to retain staff

Of the survey respondents who identified as having an acute mental illness (n=52), seven mentioned that having stability in the staff member who they engaged with facilitates more meaningful relationships and/or effective approaches to goals.

"Community mental health has a lot of problems with fly-in-fly-out staff on 3-month contracts, so you are always getting someone different which is very unhealthy and always sets you back in your recovery" (survey response)

"Consistent, partnered, face-to-face support, that takes place each week on same time/day with a carefully selected invested worker, who holds you accountable for your engagement and who does not accept excuses or cancellations without explanation" (survey response)

This was mirrored in the co-design workshops where participants supported the idea of a "concierge model"; that is, where clients and family members and carers had access to a consistent staff member who could aid them with inter and intra-service navigation and advocacy.

"Provide a one stop service provider to help navigate all the various services available. Have qualified professionals available who can pass on relevant/personal information (with clients' permission) to avoid having to re-tell your story which can re-traumatise and trigger previous trauma" (survey response)

Better funded services and more pay for skilled staff

Insecure funding for services and the lack of financial recognition for highly skilled staff was seen as contributing to poor outcomes – including the staff retention issues described above, as low pay contributes to burnout and a high rate of turnover (which were described as 'endemic' across the mental health service system). Staff often do administration in their own time, and a highly-casualised workforce creates challenges with funding and finding time for training.

"I think we know what works - that there have been excellent community mental health programs that have been defunded in the last few years (in part due to NDIS) that were never funded adequately in the first instance" (survey response)

Improving staff training and supervision

As noted by Tuna Blue (2019) the peer workforces (including peer influence, peer led initiatives, intentional peer support models and valuing of lived experience) are "key elements of a redefined community mental health support approach".

In the co-design process, peer support was consistently raised as a vital component of an effective community support. However, participants did flag the need for skilled peer workers, ongoing training and supervision structures to be comprehensive and consistent.

The survey captured some negative past experiences with general staff as well as peer workers, highlighting in particular issues with the blurring of personal/professional boundaries.

DEVELOPING AND SUPPORTING THE MENTAL HEALTH SECTOR WORKFORCE (continued)

"I was in a peer support group. It ended up becoming very complicated with a lot of intimate relationships developing between participants. Some of these got quite destructive" (survey response)

"I had a counselling session that was delivered by a counsellor who was in her bed, in her nighty because she wasn't feeling well" (survey response)

"A domestic violence action group was being run by a well-known perpetrator of domestic violence" (survey response)

"Workers were disinterested or turned up late or not at all. Some workers were bossy or lazy or literally stated they hated their job. On occasion, where English was a second language, communication was a real problem. The biggest issues though were experienced with workers who used their own lived experience recklessly or tried to counsel when this was not their role or qualification" (survey response)

There was also a lack of transparent complaint resolution mechanisms when problems did arise. These issues can be compounded by the potentially vulnerable state of clients and their families when they reach out for support.

Participants also suggested that supervision, training, mentoring and ongoing support would ensure peer-support remains valuable, effective and safe.

"Workers that are properly supervised and have ongoing reflective practice in place" (survey response)

"Staff need to have appropriate training and ongoing support when working with people with mental health difficulties. They also need the opportunity to be mentored by people in the know such as carers. Mentoring of staff is critical to assist staff understand the complexity around mental illness. It needs to be frequent and timely in a crisis. Debriefing of staff is also essential" (survey response)

EXPANDING THE USE OF PEER WORKERS

"Peer workers, or workers with a lived experience of mental health, play an important role in building recovery-oriented approaches to care, providing meaningful support to people and modelling positive outcomes from service experiences.

However, the peer workforce is sporadically utilised and poorly supported"

(Department of Health, 2017 (The Fifth National Mental Health and Suicide Prevention Plan))

State and federal governments are investing in peer development programs and qualifications. In Western Australia a Certificate IV in Peer Work is now available through TAFE and also through Consumers of Mental Health WA (CoMHWA). Also the WA Peer Supporters Network, and new peer workforce development projects are all developments that should increase the professionalisation of the peer workforce, giving peer workers the skills and resources to better navigate their work.

These efforts are currently localised, and they should be expanded to deliver benefits across the system and the state, reaching into regional WA where they are needed most. Then, to truly advance peer led options, the development of a peer led and peer governed service provider organisation will be required. Brook RED, profiled in this report, is a contemporary example of an Australian peer-led and peer-governed organisation providing supports for consumers who choose to access peer led options.

