Sector Scenario Planning Report

PROJECT | **Mental Health Sector - COVID-19 Response**

CLIENT | WA Association for Mental Health

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Aha! Consulting

When will you have your next Aha! moment?

CONTENTS

"When things are uncertain,
it means anything is possible"

EXECUTIVE SUMMARY

As part of the response to COVID-19 and more specifically, in preparation for when the state moves to a stage 3 response, characterised by widespread community transmission, a series of scenario planning sessions were held with the community managed mental health sector (the sector), and attended by key government stakeholders.

A total of four sessions were conducted which focussed on specific areas of service provision in the mental health sector:

- Supported Accommodation
- Workforce
- Decision Making
- Non-Residential Services

Each session was conducted online and between 35 - 42 people attended each session, representing community management mental health Service Providers, peak bodies, consumers and family members, and government agencies.

An additional forum was planned to explore escalation pathways for different scenarios, in a stage three response environment. This forum will require the inclusion of the sector, government representatives and Health Service Providers (HSP); as such additional time is required to coordinate the required participation and content.

The consultations also identified the need for some more targeted sessions focused on;

- Supporting family members and carers
- Assisting regional providers identify response options for their contexts

What follows are the consolidated notes from all sessions. The raw notes from each session are also provided in the appendices of this report, along with the list of organisations that participated in the workshops.

Key Themes

Aside from the complexity of the many decisions that the sector faces in relation to responding to a COVID-19 environment, there were three themes that stood out across the consultation sessions.

(1) **Playing their part:** The sector remained committed to keeping people well and out of hospital. They see themselves as well positioned to do their part to contribute both to people's wellbeing and the public health effort/need.

(2) **Do No Harm**: There are fundamental principles and ways of working that inform the practice of the sector. Approaches such as trauma informed care and the recovery model were considered as foundational to ensuring long-term harm is avoided during this time. There was concern that the dominant approach to crisis decision making was going to minimise the importance of adhering to these fundamental principles. The sector was keen to demonstrate that it is possible to be responsive to public health needs while staying aligned to the contemporary approaches that are working.

(3) **Resourcing Collaboration and Innovation**: There are ways the sector can support and already is supporting the response effort. This was seen as a time to innovate and work in a way that is both respectful and responsive and providers gave evidence of this. It was deemed important to circumvent individual organisations from each having to solve the same problems and resourcing the collaborative efforts that will be required to deal with issues such as:

a. Responding to increasing demand and new ways to deliver services
b. Retain, redeploy and upskill existing staff
c. Recruit, train and manage new staff to meet demand
d. Ensuring cultural security of communities which are no longer able to operate in a communal manner
e. Supporting the families of people with mental health issues
f. Enabling complex decision making within consistent frameworks that grapple with public health, recovery and human rights

Overall, the sector appreciated and valued the opportunity to come together in these forums. The isolation experienced by some providers and family members was noted by many participants. The access to quality and up to date information was seen as critical at this time as was finding mechanisms to support that into the future.

"Thanks for all your work and availability at this time with these seminars, it has helped especially in regard to up to date info, how our sector is responding, and most importantly not feeling quite so alone at this time."
Session Participant - Provider

"Just want to let you know that you're doing a great job with the scenario workshops. One of my colleagues mentioned that it is doing her heart good to be part of groups collaborating so well in such a short timeline.
She has been able to feed that through her own networks which includes a number of older people who are feeling particularly impacted and powerless in the current situation and reports that it is leaving them feeling better to know these solution-focussed collaborations are happening."
Session Participant – Family Member

Principles used during the consultations

During the sessions the following six principles were used to guide the discussions:

1. **SAFETY**: Keep as many people as possible, as safe as possible (infection control)

2. **WELL-BEING**: Keep people well and out of hospital if safe to do so

3. **DO NO HARM**: Being clear on the 'essential' elements to enable a rapid response while maintaining appropriate balance with what the sector knows is important to the consumer (e.g. recovery, human rights)

4. **FLEXIBLE**: Integrate a "yes if…" approach to developing new responses to new situations

5. **COLLABORATIVE**: Looking systemically – how can we each contribute to the response needed?

6. **INTEGRITY**: Not letting the crisis get in the way of quality and not letting the ideal get in the way of necessity

What the Sector Is Currently Experiencing?

From the consultations to date, it is clear that there has already been a number of key changes for Service Providers.

Service provision changes

- Shift to phone and virtual support for most providers, for most consumers, with the exception of supported accommodation services although with some face-to-face support still occurring for consumers of non-residential services.
- Increased demand for phone and virtual support to support consumer wellbeing
    - This type of work takes more time and resources – consumer wanting more contact than face to face visit
- Staff require training on how to deliver support work differently
    - Effective ways of working for phone and virtual support, and self care, de-briefing and boundaries in remote context
    - new management and supervision practices required to support consumer outcomes and staff in a remote and complex environment, and enable reflective practice
    - Leaders and managers require development and support (including peer to peer) on change management in a complex rapidly changing environment
- More people who do not normally access services reaching out for help
- Reduction in workforce numbers through personal circumstance/fears
    - Concerns about access to PPE and infection control
    - Commitment to consumer support remains strong
- Loss of NDIS work for casual staff of NDIS providers
    - This presents a long-term risk to sector capacity if they are not able to return to work and/or client support
- Some retailers (supermarkets etc.) assisting with giving consumers access to provisions
- Support Aboriginal staff who do not have a 9 - 5 role in their communities
- Regional providers working out how to manage the various scenarios and consumer needs with limited resources and isolation options
- Consumers scared to leave the house and unsure where to go for support
- Co-Morbidity factors (AOD, family violence) becoming more extreme

"Staff are working with clients that they are not familiar with which can be challenging for both parties. Some clients want specific staff members."
Session Participant - Provider

"Clients may 'disappear', particularly with AOD ... how to find them again if they disappear?"
Session Participant - Provider

Changes for consumers and families

- There are a range of impacts on consumers being noted by providers and families;
    - Some consumers are taking more extreme self-isolation measures than currently required, raising concerns about their ability to access necessary supports and extending the time they will be isolated as restrictions increase
    - Some resist or are unable to comply with social distancing requirements, causing additional risk/stress for family members and Service Providers
- The move to new phone and online modes of service provision is being met with a mixed reception;
    - Some consumers are responding well to this approach
    - Some have negative past associations with online (e.g. online bullying of LGBTIQ people), so are less enthusiastic about its uptake
    - Some do not have the digital resources to engage in remote support
- Aboriginal consumers and their families struggling with the impact of social distancing on their cultural way of living and support for each other
- Families and services trying to work out how to best support people
- Consumers needing practical support such as food and essential items being dropped at their door, especially those who only use cash
- Consumers and families dealing with job losses and financial distress

"Impact whole of WA – some services are changing service delivery, e.g. food security, care packages, drop off service to help clients."
Session Participant - Provider

"Challenging knowing that the perpetrator is back in the house ... fewer 'eyes' on vulnerable people and children at risk."
Session Participant - Provider

Systemic issues

- Identifying the critical threat to ongoing sector viability – cash flow, continuity of staffing etc
- Maintaining and growing a sector-wide workforce
- Need for clearer assurance and direction on the parameters for repurposing existing funding for the required client supports and response activities (e.g. moving individual support to include shopping etc.)
    - Focus on additional resource to handle the surge in required capacity and changes to mode of service delivery
- Working out how to respond to the changes made in other parts of the system including increased need to support consumers who may otherwise access face to face services from community mental health treatment teams or emergency departments if acutely distressed
    - Providing enough PPE for those scenarios where face to face contact is essential
- Unclear information about the specific changes to the whole of the health and community sector
- Need for sector wide collaboration and information sharing to continue
- Need for clearer communication about government expectations of NGOs and changes to service delivery in public mental health and associated systems
    - Clarity on the escalation and clinical service that will be available during a stage three response. More clarity on what can be done.

"Anxiety is heightened with consumers and in the sector, there is no clear pathways for serious mental health challenges that would have people traditionally placed in hospital."
Session Participant - Provider

What the Sector Is Preparing For?

As the COVID-19 response transitions from level 2 to level 3, where the focus shifts from containment to management, there are a few critical areas that we will need to prepare for.

1. Developing safety frameworks for decision making to ensure that the public health needs do not overly dominate the human rights, trauma informed and recovery approaches that prevent long-term harm and advance people's outcomes
    - These models will need to provide guidance on a range of issues, including but not limited to:
        - Dealing with infection within residential facilities
        - How to manage escalations in an environment where tertiary resources are constrained
        - How to maintain service delivery to support those most vulnerable including both consumers and family members
2. Identifying new models to provide support to consumers and families
    - Looking at further innovating and enabling recovery models in this context e.g. open dialogue as well as the very real practical supports to be provided to enable consumers to meet isolation or quarantine requirements (e.g. shopping etc.)
    - Ramping up carer and family support through existing carers, carer support providers and into other organisations
3. Identifying new forms of residential accommodation
4. Building the capacity of staff to deal with more complex cases within the community sector, as the resources of tertiary facilities and the wider health system become focussed on the COVID-19 response
5. Identifying new resources and new staff who can assist with the emerging and expected surge in demand
6. Finding ways to manage the anticipated increase in AOD and other dependencies and their flow on impacts on consumers Mental Health.
    - Clarifying the expectations for working with co-morbidity AOD and MH issues
7. Supporting existing staff to:
    - Know what work is 'essential' and how to do it safely
    - Find new ways of working and providing support
    - Preventing burn out
8. Self-isolation, compounding co-morbidity factors that can lead to an increased incidence of mental health breakdown and other health problems
    - E.g. family violence, AOD
9. Identifying strategies that will work in rural and remote areas

What is needed to support preparations?

During the consultations, the sector had been expressing its dedication and commitment to supporting mental health consumers and their families. There also remains a strong commitment to do what is needed to keep people safe, minimise spread of COVID-19 AND to ensure that long-term harm is not caused by an approach that becomes too focussed on the legal compliance to public health requirements.

There is confidence that the public health needs can be met whilst still adhering to the practice principles that underpin the sector's way of working – with the right support, guidance and development of new service options.

With the right supports and resources, the sector's capacity to provide flexible and innovative responses that contribute to the COVID-19 crisis can be significantly enhanced.

At this interim phase of the consultation, the required supports and resources can be described as:

1. **Building and expanding the infrastructure and service capacity of the sector**
    - Identifying and resourcing alternative forms of supported accommodation (metro and regional)
    - Identifying tools for online and virtual support (e.g. access to telehealth) and enabling consumer access to the digital resources required to engage
    - Exploring and developing new models of care including non-residential service expansion that support recovery in this changed context and offer practical support
    - Exploring and developing expanded safe supported accommodation and isolation options
    - Providing sufficient PPE for the required face to face consumer and family support work

2. **Supporting decision making in complex cases**
    - Establishing a call centre type facility to enable reflective practice on difficult decisions to increase the sector's confidence in their decision making
        - Hosted by a multi-disciplinary team that includes people from the sector with expertise in areas of recovery and trauma-informed care
        - Alternatively enable coaching and reflective conversations between sector leaders that support providers to talk through the application of public health guidance to service provision in a recovery framework
    - Developing a safety matrix and risk assessment tool that provides guidance for key risks and ethical considerations in key scenarios
        - Mapping escalation procedure for both COVID infections and escalating distress in a changed service delivery environment

        - Clarifying the procedural difference for licensed facilities and non-licensed facilities
        - Clear guidance on the expectations for service delivery, including essential services
    - Providing legal advice on the interplay between the Public Health Act and the Mental Health Act
        - It was important to ensure that this advice is provided in the context of a reflective decision-making process
    - Resourcing advocates to work with agencies, consumers and families

3. **Supporting sector collaboration and innovation**
    - Developing a portal and communication platform or community of practice for the sector to more immediately and easily coordinate, share resources and information, share emerging innovation and good practice, and jointly problem solve, with a focus on connecting and collaborating
    - Clarifying the directions and parameters for repurposing existing funding for the required client supports and response activities, and extending the time period to which this applies.
    - Providing some dedicated resources to support services in regional and remote WA to plan for their specific contexts

"Sector support like this has been really good and I hope it does continue in some form. The support we have had from WAAMH has been one of the silver linings. Even though meetings may not be as regular, we need a space to talk about issues and learn from what others are doing to get around them going forwards."

Session Participant - Provider

4. **Building staff capability**
    - Upskilling existing staff to understand what services are critical and how to deliver them safely
    - Upskilling existing staff in remote practice
    - Upskilling existing supervisors and managers in supporting staff practice in a remote context
    - Explore supports (incentives, resourcing) that will keep staff working, especially in face to face support, where it is essential and safe to do so
    - Investing in developing staff capacity to work with more complex cases
    - Supporting Aboriginal workers, whose role in communities brings extra demands

5. **Expanding staffing capacity**
    - Coordinating redeployment to address staffing gaps by, for example shifting staff no longer needed, such as NDIS workers, into services that do need them
    - Streamlined HR and recruitment process to fast track employment
        - Ensure there is a fit for sector values charter to ensure stigma is not brought into the system
        - Accessing special recruitment companies with human services experience
        - Delivering induction by the sector to ensure cultural fit and consistency of service delivery
    - Identify pools of new employees, as in
        - Re-employing recent retirees
        - Redeploying people from other human service sectors
        - Recruit from recent graduates or final year students

6. **Supporting families and Carers**
    - Working with families to better identify their needs and ensure they have access to both practical and psycho-social supports, while broader systemic support is less available.

Conclusion

In unprecedented times is the opportunity to try unprecedented things. The response from participants to these sessions has been an appreciation for the opportunity to collaborate and learn collectively and a willingness to support each other and strengthen the broader response effort.

The sectors' leadership and responsiveness was evident in existing adaptations made.
The sector is uniquely skilled and positioned to support people to stay safe and well during this time and the scenario planning sessions affirmed the sector's commitment to providing that support.

Some of the recommended responses are calling for new levels of creativity to find ways that enable –

- Staff from different organisations to be deployed for the benefit of the whole sector and the consumers and families they serve
- Organisations to deliver services that may be divergent from the terms of the original contract in line with the emerging need
- Support for collaboration, hiring staff, recruitment and induction process
- Staff, consumers and families to feel supported through these times
- Support for sector wide support, information, collaboration and practice development

Some of the recommendations will require people who are empowered to thinking laterally, ethically and rapidly, so that problems can be solved once, solved well and shared rapidly. Other recommendations will require a more considered approach.

While there is some existing capacity and an abundance of commitment, commitment alone will not meet the foreseen need for increased service delivery and coordination.

APPENDIX A: Supported Accommodation Workshop

The supported accommodation session focussed on five scenarios

- **Scenario 1** - Service continuity – staffing levels
  - Due to reduced number of staff the service is less able to provide support to consumers
- **Scenario 2** - Service continuity – COVID infection
  - A resident becomes infected with COVID-19
- **Scenario 3** - Consumer discharged from tertiary facility – COVID
  - A tertiary facility needs to free up beds and discharges a consumer who needs support and is infected with or suspected to have COVID-19
- **Scenario 4** - Expanding capacity – mass ward closure
  - Preparing for imminent mass ward closure of inpatient beds
- **Scenario 5** - Expanding community capacity – free up hospital beds
  - Remove existing blockage in hospital capacity by discharging consumers with no clinical need to be in hospital

With participants being asked

- What are the considerations in finding a solution to this scenario?
- What are the possible solutions to this scenario?
- Rank in order the priority in which these need to be dealt with
- Why do you think this is given this priority?[1]

What follows are the raw notes from the work of the group/s.