Peer Work Resources

Source: Peer Health Network

Best Models for Carer Workforce Development: Carer Peer Support Workers, Carer Consultants, Carer Advocates and Carer Advisors. Paton, N., & Sanders, F. on behalf of ARAFMI Mental Health, Western Australia (WA), 2011.

This resource was prepared for ARAFMI WA in November 2011 and outlines a project designed to investigate best practice models and the body of knowledge around carer needs, peer support, participation, advocacy and mentoring models.

Orientation Manual and Toolkit Training for Carer Peer Workforce. Carer Consultants Network of Victoria, 2012.

This resource developed by the Carer Consultant Network of Victoria in June 2012, provides a manual to orient and establish carer consultants to their area and the mental health system as a whole. This includes information on important policy and legislative information governing practice. The manual indicates an entry point for further investigation, networking with services, and support organisations available.

Centre of Excellence in Peer Support Mental Health

The Centre of Excellence in Peer Support provides a centralised specialist clearinghouse and online resource centre for mental health peer support. The site contains a resources directory and a research directory as well as an interactive discussion forum, designed to foster a community of practice for those using and providing peer support services.

Mental Health Peer Workforce Literature Scan. Mental Health Peer Workforce Study. Health Workforce Australia, 2014.

The Health Workforce Australia Literature Scan was conducted to inform the Peer Workforce Study which examined the status of the peer workforce across public, non-government and private mental health services. These activities provided a national picture of the mental health peer workforce and identified opportunities for more structured and strategic approaches to peer workforce development.

National Mental Health Workforce Strategy, 2011.

Endorsed by the Australian Health Ministers' Conference in September 2011, the National Mental Health Workforce Strategy details five key priority areas for national action focussed on social inclusion and recovery, with further expansion and development of a peer support workforce.

Peer Work Hub

The Peer Work Hub contains a variety of online resources for organisations with ambitions to develop and grow their peer workforce. Resources include peer worker profiles and video, current news and information on peer work initiatives and a toolkit of templates to assist employers to implement a peer workforce.

PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance –STEPPED CARE

This guidance document provides overarching advice on a stepped care approach to mental health and outlines expectations of PHNs in its implementation. Stepped care is central to the Australian Government's mental health reform agenda and should be used by PHNs to guide mental health activity. PHN regional mental health planning and commissioning of services should be based on a stepped care approach.

Policy Direction Paper: Embracing Inclusion – Employment of People with Lived Experience. RichmondPRA, 2013

RichmondPRA (now T/A Flourish Australia) provide background context, considerations and principles for implementing a workforce strategy for the employment of people with lived experience of mental health issues. The paper considers support for employment of staff with a lived experience, regardless of their job role, but also gives comprehensive coverage of peer work philosophies, principles and models.

Victorian Mental Health Carer's Strategy: Proposed Objectives. Tandem Carers.

This document was prepared as a basis for the Victorian Mental Health Carer's Strategy. The strategy poses four key objectives, including carer involvement, carer support, carer participation and carer peer workforce.

INCLUDING SUPPORTS THAT STAND ALONE FROM NATIONAL DISABILITY INSURANCE SCHEME

At a system level, the importance of funding and staffing supports outside of the National Disability Insurance Scheme (NDIS) were raised repeatedly throughout the project, by consumers, family members and service providers alike. The NDIS has shifted the focus to one-on-one support; while this is undoubtedly valuable for some clients, other people lose opportunities to participate in centre-based programs. Service providers feel they have become powerless to support these people well, or to provide flexible options.

"I manage a centre-based psycho-social program for clients experiencing severe and complex mental illness. For the past 13 years our organisation has met the essential psycho-social needs of a cohort who would often isolate from community, friends and family. The new proposed price guide of the NDIS service model for centre-based activities is untenable and program may have to cease. This would be to the detriment of clients who will only have access to one-on-one support in their NDIS plans" (survey response)

"There's always a need for more block funded psychosocial outreach community supports. For this service not to be taken away by NDIS" (survey response)

The perceived inflexibility of NDIS is hindering the need for variety and choice within the mental health sector.

"NDIS is too rigid a system for psychosocial disabilities" (survey response)

"There are individuals whose needs fall through the cracks of what the NDIS considers 'reasonable' and 'necessary' and outside of what 'available' evidence-based research and clinical reports can confirm. ... At present [some supports] are still considered 'experimental' within mainstream society and 'not eligible' for funding" (survey response)

There have also been experiences from those within the NDIS system which indicate a lack of nuance that is necessary for the varied circumstances of the consumers. Policies that focus on telehealth, for example, risk overlooking or being in accessible to populations who most need support.