[1] Please note that priorities given in this section are the work of a single group. There was not time to check the priorities with the wider group or to standardise the prioritisation process.

Scenario 1 – Service continuity – staffing levels

What are the considerations in finding a solution to this scenario?	What are the possible solutions to this scenario? The solution can factor in multiple considerations	Rank in order the priority	Why do you think this is given this priority?
25% of staff may become ill with COVID-19	St Bart's - is repurposing executive to be LARU trained supervisors	Repurposing – may be staged and short-term; Tiered approach, through continuum of skill levels	Emergency strategies versus short-term, medium-term and sustainable longer-term options
Underlying health concerns in current staff, may lead to increased personal leave	Drawing from Community Services to increase capacity in primary health sector	Sharing staff	Values and concepts remain the same throughout differing levels of service, on the continuum
Collaboration between agencies and what that looks like operationally (disability services)		Upskilling – university students on board	
Impact on casual workforce is high, given risk of service delivery	Fostering collaboration and sharing of resources	How do we train people – bring them on early	
Can we identify other roles and positions, that can be repurposed and retrained?	Upskill some staff (supervisory) to bring in less skilled staff	Reducing staff attrition – due to staff concerns for own health and wellbeing	
Question: Have we looked at previous models, during an outbreak of similar nature	Accessing agency staff (they will come with a level of clinical capability and screening)	Leveraging federal grants that have been provided to aged care workers; recognition payment	
Risk assessment of individuals who are healthy and prepared to carry on the service	Accessing final year university students (OT, social work, psych etc.) – may be well suited to provide support		
Are there cohorts of people/staff in WA who could be skilled up to support the lower tiered situations	Using on online orientation system that can be made available to others		
Services looking at their supervision processes			
Cost of accessing agency staff (cost more than normal staff)			
Some other agencies have tried using agency staff but are finding the competition with other sectors hard			
Ensure we are looking after staff and not putting them at risk			

Scenario 2 – Service continuity – resident with COVID-19 infection

What are the considerations in finding a solution to this scenario?	What are the possible solutions to this scenario? The solution can factor in multiple consideration	Rank in order of the priority	Why do you think this is given this priority?
Testing for confirmation and how to access that testing – particularly challenging for those in remote areas. Lack of PPE creates risks in transporting residents to testing facilities.	In situ testing so that people don't have to go to clinic – minimises risk in absence of PPE and minimises distress. Ensuring access to testing kits in remote areas – getting kits to where people are.	1	Because this information is critical first step to knowing whether to take next steps
Where can people be isolated to? No space.	Having timely access to alternatives	6	Accessing alternatives is the final step in this process and so there need to be those alternatives
Being able to cross regions to access alternatives in remote areas	Agree on protocols for cross regional travel to enable relocation for purposes of isolation	6	In order to access any alternatives in remote areas, providers will need to have confidence that cross regional travel will occur and that this will be classified as essential travel
Supported decision making for people in relation to infection control (physical distancing and isolation)	Identifying and sharing some particularly effective resources (easy English, pictorial)	5	Obviously, we want to minimise the need to escalate situations in order to comply with the Public Health Act
Ensuring timely communication of test results to services – privacy, guardianship	A protocol by OPA to establish prior consent by guardians for test results to be communicated to guardian and service	2	So that outcomes can be communicated in order to be acted upon
Testing of staff	Put in place response protocol for the staff and other residents who are in the same facility (what does close contact mean and how to respond)	3	To ensure infection control response
Finding an exemption to allow people to be moved between regions so they can access services	Check how the Commonwealth guideline can be applied	3	
Commonwealth management website has residential care facility guidelines and flow charts	**Escalation plan** for people incapable of self-isolating (Public Health Act overrides mental health) – sector level guidance	5	This is needed to ensure that we respect principle of 'do no harm' in application of the Public Health Act and to ensure that services have confidence in how to make decisions in this regard. Services need to be clear about their legal obligations.
How to deal with people incapable of self-isolating			
How to retain the public health responsibilities but not damage the recovery/human rights requirements (the legalities and the practicalities)			

Scenario 3 - Consumer who is infected with COVID-19 discharged from tertiary facility

What are the considerations in finding a solution to this scenario?	What are the possible solutions to this scenario? The solution can factor in multiple considerations	Rank in order of the priority	Why do you think this is given this priority?
Issue of the power to force a person to go to a place designated for COVID patients discharged from a ward	Need residential pathways for different scenarios, e.g. COVID-19 but no symptoms, has symptoms but manageable in that facility and symptoms which need clinical input but not hospital admission		
Issue of whether supported accommodation could/should accept a person being discharged with COVID – there are residential care guidelines says LARU	Clarity needed around legal rights to keep a person in isolation	2?	
Often not a say by the supported accommodation provider about discharge – issue of communication by the HSP to the provider	Use family network to help person understand need for isolation		
GP support or other clinical support needed	In-reach by community mental health services		
Lack of supported accommodation now – need more	Communication plan with family and carer to ensure they are in the picture	1	communication and discharge planning is key
Support for people/families at home – is it available?	State solicitor office is looking at rights-(?) – who will then communicate the outcome?	2?	
When does this scenario come into effect (when there is already endemic spread) when containment is no longer the public health focus?	Discharge plan – need to consider the parents' age	1	Improvements needed with care plans and consistent discharge planning across all hospitals
	Hospital in the home program could be a model to extend this support		
	Having a single point of contact for information and advice for non-clinical services (such as hostels) which accept people who are Covid positive and for people with mental health needs – ideally through the existing COVID hotline and with people specially trained to take these kinds of queries, e.g. what to do when someone is not adhering to self-isolation, how to escalate care if needed	1	Helpful for all of the scenarios, not just this one
	Everyone discharged needs to have someone from a community MHS assisting them upon discharge		

	Community MHS needs to be bolstered		
	Need for a personalised pack upon discharge including hygiene products and a clear communication plan re. maintaining hygiene	1	
	Need for a safeguarding plan as distinct to a discharge plan upon discharge which includes a COVID-19 response	1	

Scenario 4 - Expanding capacity – mass ward closure

What are the considerations in finding a solution to this scenario?	What are the possible solutions to this scenario? The solution can factor in multiple considerations	Rank in order of the priority	Why do you think this is given this priority?
There won't be the lead in time we might usually expect for other scenarios (other than COVID-19 times) – lack of time to plan response		1	We can start with identifying what's available now... already some details available to start with, e.g. LARU – number of beds, staffing, support provision (only for licensed facilities) MHC with support from WAAMH Who is arranging accommodation options?
Understanding our current consumer/patient population – understanding severity and location		2	Progressing pool of casual staff and clinical support – crucial for care of consumers
Understanding the downstream availability – psychiatric hostels, private hospitals, supported accommodation – easily available to clinical staff	Identifying what services and capacity are available now and then; what services can we commission? Provide isolation spaces so hostels don't have to keep beds available for this. Ensure we consider utilising private psych hospitals.	2	Strengthening adherence to discharge information to ensure providers have adequate information – including other factors that need to be taken into consideration
What are the existing communication mechanisms/pathways between providers?		3	One point of contact' for clinical support (similar to MHERL) to provide advice to supported accommodation providers – specific to consumers (not general COVID-19)
What community clinical support will be available for non-clinical providers? Is there a plan for providing support in the current environment?	Pools of casual clinical staff and clinical support dedicated to specific hostels only. Carers Plus		
What are the Plan B options if it doesn't work at a supported accommodation provider?	Private hospitals, hotels, private psychiatric hospitals – depending on the severity		
Ensuring transition management and ongoing care for consumers	Abbreviated discharge summary to enable matching consumers to services and what t hey are able to provide – e.g. support required and level of independence		

Scenario 5 - Expanding community capacity – free up hospital beds

What are the considerations in finding a solution to this scenario?	What are the possible solutions to this scenario? The solution can factor in multiple considerations	Rank in order of the priority	Why do you think this is the preferred approach?
Alternative pathways for isolation or venues for care provision	Utilise hotel beds or rooms – with support	1	Already happening and demonstrating efficacy. Expanding what hotel beds get utilised is realistic and accessible.
Some of the 27% of consumers in inpatient beds could be discharged if supported accommodation available – out of hospital?	Increase hospital in the home capacity – in-reach either to hostels or to an alternative venue – both MH HITH and general. scale these options to increase service capacity		
Workforce is an issue here – if we increase capacity, who will provide that support?	Database on what vacancies are available across accommodation services	1	Bed flow. Should we / how do we keep some services for people who are well and other services for people who are infected?
Solutions for intoxicated people? Often end up in emergency if no sobering up centre available; perhaps there is a better solution?	Utilise step up and step down services		
	Support accommodation services to build their confidence to carry a level of risk in the community, e.g. high risk behaviours, eligibility criteria to their services, discharge planning from hospital	1	One view is that this should be a first priority; this could support some earlier discharge.
Work camps and mining sites – local to small towns – if they have reduced capacity ,can people go there?	Workforce development – people who have started some training,. e.g. MHFA. These people would need the confidence and an employment opportunity.	1	From a RRR perspective – workforce development to do things like hospital in the home. Managing within region boundaries and available and building on currently very limited community capacity; e.g. one nursing post. WACHS. Could Aboriginal health workers see the patients before seeing the clinician, going door to door in the community and check on those who require support? Some agencies have capacity for training within their role – trainers within regions to train in their communities.
Caravan parks – regional option and maybe some of the hotels (Meekatharra)	Increase Aboriginal health worker training in the regions		

Asking local community members and Aboriginal people who have had some training			
Social isolation and AOD issues that could result from this crisis in regional and remote areas			
Will remote communities trust staff coming in from other areas? Where would we house them?	Asking trusted Elders and community voice as to who locally would be suitable		
Consumer willingness to move to an alternative option	Are there any recently decommissioned facilities that can be recommissioned? Or converted in terms of use? Look at current stock available, maybe wider than Health.		
Sobering up centres facing issues – people can't get in anywhere else	Call out to private providers to identify potential facilities that could be transitioned to alternate use (safe and timely way)		
Having enough space for isolating people and being confident they can isolate	E.g. camps – Ern Halliday, Woodman Point. Dormitory style. but those staff have no work.		
Social distancing is a bit of an issue in these settings	Regional areas that don't have HITH – can we get HITH staff or community health workers?		

APPENDIX B: Workforce Workshop

During the workforce session, participants were asked to explore five overarching goals for workforce during this time.

- GOAL 1 - Support staff and reduce attrition
- GOAL 2 - Build the capacity of the sector to respond to more complex cases
- GOAL 3 - Streamline recruitment and HR process
- GOAL 4 - Source additional staff to maintain and extend service provision
- GOAL 5 - Maintain quality and standard of services

More specifically, participant were asked "What is needed to develop a sector-wide response to achieve this goal?"

What follows are the raw notes from the work of the group/s[2].

[2] Please note that priorities given in this section are the work of a single group. There was not time to check the priorities with the wider group or to standardise the prioritisation process.

GOAL 1 - Support staff and reduce attrition

Task	Resources	With Who	Priority
Increase team cohesiveness and practise mindfulness as a group on a daily basis	Website	Sector-wide set up, overall resource sharing	
How do we address the "Them and Us" – those who can work from home and those who can't? Quest – how do we create a sense of safety where communication is about risk?			3
Identifying what is an essential work-based activity versus non-essential, i.e. using technology to provide service in place of person to person	IT/Internet	Sector-wide	1
Assisting staff to understand what makes us an essential service and how to mitigate risk. Valuing staff, acknowledging risk to individual staff.		Sector-wide	
Increase communication around financial remuneration to staff, if ill or self-isolating Is there consistent financial support – for the front-line staff, which will enable them to move from worrying about survival to how to operate at full capability	Peak body to communicate via messaging	Sector-wide	2
Address staff who have been tasked to undertake a level of health services without appropriate training … NDIS			
Require access to a list of nursing agencies with staffing resources	Payment rates are not affordable for a service	Sector-wide	
Message out from management/executive/CEO – appreciation to staff and acknowledgment			
	Messaging that addresses the inconsistency		3

GOAL 2 - Build the capacity of the sector to respond to more complex cases

Task	Resources	With Who	Priority
Ensuring administrative requirements don't become a barrier to responding quickly How do we cover all the things we need to cover without heaps of paperwork – allowing us to respond quickly (e.g. risk assessments)	Having less of other administrative burden Having staff resources to complete these tasks effectively – existing shortages in country areas		
Managing dependencies within new service and support environments (e.g. AOD and other dependencies) where withdrawal might cause physical harm	Staff skill development to understand impact of dependencies and how to manage those effectively Ensuring access to pharmacological needs (e.g. those things that can only be accessed by being physically present in pharmacies – announcement yesterday??		2
Supporting people in country areas – local resources – access to internet, community networks, supplies – physical isolation exacerbates Are there flow on effects of this on how services must be provided?	Enabling organisations to respond more flexibly to be able to address these gaps where possible Access to technology		
Ensuring staff capacity (including skills and confidence) to respond to	Looking at supports to enable more experienced staff to provide supervision		1
Clarification of expectations in relation to co-occurring AOD and MH			
Challenge: Most experienced workforce that is best equipped to respond to complexity are the ones that are in vulnerable cohort, so might no longer be working Task – support older workers to work safely OR try and pass on their practice wisdom to others – these staff are no longer providing face to face support but could provide supervision of younger workers			2
Resources – ability to have $$ to provide more than one worker (where face to face is occurring, such as home visits/outside appointments) and, if someone is in a high-risk situation, how else it might be. People with more complex needs are likely to be more vulnerable and need continuing face to face contact	PPE and additional resources to allow for enough workers to enable face to face visits where needed		1

Challenge: How well does non-face to face contact work with people with more complex needs? Task: More frequent tele contact required, which has an impact on staff resources	Additional resources to enable more frequent tele contact time with those with more complex needs Resources to ensure service users have access to technology in order to access non-face to face services Enabling organisations to address the other material needs of people (Lottery West announcement – ensure it can be accessed quickly)		
Enable peer support (paid and volunteer) to provide more support	Peer based supervision (not clinical)		2

GOAL 3 - Streamline recruitment and HR process

Task	Resources	With Who	Priority
Identify sector recruitment needs – are we talking about direct support needs/community sector or health sector, direct support needs/peer workers, peer supporters	- E survey of services - Knowledge of existing direct support needs Agency skilled with coordination – e.g. private sector – employment agency • Peer workforce recruitment	Existing direct support service workers	3 (working with the private recruitment partner)
What pools of people do we want to recruit from, e.g. underutilised staff from existing services, community service students, volunteer pools, HBF staff, Qantas staff?	• E survey of existing community services staff who could be redeployed • Agency/staff to compile the survey and examine the data collected		
Skill audit/ appraisal/ training needs/ need for intensive induction	Money to conduct the research, money to pay the private agency which would conduct the recruitment Agency in sector with capacity to train all of the new recruits Identified practice supervisor for clear point of contact that workers are encouraged to reach out to for support		4 (sector leaders working with the private recruitment partner)
Identify private agency – partner with external HR provider; identify existing health specific HR firms (focus on skills AND **values** to ensure the candidates don't contribute to stigma)	Getting private employment agencies to do this recruitment They have existing tools and resources – it would need sector-led training/induction Educate on values based recruitment Forum for organisations to post which HR agencies they know and can work with		2.
Development of a standard process? Skills/knowledge matrix			
Consider the remuneration that applies across the whole workforce			
Clear governance structures, good support systems in place. Specialist roles should be built into this structure, for people joining the sector.			1
Develop a sector pool of existing workers for deployment across the sector as organisational needs change			2.1