"The current Federal Government places more importance on online services, which is very uninformed given that minority groups in the mental health space are the largest group of Australians who do not have access to the internet. These groups are very isolated due to social stigma and do not have capacity to attend public libraries to access online Mental Health Services which receive the bulk of Federal Government funding, even over and above public mental health services" (survey response)

ENHANCING DIVERSITY AND INCLUSION

The experiences of those with CaLD backgrounds are often exacerbated by the lack of services tailored to their needs. For those coming from vulnerable circumstances, such as refugees, or persons new to Australia, there are often other factors that need to be included when considering their mental health.

The Youth Focus Group spoke of the need for intersectional and culturally safe services, where an individual's experiences of mental health is considered within the context of their cultural background. For example, anonymity may be particularly important for participants from certain CaLD groups for whom mental health support carries a social burden or stigma. In this case, a support may ostensibly shift its focus from 'mental illness' and continue to provide mental health support through the lens of facilitating community connection or practical assistance (as described in the general support approach in Section 3).

A culturally safe service is inherently linked to the need for a well-trained, informed and stable workforce.

"People from a migrant and refugee background [have limited options for mental health support]. There is very limited culturally appropriate support and difficulties in maintaining a stable permanent workforce"

(survey response)

ENHANCING DIVERSITY AND INCLUSION (continued)

For non-permanent residents or refugees, the financial burden of accessing support can be overwhelming.

"There is not enough supports or suitable supports for people in particular on bridging visa awaiting refugee status or people who have obtained refugee status and exited the Humanitarian funding stream. Also, there are siloes in place which create a separation for these people from other permanent residences and citizens. The competitive nature of funding stream seeks to create discord between services that provide specialised mental health supports. Funding for people with a migrant or refugee background is a lower priority which reduces the ability for Community service providers to maintain staff with the expertise required or even just provide a wrap-around service..."
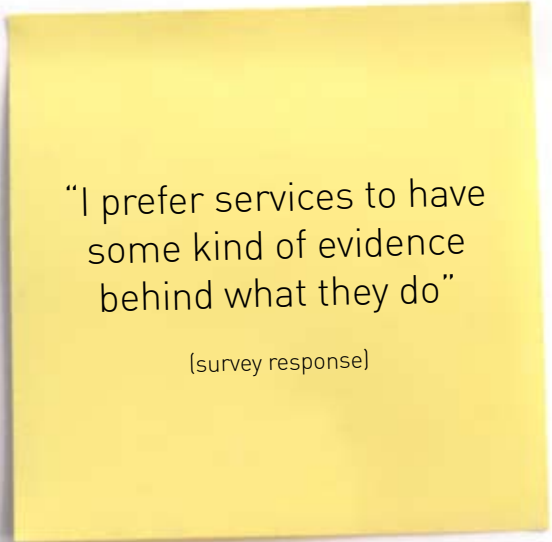(survey response)

EMBEDDING 'EXPERIENTIAL AUDIT' AND EVALUATION MECHANISMS

Evaluation was considered, by some participants, as one of the most important principles. For example, the Aboriginal and Torres Strait Islander Focus Group indicated that of all the principles discussed, independent evaluation mechanisms were the most critical. The survey responses provided insights into the value of evaluation. It was recognised that community-based supports are less likely to be evaluated, compared to medical interventions in clinical environments (for example). In addition, community organisations generally have less formal structures to support quality assurance and improvement. Where people are dissatisfied with a support they feel they have little recourse.

The idea of an 'experiential audit' builds on the point about "the feel" of a service being critical to consumers, and also foregrounds the experience of consumers and positions them as experts and advocates for their own needs. An experiential audit may also be supported by quite simple, agile consultation processes and not need to be as expensive as other evaluation approaches. Capturing the experiences of consumers, by an independent evaluator and/or mechanism would provide incredibly useful feedback loops, should a support not be optimally effective or safe.

In general, evaluations using participatory approaches that actively involve consumers and family members, and bring in their perspectives - and are publicly available - would be a critical companion piece to putting these principles in practice.