GOAL 4 - Source additional staff to maintain and extend service provision

Task	Resources	With Who	Priority
Look at alternative remuneration and benefit structures • In particular for regional areas	Funds, Research, Time	CCIWA	
Investigate consolidated recruitment across sector, including students	Immigration support, time		
Peer worker program	Promotional		
Recruitment of retirees	Promotional, Government		
Employee pool via central conduit (This will need to have a mechanism for regional needs)	Sector wide collaboration, central resource	Entire sector/across sectors	1.1
Understanding clinically relevant skillset of those who have taken alternative employment (e.g. nurse now working in office)	NGO surveys	Government departments	
Agency staff	Funds (higher hourly rates)	Recruitment firms	
Capturing NDIS workforce during COVID-19 for redeployment Keeping this workforce connected	Sector wide collaboration	Entire sector/across sectors	2.1
Moving volunteers to paid roles	Formal training, funds	Other sectors (experienced with transitioning volunteers)	
Considering regions and more vulnerable parts of the population			
Flexible and family friendly hours to attract people who are currently at home			
Look at similar industries (aged care, acute care, childcare, hospitality, airlines)		Various industries	
	Ongoing working party		

GOAL 5 - Maintain quality and standard of services

Task	Resources	With Who	Priority
Distinguishing for each sector what they will have to do more of as this escalates. Managing trauma and challenging behaviours.	MH POD – training resource		
Workforce development and upskilling, for instance PPE. What is the benchmark?	Skilled trainers who are the subject matter experts Online training		
Define what PPE and what training are available	Department of Health training and guidelines		
More centralised information sharing for organisations	Networks		
Key messages and training for consumers, carers and families. Lots of information coming through – maybe a campaign?		CoMHWA	
Service and sectors maintaining human rights. Complexity of maintaining the Health Act and human rights Working together on developing resources	A guide to the more complex scenarios A guide to the tension to staff safety and consumer rights	Need open dialogue to hold the tensions	
Paid advocate in the system to help feed into a quality improvement model	Someone who can highlight the need		
Build reflective practice			1.
Hygiene and protective practice			
Move to relational recovery, structural and conceptual competencies (open dialogue models to hold diametrically opposed requirements)	Find the tension point – and how to hold this in the face of a crisis How to grow the capacity of people to do this and scale this up – having enough skilled practitioners to model how to do this		
Problems that could emerge between the interface of the Public Health Act and the Mental Health Act. Maintaining people's rights and a recovery focus.			1.2
Educate and communicate to people what they have to do to maintain their health safety. Maintaining wellbeing and recovery, principles.			2
Clear centralised communication to sector families and communities			

APPENDIX C: Decision Making Workshop

The decision-making session identified six scenarios; based on the group size, five scenarios explored by the group.

- **Scenario 1 -** What does community lockdown mean – the impact on face to face client services
- **Scenario 2** - How do we maintain people's mental health during a lockdown?
- **Scenario 3 -** How do we manage increase in FDV/AOD use in the community during COVID-19?
- **Scenario 4 -** How do we support people with AOD dependency during isolation?
- **Scenario 5 -** Managing a resident who is COVID-19 positive
- **Scenario 6 -** Managing clients with dangerous behaviours relating to infection control

A crisis decision making tool was developed[3] to support the group discussions that worked each scenario through seven steps.

- **STEP 1: Set the purpose of the decision:** What is the primary goal of the decision?
- **STEP 2: Determine required information:** What information is required and from whom?
- **STEP 3: Define principles/criteria:** What are the fundamental principles for assessing the options?
- **STEP 4: Brainstorm and analyse options:** Who needs to be part of the options analysis? And how/where does the analysis happen?
- **STEP 5: Select the best option:** How is the best option identified and who makes the decision?
- **STEP 6: Implement:** Who and how does this decision get implemented?
- **STEP 7: Monitor and evaluate (process and outcome):** How is progress tracked? How is the decision-making process reviewed?

The group was then asked, "What supports/resources would assist in this kind of decision making?"

What follows are the raw notes from the work of the group/s.

[3] Adapted by Aha! Consulting from :**https://d4htechnologies.com/blog/20150811-crisis-management-8-steps-for-formulating-your-decisions**

Scenario 1 - What does community lockdown mean – the impact on face to face client services

STEP 1: Set the purpose of the decision What is the primary goal of the decision?	The purpose is to determine what you are able to support someone to do; keeping someone well and keep people safe from COVID Setting the structures around what we can and can't do (ensuring we are clear about what lockdown means – e.g. people can't attend appointments if outside of their regional location?
STEP 2: Determine required information What information is required and from whom?	Clarity about the limits on people movements at each stage – what are the rules? Is the presenting issue someone who has psychosocial need an essential need or not – e.g. in accessing some other form of service Who has the power to make what decisions in my organisation – what decisions can a support worker make and what requires a decision by others (practically as distinct from legislatively)? Who has the duty of care in the particular scenario? Can the person be tested? What's an appropriate benchmark – a normative benchmark of behaviour A new type/measure of high-risk behaviour Define criteria to assist in determining whether a behaviour puts others at risk This criteria and type/measure need to be mental health/AOD specific/relevant – reflecting the principles we hold dear, that we grapple with In this circumstance, what is good enough?
STEP 3: Define principles/criteria What are the fundamental principles for assessing the options?	Duty of care to person and self and to staff and other consumers This criteria and type/measure needs to be mental health/AOD specific/relevant – reflecting the principles we hold dear, that we grapple with A simple risk framework – the consequences and implications, for individual, others, services What level of risk would be acceptable? What capacity do we have (organisationally and within the sector) to manage the potential options (e.g. isolate someone)? Do we have the capacity to manage the risk? Are we as an organisation prepared to manage that risk? Am I as a staff member prepared to take that risk personally? Is what is required to manage this risk or scenario within the scope of my agreed service?

No responses developed for steps 6 & 7

Scenario 2 - How do we maintain people's mental health during a lockdown?

STEP 1: Set the purpose of the decision What is the primary goal of the decision?	To maintain the individual's wellbeing and, where possible, keep them out of ED and thereby contribute to not overburdening the system
STEP 2: Determine required information What information is required and from whom?	From the person and their family and other supporters Need to know from an organisational perspective what resources we have/may need to advocate for if we don't have them Good to know what others in the sector are doing, so we're not replicating but collaborating as much as possible Need to know what the person is experiencing and are there particular triggers that are exacerbating this Be mindful of how we are assessing what 'triggers' means Workers to broaden their frame of reference re. what 'triggers'/ 'symptoms' are – caution not to medicalise, it may be a trauma response
STEP 3: Define principles/criteria What are the fundamental principles for assessing the options?	Understanding that there are different frames of reference for understanding human behaviour – more humanistic and culturally responsive, inclusive of trauma and issues such as AOD Sector needs to advocate for why principles stand (not just defend them) – person-centred, recovery Safety for the individual and the staff involved Confidentiality (esp. for young people) but also how this is used (not as an 'excuse' for withholding relevant information from key stakeholders, e.g. family)
STEP 4: Brainstorm and analyse options Who needs to be part of the options analysis? And how/where does the analysis happen?	Multidisciplinary Client/family and supporters How to manage communication remotely is an issue – are there checks to see if person has a phone/has enough data. Option for government to talk to telcos re. basic options to facilitate communication Has the person got enough information/too much information to address anxiety? Currently, information is felt to be too bureaucratic/not fit for community purpose. Good resources available in Aboriginal space that could be more broadly used. Let's not reinvent the wheel. App on the COVID virus from government. available – providers can use this to print off resources

STEP 5: Select the best option How is the best option identified and who makes the decision?	Recognise that support is provided by multiple disciplines and make warm referrals to ensure holistic care. Be flexible with frameworks. Communicate clearly with our clients/families regarding our expertise and explain referral options as appropriate (warm referrals important) Who needs to make the decision within the organisation? Clinical, GP What if there's a difference of opinion between community service and clinic – support for consumer/family to escalate Could be case manager if in line with current advice Same issue as currently – very difficult if clinical response is different to psychosocial perspective

No responses developed for steps 6 & 7

Scenario 3 - How do we manage increase in FDV/AOD use in the community during COVID-19?

STEP 1: Set the purpose of the decision What is the primary goal of the decision?	Is assumption that there is an increase in FDV and AOD true? Yes, need some separation of two issues. Need pathways to report and seek help in these instances System needs fine tuning to respond at varying levels of lockdown
STEP 2: Determine required information What information is required and from whom?	What are the existing pathways and what is still available now and going forward? What new pathways are needed for both sending and receiving information or asking for help? How can people stay safe in lockdown?
STEP 3: Define principles/criteria What are the fundamental principles for assessing the options?	Ensure no loss of service Safety for all, staff and clients Choice for clients and staff How to get the 'hardware', i.e. furniture, clothes etc. when moving if services are not working Information being available in appropriate form Transparency between services Services need to be available
STEP 4: Brainstorm and analyse options Who needs to be part of the options analysis? And how/where does the analysis happen?	Police and Dept of Communities, family members, neighbours Plan that takes into account all the stakeholders (manages this) that are sharing information Regional and remote have lack of services How do we deal with lack of Wi-Fi, connectivity, phone coverage? Will still need some face to face contact
STEP 5: Select the best option How is the best option identified and who makes the decision?	In discussion group, not main area of expertise! Services need to continue to have higher contact via phone etc. when face to face not available
STEP 6: Implement Who and how does this decision get implemented?	Peak bodies need to be consulted and working on this with government and community organisations to find a real solution

No response developed for step 7

Scenario 4 - How do we support people with AOD dependency during isolation?

STEP 1: Set the purpose of the decision What is the primary goal of the decision?	Establishing if there's a substance dependency issue and then the severity and the impact
STEP 2: Determine required information What information is required and from whom?	Using a standardised validated tool to establish this (there are a few around). There is AUDIT, DUDIT, SDS and there may be others Information needed – individual's needs; psychotherapy, hospital withdrawal (they might not want this and hospital may not have capacity), service protocols for AOD on site; is pharmacotherapy going to be available for them? Access to safe injecting equipment, issues for remote communities, English as second language
STEP 3: Define principles/criteria What are the fundamental principles for assessing the options?	Harm reduction, severity of impact, physical safety, humane response, mental wellbeing, trauma informed consideration, CALD background, suicide risk, referral and follow up processes, principle of self determination
STEP 4: Brainstorm and analyse options Who needs to be part of the options analysis? And how/where does the analysis happen?	ACCHS-O, family members, consumers, counsellors, peer support workers, Mental Health Commission, prescriber/doctor, alternatives to hospital (e.g. hotels with required professional support), legal advisories *A 'whole of sector' approach is important and this needs to happen now. A centralised communication strategy (taking reflecting fundamental principles); not reliant on 'links'... a simple message that can be put out to the public.
STEP 5: Select the best option How is the best option identified and who makes the decision?	Have a team response (dependent on situation and consumer capacity)

No responses developed for steps 6 & 7

Scenario 5 - Managing a resident who is COVID-19 positive

STEP 1: Set the purpose of the decision What is the primary goal of the decision?	Keeping the client safe. Keeping staff and residents in the facility safe. Keeping the community safe.
STEP 2: Determine required information What information is required and from whom?	How many other residents may have been exposed? Does the client require hospitalisation (for COVID or mental health)? What is the cohort of other residents and what are their risks? Can the client understand instruction and remain isolated? Can the facility allow self-isolation? What is the structure of the facility? Do they share bathrooms/bedrooms? – lodges, hostels Comorbidities of other residents (client may have mild symptoms; residents might have COPD putting them at greater risk of COVID 19 infection) What is staffing availability like? What are the transport to hospital requirements? Are other accommodation options available? Availability of PPE in residence and other additional staffing resources Information required from – Who should be going into a specialist isolation facility?
STEP 3: Define principles/criteria What are the fundamental principles for assessing the options?	Human rights – restrictive isolation, other residents who are exposed, rights of everyone to be safe, will human rights be cut off? Who will take up the responsibility for the client? Legal rights – Availability of continuity of care Least restrictive practices Public Health Act Residential facilities policy and procedures Police involvement Human resources – staff at risk of losing their jobs. Important to keep the workforce in WORK Delegated authority? (security) Cruise ship analogy – lots of stationary cruise ships in the state

	Who will provide the clinical care? Who will provide the staff? Mobile workforce (like a mobile testing group) NDIS staff – not doing direct care Residential facility Analysis at facility level
STEP 4: Brainstorm and analyse options Who needs to be part of the options analysis? And how/where does the analysis happen?	The facility the resident is at State hospitals Isolation facility First stage: self-isolation in place/hostel Second stage: if cant self-isolate, due to lack of resources or cognitive impairment, move to another facility Third stage: needs decision making matrix for how to determine who should go into an isolation facility voluntarily/involuntarily
STEP 5: Select the best option How is the best option identified and who makes the decision?	The person/client/resident Family and carers/guardian Facility management/Housing/lodge provider

No responses developed for steps 6 & 7

What supports/resources would assist in this kind of decision making?

Clear escalation process laid out • Consideration given to legal rights of individuals • **Consideration given to rural areas that have limited isolation options** • Safety matrix frameworks that outline and support the assessment process and enable weighting of different options (cultural appropriateness)
Call centre to assist in navigating different situations (advice and sounding board) • Ensuring these people understand the context of Service Providers and are not just driven by clinical decision making – contemporary mental health • Accessible for rural and remote • People able to facilitate the process of decision making
Maintain normal contact procedures • Licensed and non-licensed facilities
Providing advocacy for consumers and for our staff so that the two needs are not played off against each other
Clear guidelines on the requirements of each stage of response (each stage 2 and 3) • The options available will change, based on the response level
Can the Public Health Act allow services like tele-health to be made available to this sector, to enable remote care? • Are there other models of care? • Ensuring flexibility for access for rural and remote • Looking to provide more frequent supports that it not face to face
Models of care that provide the additional support needed by existing clients and by people who are in greater distress who would not normally need our support • Repurpose NDIS staff to provide this support that is not face to face
Access to PPE for stage 2 to enable the required support
Look to flexibility of funding and service deployment of NFPs to allow alternative forms of service to be established
Which remote counselling/support options, particularly online, meet privacy standards and legislation where they don't have access to telehealth?

APPENDIX D: Non-Residential Services Workshop

The Non-residential service workshop focussed on four main questions.

- What changes have you observed in the community and other types of services (e.g. medical etc.)?
- How are these changes impacting on non-residential service and staff?
- How are these changes impacting on non-residential consumers and clients?
- What are the top six things that would support your organisation at this time and why?

What follows are the themed notes for each question and the raw notes from the group/s.

What changes have you observed in the community and other types of services (e.g. medical etc.)?

Changes to physical contact

- Increased physical distancing in social settings
- Reduction in face-to-face consultations/services, e.g. tenancy inspections
- Increase in telehealth consultations; minimising walk-ins

Changes to work practices

- Increased frequency in contacting mental health program participants
- Decrease in group work, including support groups
- Home visits done via telephone
- More variable contact with consumers and clients, though more flexible arrangements
- Increase in health & infection control protocols
- Limited face to face contact where service considers it essential, moved to outdoors settings
- Working from home, including online meetings
- Glass screens in health services/chemists
- Challenges towards cultural practices of funerals
- Unable to visit remote and indigenous communities
- Greater risk to staff health

General community changes

- Work loss and uncertainty in job security, particularly for those unable or unwilling to provide face to face support
- Variable consumer desires: face to face vs telehealth
- Shortage of groceries
- Increased personal distress and uncertainty about personal/others' hygiene
- Decrease in socialising
- Concerns for safety due to family/partner violence
- Increase in flexi-work
- Decrease in workforce wellbeing

How are these changes impacting on non-residential service and staff?