"I prefer services to have some kind of evidence behind what they do"

(survey response)

"I have had some very bad experiences with counsellors for example who had really poor boundaries. It was hard to address because you never wanted to put a niche service at risk, and anyway there weren't good avenues to address concerns. Would be very reluctant to be involved in more community support groups as I haven't experienced them as very safe. In my experience, they can be a bit like bad social media and act like an echo-chamber for every conspiracy theory going. Have also had poor experiences with other members of the groups not respecting boundaries and calling at all hours seeking support. I'd like services to work with my clinical supports but they seem to act like the clinical system is the enemy"
(survey response)

The articulated need for evaluation aligns with government commitment to continuous evaluation of services, ensuring that an individuals' experience of care is used to inform quality improvement activities (Australian Government Department of Health, 2010b). Embedding rigorous evaluation processes in the community mental health supports would also enable the evidence gap about the effectiveness of these models to be addressed.

CONSIDERATION GIVEN TO SPIRITUAL NEEDS, FOR SOME PEOPLE

Tying in with the notion of a person-centered support approach, participants noted that an individual's spiritual needs were too often overlooked or poorly incorporated into currently available community mental health support. While not applicable to everyone, spirituality was integral to some consumers' recovery journey.

"For me, it would look initially like someone actually asking me about my spiritual beliefs... and then incorporating that into my supports. Access to a spiritual leader or traditional healer may be important for my recovery and the service could proactively ensure that happens because they have understood the importance of that to me" (co-design workshop)

One interview with a service provider in a remote community reiterated this point, explaining that for Aboriginal people enabling practical ways to heal on Country (through providing transport or petrol money), and access to an Aboriginal Traditional Healer were the most effective recovery approaches. The key message we gained across multiple co-design processes was that if services shy away from asking about the spiritual needs of people from all cultures, and supporting them to meet these needs, they are missing an opportunity. The opportunity in community mental health supports is that all lenses may be considered, and the broadest understandings of what may enhance the wellbeing and mental health of an individual can be effectively accommodated. It is hoped by some co-design participants that in the implementation of these models, these perspectives may be considered.

IMPROVING ACCESSIBILITY

The idea that community supports should be easily accessible is not new (Tighe et al., 2019). However, this theme was reiterated throughout the co-design process, and a top-of-mind consideration across all models. Flexibility and options were seen as key to getting this right.

"Be more flexible I am currently working and groups are always in the day time which would mean often taking time off work to attend. This makes me upset as I feel like I am letting my employer down, increasing stress I don't need" (survey response)

Among the solutions suggested, were transport to and from services, phone check-ins, video links, home visits, assertive outreach and increased availability on weekends and evenings.

On this issue there was a particular focus on the difficulties faced for people in regional areas due to the lack of services, long distances to available services, compounded by the potential stigma of organising transport to a mental health service, as well as issues with fitting mental health services into schedules.

ENHANCING LINKS TO EMPLOYMENT

The lived experience voice highlighted a strong need for community mental health supports to link effectively to employment opportunities or services. Workforce participation was seen as a vital social determinant that supported wellbeing and recovery, and was sometimes overlooked. Survey respondents gave examples of practical assistance a community support could offer, including help navigating employment services, business coaching and access to training courses.

"I really need/want to work but my disability job network provider is not equipped to help me. And again services should be interlinked, it also prevents having to explain yourself and story over and over again" (survey response)

The youth focus group also spoke of the necessity of training programs with a direct pathway into employment opportunities, particularly for rural and remote young people who are often disproportionally affected by high rates of unemployment.

"It's all good to offer the support but without ability to engage with an employment provider, we will, for the rest of our lives, live in extreme poverty" (survey response)

EMBEDDING ABORIGINAL MENTAL HEALTH WORKERS IN MAINSTREAM SUPPORTS

The focus group with Aboriginal and Torres Strait Islander mental health workers highlighted the need for good quality and well-trained Aboriginal Mental Health Workers to be incorporated into mainstream supports.

The sector challenge is to provide comprehensive training and mentorship to workers so that a pool of skilled and available Aboriginal people are well equipped to do this work; then the best quality workers can be recruited into mainstream services. The focus group participants believed that as long as the supervision within these services engenders trust and enables the Aboriginal Mental Health Worker to be empowered and work in ways that would be effective for the community and for Aboriginal consumers, this is the most effective model to support Aboriginal and Torres Strait Islanders for this time.

"We need more Aboriginal workers on the ground, more on Country and in the in-house recovery programs"

(survey response)

PROVIDING CONSUMERS WITH MORE HELP TO NAVIGATE SERVICES AND SYSTEMS

One gap that was highlighted repeatedly throughout co-design processes is the need for help with understanding and navigating the mental health system. Survey respondents and co-design participants called for more effective integration between mental health services, along with advocacy from support systems.