- Increased frequency in contacting mental health program participants
- Increased pressure to adjust work procedures
- Increased physical health risks
- Increased stress and uncertainty
- Requires staff to undertake COVID-19 risk assessment
- More mindful of health and safety risks
- Requires learning technology for online services
- More difficult to build rapport with client
- Increased burnout due to additional work demands
- Having to consider the prioritisation of clients due to limited resources; adds stress to staff due to being unable to meet community needs
- Vulnerable staff are working from home
- Challenging to upskill or train staff in different roles

How are these changes impacting on non-residential clients and consumers?

- Challenging to run meetings with external stakeholders
- Consumers feel less supported
- Increased confusion or uncertainty towards services available
- Increase loneliness and isolation add pressure to staff
- Increased apprehension towards telehealth and online meetings
- Increased attendance of sessions due to flexibility
- Decrease in group session work
- Changes to funeral and cultural practices add stress for families and individuals
- Clients unable to see preferred staff/consultants

What are the top six things that would support your organisation at this time?

- Greater accessibility and flexibility of technology for clients. This includes having technology services that allow group sessions and online services that meet privacy standards
    - This was a priority to ensure the wide distribution and streamlined access to services
- Addressing workers' wellbeing, mental health and self-care, having supportive leadership and ensuring worker safety in face-to-face services
    - This was a priority to ensure that staff could continue to provide a high level of services
- Ensuring flexibility from management in order to provide services, including increased funding and staff capacity and providing support in working from home
    - This would ensure being flexible in adapting to changing circumstances in client needs and ensuring that services are running at maximum capacity
- Clearer procedures in place so clients and families are able to better understand what services are available in routine and non-routine situations, as well as resources and support to ensure cultural security in service provision
    - This was a priority to ensure that clients could be provided with the relevant support and to ensure that families are better able to support the individual
- Greater availability of carer support for clients and families, including access to transport and delivery services and access to cleaning supplies
    - This was a priority because families could also provide support to individuals

Raw Notes of Each Group

Group 1 - Service Providers and staff

What changes have you observed in the community and other types of services (e.g. medical etc.)?	How are these changes impacting on non-residential service and staff?
Telehealth	External stakeholder meetings difficult to run, limited technology. Staff using phone and internet to reach out to people
Physical distancing and stay at home rules	RW – face to face initially and then other support through phone Adapting to seeing people outside so physical distancing can be managed
Shortages of items in the supermarket	Stressful for people trying to get shopping (many people live in poverty and are used to shopping daily), items like sausages were not on shelves
Reduction in face to face psychosocial support	Loneliness and isolation are increasing for consumers and clients, adding pressure to staff
No face to face tenancy inspections	Reduced services
Increased distress for some people	Increased pressure on staff to work differently
The way that the public trustee administers funds, i.e. every second day, can mean that the person is accessing supermarkets etc. more frequently	Increased physical health risk on staff creates stress on person and staff
Workforce wellbeing and concerns with job security	High levels of stress and uncertainty
Overall reduction in face to face practice	Staff are having to undertake COVID risk assessment of clients prior to home visits
	Staff are more cautious

	What are the top six things that would support your organisation at this time? (#1 = highest priority)	Why is this the priority?
1	Access to transport and/or delivery services	To enable tenants/clients to be able to self-isolate without hardship
2	Clear understanding of pathways if emergency dept/ hospitalisation are no longer options, including disparity between consumer report of own wellbeing compared with family/mental health support reports	High risk clients – potentially high risk consequences
3	Addressing burnout of workforce – supporting social and emotional wellbeing	The mental health workforce are highly skilled and hard to replace
4	Alternatives to telehealth – including clear guidelines about which services meet privacy standards	Some service access is poor, not every client wants to use it
5	Resources and support to ensure cultural security in service provision, including access to advisers/clinical advisers/cultural mentors	WA is a multicultural society also LGBTIQ+ and other vulnerable cultural groups
6	Provision of technical or other resources, including crisis support to support vulnerable clients, e.g. DFV (for example crisis support team available 24/7)	Increased vulnerability of some key client groups, frustration at lack of access outside of 'working hours'

Group 2 - Service Providers and staff

What changes have you observed in the community and other types of services (e.g. medical etc.)?	How are these changes impacting on non-residential service and staff?
Depot appointments still occurring; however, would like more phone contact check ins in between ... could even be different staff doing this	Family not sure about what happens if someone becomes very unwell/distressed?
GPs/chemists – glass screens up; some chemists don't allow customers in	Increased anxiety and paranoia?
Some services mostly working on the phone now for sessions … changed the nature of how we're doing it. Contacting mental health program participants more regularly to see how they are. Using Zoom a lot and also rostering staff at the centre. Ensuring staff feel connected and supported.	Noticed reaction from clients initially due to changes of not being able to go to groups ... a lot of apprehension at first of how it will work. Have noticed, however, they feel quite supported and clients are appreciative of being 'reached out to'. Less DNA (do not attend) with counselling sessions ... clients attending sessions more via phone ... maybe fewer transport constraints. Wonder if this will change as we progress through stages. Staff have also adjusted well to working from home. Pressure on staff to get groups on line. A lot of work, transitioning all the 'tech stuff' set up and then expecting them to capture information. Getting a bit behind ... telling staff to do what they can. A big part of work was groups and we have lost this due to physical distancing.
Home visits are now done via phone Offering Zoom, video, WhatsApp. DCP not doing home visits now	Positive feedback from clients ... able to have more flexibility and check in more often. Building a rapport with new clients is more challenging over the phone. If we could meet once that would make a difference. Video, Zoom etc. don't always work for clients. Challenging knowing that the perpetrator is back in the house ... fewer 'eyes' on vulnerable people and children at risk. Clients may 'disappear', particularly AOD .. how to find them again if they disappear.
	Increased pressure on staff all round ... concern about further stress added

	What are the top six things that would support your organisation at this time? (#1 = highest priority)	Why is this the priority?
1	Access to technological modality (IT platforms and skills) by staff and consumers – it's already occurring but to further advance it would be good, to make it more readily available; people are now asking for it more than they did previously. Not just for 1:1 but also for groups – allowing group members to talk to each other. MS Teams and Facetime are some that are currently being used. Have looked at Messenger, the non-FB version.	To enable shifts from face to face where necessary
2	PPE Self-care (wellbeing) of workers who are at the coal face – to ensure workers mental health (external reminders)	So staff and consumers can all feel safe
3	More regular updates from what other local services are doing in terms of their changes in service delivery in a centralised place Including somewhere to ask questions for remote areas about being able to move between places in remote areas – is that about someone to ask for clarification questions or about understanding the new rules in practice?	So that we know what's happening elsewhere and can ensure people have up to date info on service delivery
4	Additional capacity down the track – think that there will be a need for additional capacity as lockdown continues to address increase in expected demand Retain NDIS workforce – e.g. group work that used to be done under NDIS is now done 1:1 – can't meet all those needs with the envelope Increased drug and alcohol support and ensuring people can detox safely, especially in regional/remote areas – if they have to be removed to Perth	
5	Ensuring flexibility from management Feedback from staff at coal face about what is happening on the ground being actively sought	To ensure good organisational culture
6		