"Rather than having to do the ring around myself it would have been get to visit a hub where I could have been connected up with supports that I was eligible for and that met my needs"

(co-design participant)

"Advocacy support for when people are having difficulty navigating the various 'systems' i.e. finding a job, accessing financial supports, finding support groups, dealing with families and doctors" (survey response)

"I think if the services (disability payments, housing, etc.) were more aware of each other and co-existed as a team a person would be more likely to feel supported and improve" (survey response)

Some of this assistance involves the recruitment or empowerment of staff with the capacity to research available grants, and provide support across services, even if they are not typically in the 'mental health' space. One response below speaks of the inherently linked nature of poverty, insecure housing, and mental health distress:

"I think help navigating the mental health system, housing and Centrelink would be a huge help. Poverty and insecure housing are big problems, as is trying to find clinicians suited to clinical needs. But it is hard to know where" (survey response)

"It would be great to have people with skills in researching available grant funding and applying for grants for individuals whose needs fall through the cracks of what the NDIS considers 'reasonable' and 'necessary' and outside of what 'available' evidence-based research and clinical reports can confirm" (survey response)

PROVIDING CONSUMERS WITH MORE HELP TO NAVIGATE SERVICES AND SYSTEMS (continued)

In keeping with safety and trauma-informed care, several participants spoke of the detrimental effects of having to tell their story "four thousand times" (in the words of one co-design participant), and in doing so, are forced to re-live traumatic events. A suggestion closely linked with the service navigation considerations is to have improved information sharing between supports, while keeping in line with professional standards of confidentiality and clients' autonomy:

"Provide a one stop service provider to help navigate all the various services available. Have qualified professionals available who can pass on relevant/personal information (with clients permission) to avoid having to re-tell your story which can re-traumatise and trigger previous trauma" (survey response)

"The devastatingly difficult time when a referral is needed to attend a service. I tell my story to my GP. I get to a service, and tell my story to an 'intake' person. I get accepted, and then have to tell my story again to the worker assigned to me. That person leaves or goes on holiday, I get another person and I tell my story yet again. The constant re-assessment, and re-telling is traumatising. It seems like no-one trusts anyone else in the service sector (and especially not me). One assessment, one story, once" (survey response)

Instead of a focus on system navigators, one suggestion is to take a sector-view on this issue. One perspective is that the system is so hard to navigate because there are more gaps in the system than there are services. With estimations that currently only 20% of demand is being met, the image is of a system where there are more gaps than services. If there were enough services, and they were geographically, evenly spread and available to all cohorts according to need, some of the navigation challenges would drop away. Consumer difficulties with navigation is a sign of a system that is fragmented – therefore navigation support will always be a band-aid.

4.3 Conclusion

This work combined co-design and research methods to better understand the mental health support needs of Western Australians. In particular, this project considered priority cohorts who are less likely to access support, due to service gaps or additional barriers to engagement. Young people (high school aged and young adults), family members and carers, and individuals with high acuity mental health issues and multiple unmet needs (including co-occurring alcohol and other drug issues), and people living in rural and remote WA engaged in a variety of methods to express their needs and wishes for how their mental health can be better supported.

The Mental Health Commission has formally recognised that consumers are integral to service design, and their involvement ensures "that models appropriately respond to the real, rather than perceived, needs of their clients" (Mental Health Commission, 2019b). In seeking the views of over 200 people, and working closely with about 20 people (including the Lived Experience Advisors as well as about 15 participants who attended both workshops and other processes), we have confidence that these models represent some of what is wanted and needed in WA at this current time.

The support models proposed draw on the views of those with lived experience, and their ideas about contemporary, person-centred approaches integrate well with current policy frameworks and strategic directions. Individual-led recovery, peer workers and peer support, social connection and a range of access options and engagement activities are the critical components that people asked for, and all of these options help to realise the vision outlined by the Australian Government Department of Health (2010b) – that individuals are empowered, and their preferences are at the centre of the care they receive.

These models are in preliminary stages – aimed at encapsulating the lived experience views and sketching out what this may look like in practice. However, there is certainly a need – and a hope – that these models will undergo further co-design processes with specific local contexts in mind. More proactive engagement with some priority groups may also be required to further develop or resolve specific issues. We hope that the participation information outlined in this report can assist in making assessments about next steps, which may look different for different models or priority groups.

These proposed next steps will ensure that the models are fully developed, resolving areas of tension or non-consensus and outlining ways to operationalise the models with more detail. Ideally, a costing process will allow the next stages of investment to be put into motion.

RECOMMENDATIONS

The introduction of this report explored the need for rebalancing the mental health system to fund more community mental health support options. National and state policies and frameworks express the need to significantly increase community supports as an essential component of an effective system that meets people's needs. The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan, 2015) asserts that community supports are the service type that is least able to meet demand, with only 20% of demand met. One of the primary strategic goals of the Plan (2015) is to increase these supports. This has been a state government commitment which is, as yet, unrealised. It is also a worthy change given:

-   the documented benefits of community mental health supports in meeting the needs of consumers (especially consumers or priority groups who find non-institutional settings preferable, more effective to support their personal recovery or easier to access), and

-   the system-level and cost savings benefits that flow-on from supports that can effectively keep people well in the community, out of crisis and reduce the need for acute mental health services.

Broadly, people asked for supports to be responsive to their needs and to provide a positive 'felt experience'. Community mental health support models have advantages in fulfilling these wishes, compared with the system constraints that clinical services face.

RECOMMENDATIONS (continued)

This report seemingly presents models as if they are new supports to be funded. This meets system-level strategic goals to increase overall funding for community mental health. However, although more community mental health supports are needed, funding new services is not the only answer. There is scope to use the insights lifted out of the co-design processes to improve existing services, for example:

- building peer-led activities and peer workers into current services,

- expanding the mental health capacity of existing and well-utilised supports for priority groups, such as youth drop-in centres,

- for regional and remote areas, build on existing neighbourhood or community resource centres, and

- adjusting funding structures for current services to provide more flexibility (for example to build in group activities or be available outside office hours).

In some ways there are advantages to the 'improving and expanding on existing services' approach. The simple addition of new services without thoughtful integration and well-developed links into the existing service landscape (including into clinical supports), can contribute to the fragmentation and system navigation problems that consumers report (integration and fragmentation are raised in both state and federal mental health plans as key issues).

With all of the above in mind, some suggestions about next steps are outlined below.

1. Scope ways to invest further in community mental health supports across geographical locations, prioritising rural and remote areas of the state, as part of the commitment to significantly increase community support programs across WA.

2. Employ further co-design processes to adapt these models to local needs and accommodate the diversity within local populations. While closely considering local contexts, consider the need for strong integration, or options to expand or improve existing services.

3. Ensure procurement processes for these models have deep alignment with the principles expressed by lived experience participants and do not inadvertently disrupt, compromise or constrain what is most important in service delivery. This may mean strong consultation with service providers in developing funding models.

4. Share the findings of this co-design process with commissioning bodies and service providers to enable the lived experience perspective to assist with continuous improvement of existing community supports.

The emphasis on peer workers and peer support in this project warrants the accelerated development of the peer workforce in WA. As mentioned earlier in this Section, state and federal governments are investing in peer development programs and qualifications to expand the peer workforce, increase its professionalisation and assist peer workers to navigate their work. These developments are encouraging and should be applauded as aligning with the needs that consumers have expressed. They enable funders to integrate peer workers into community mental health supports, with increasing confidence in their skills and effectiveness.

Nationally and internationally, mental health leaders agree on the centrality of advancing and developing the peer workforce as an integral component of an effective and person centred system. To truly advance peer led options, the development of a peer-led and peer-governed service provider organisation should be considered. Brook RED, profiled in Sections 2 and 3 of this report, is a contemporary example of an Australian peer-led and peer-governed organisation providing supports for consumers who choose to access peer led options.

This is one of the many examples presented in this report where alignment exists between strategic vision, policy direction, effectiveness and cost effectiveness evidence, and what the consumer and family voice calls for. The fact that such strong alignment exists should give us the confidence that increasing and improving community mental health supports will surely move the mental health system in the right direction.

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Appendix A: Co-design Workshop Template

Priority group → [add group name   ]

FIRST STEP   **PARTICIPATION**   **NEXT STEPS**

What really counts to the consumer and family member at this stage?

What do they hear and see around them that creates obstacles, fear and/or frustration?

What do they hear and see around them that makes it welcoming?

What are the critical elements for support to include or exclude at each stage?

Why are they critical?

Critical Elements (include/exclude)	Why?

Critical Elements (include/exclude)	Why?

Critical Elements (include/exclude)	Why?