Group 3 - Service Providers and Staff

What changes have you observed in the community and other types of services (e.g.: medical etc.)?	How are these changes impacting on non-residential service and staff?
Telephone GP appointments more readily available	Organising clients and GP appointment and ensuring that goes ahead Medication and scripts
Self-select to isolate – have to be more flexible with telehealth and have to provide services. Coaching them through meal prepping over the phone rather than helping them in the home	Be more diverse, think outside the square. Less of a recovery mode and more of 'doing' during this period of time More flexibility
Staff – vulnerable staff 50 years and over. Introducing telephone service and minimise walk-ins. Uptake getting better	Staff are frightened but are coming to work, need to pay the bills. Can't volunteer to stay home. Change service delivery, e.g. telephone service. Burn-out – for Aboriginal communities it is not just a 9 - 5. Staff take many calls after hours and can get burnt out.
Cultural practices have been very hard especially when it comes to funerals	Funeral, law time, SEWB, cultural practice – very hard and are impacting on the whole family
Social and emotional wellbeing – people who have lost jobs; poverty has been hard	Impact whole of WA – some services are changing service delivery, e.g. food security, care packages, drop off service to help clients
Be more flexible with workforce – more people around organisation to keep staff hours up.	Staff are working with clients that they are not familiar with which can be challenging for both parties. Some clients want specific staff members.
Way we communicate for business – we used to get everyone together in a room and now we are connected via Zoom	Face to face meetings aren't happening. Less informal chat. Zoom meetings are more matter of fact.
Very quiete on the streets/no physical contact with people (friends, family)	
Move away from transporting clients – now we have to transport them as they don't want to take buses etc. Other services have to increase services.	
GP flu shots – GPs doing home visits	
Regional and remote – where do people go for services? Frightened to go outdoors. Transmission from overseas	

travel/cruise ships. Discussing how to contain within community?	
Cultural protocols – viewings for a passing family member Changes to visitors in hospitals Carers can no longer fly in from rural and remote, patients only	Big impact on staff
NDIS support packages	

	What are the top six things that would support your organisation at this time? (#1 = highest priority)	Why is this the priority?
1	Looking out (calls) to the support network and families of the consumer/client	This allows the support network of the consumer/client the chance to get the support to then pass this on
2	Ramping up carer and family support through existing carer and into other organisations Carer supports now being asked for around COVID-19	Carers/families are often the critical support for consumers, perhaps more important than ever
3	Workforce – security and increased workforce. Need to ramp up shared workforce collaborative recruitment, onboarding and deployment. One provider noted they are are doing this already through MOUs with other organisations. If block funding continues, at least we can sustain workforce (even if not at capacity right now, it may be needed very quickly). Ability to go work for another provider for a while. Difficulty - IR leg (Fair Work) and alignment across organisations.	
4	Some consumers have had all their support withdrawn. Needs to be flexibility within the funding/contracting side of things. This is more of an issue with NDIS than the block funding. NDIS is quite restrictive. Hostels are locked and support workers can't go in.	Organisations need to be able to respond flexibly to the changed environment This is still not clear enough or flexible enough
5	More resources to ramp up services – for phone line staff for example – to respond to emerging and anticipated increased demand	
6	How to provide supports one on one, e.g. in open space. Clarity around what is ok, what is essential and what isn't. One staff not always enough where there are concerns (may need two workers) – impacts the most vulnerable	

Group 4 - Consumers and clients

What changes have you observed in the community and other types of services (e.g. medical etc.)?	How are these changes impacting on non-residential consumers and clients?
Dramatic change – usually do 1:1 and group work and all group work has ceased which is a substantial loss of contact time. Sometimes we are the only contact someone has in a week. Trying to still maintain 1:1 contact with group members via phone but also sending out group texts that go to all consumers; reminding them we're available, useful info, things. Some we have to contact several times. Some are happy to be isolated. Still doing some face to face with 1:1 with physical distancing and hygiene in place but no PPE, but some consumers don't want face to face at all	Heavier on staff resources Staff morale is good and that flows on But we can't be in touch with everyone We do educational groups and physical health groups – such a wide range of groups. Some people are now very isolated.
Still doing face to face – but can't visit remote or Aboriginal communities. Getting hold of people on the phone is very difficult, so still going door to door to check in with people – observing physical distancing – made easier Because of where we are it's easy as everyone knows us – e.g. we beep from out front Still lots of people breaking the rules – lots of people coming into town from communities	Phone contact is not reliable – and so, if we weren't being active just wouldn't connect with people at all Still managing to maintain cultural safety Prioritising most vulnerable – so they know we are here Local supermarket is supporting prioritising supplies to our clients Both members express great confidence in ability to adapt and manage their face to face services and confident about observing physical limitations and hygiene Very supportive organisational leadership in terms of taking an inclusive/holistic approach to mental health. Haven't had to step out of boundaries as the boundaries are wide/holistic.
Little information from shire or police about what they are doing (e.g. to keep people in communities observing restrictions)	
Re. changes – it will impact as weeks go on but not yet. We have many shared consumers with public community mental health teams. The community mental health teams or our staff are often the only people that [incomplete]	

	Express confidence about understanding the guidelines and how to incorporate them in face to face contact – no staff are put in a position where they aren't comfortable. Vulnerable staff are working from home.

	What are the top six things that would support your organisation at this time? (#1 = highest priority)	Why is this the priority?
1	Support from your organisation to complete your work in a different setting and be adaptable, particularly with the changing circumstances and external pressures such as working from home and home schooling	So that people can continue to function and meet all of their commitments
2	MHC should commit to ensure that they help take the pressure off and not add to pressure – every organisation has a plan to stay active and thrive and keep providing meaningful services for at least six months	Viability of each organisation benefits the sector and MHC in the long term
3	Funding parties recognising the commitment and adaptability to continue to provide services. Recognising that, although some clients are reducing, services are increasing and that funding needs to be ensured to continue to provide services.	The fluctuating environment needs fast response and security of resources is needed to continue to operate at maximum capacity
4	Practical solutions to the delivery of services (tenants) – helping people have access to essential services and have connectivity (phones and internet), reducing financial pressures on tenants and making sure they can get food, pharmaceuticals and goods delivered to clients so that they can isolate. Important to have practical essential services to keep vulnerable people out of the community, particularly for the most vulnerable – to extend the landlord function to ensure people are getting what they need.	Making sure the most vulnerable people can have their needs met and can avoid risk by isolating
5	Access to adequate and appropriate personal protective equipment (PPE)	Health and safety of staff and clients
6	People in shared living environments – cleaning procedures for people in congregate living arrangements which increase risk. Ensuring adequate cleaning supplies and regular cleaning protocols of shared living spaces and frequently used features.	Health and safety
7.	More resources to enable flexibility of responses now required, particularly in relation to technological equipment and resources delivered expeditiously so that responses can be swift and effective	People now isolating need access to the technology if they do not have it so that they still have access to services

Group 5 - Consumers and clients

What changes have you observed in the community and other types of services (e.g. medical etc.)?	How are these changes impacting on non-residential service and staff?
Loss of group work – ability to run support groups and group sessions	Impact on consumers, feeling less supported
Services delivering one to one via Skype and other alternatives	Upskilling client cohort with modern technology – in a hurry Difficult for some consumers to set up video technology Some staff working from home can only offer telephone access, need adequate resourcing
Loss of some aspects of services provision (AOD sector)	
Staff stood down from some services reassigned to support whole of operations, as part of remodelling	Challenge to upskill staff in other service delivery where staff reassigned to different roles
Increased contact with consumers, flexible support options provided to maximise control the client has in this situation	Overall good response from consumers; has helped staff that this has been received positively
Uncertainty around what will need to change with the next phase	
Some services putting a hold on intake as unsure whether able to support these clients	Waitlisting gives staff a sense of not being able to meet community need, particularly if consumer has an urgent need

	What are the top six things that would support your organisation at this time? (#1 = highest priority)	Why is this the priority?
1	Leadership that is supportive, encouraging and the central point for guidance. For the sector in general relating to COVID-19	This will assist in providing a clear line of communication between government regulations and sector practice. This would be a central point of information as well, to help people understand where we are at as a sector and what that means. Support in preparation for COVID-19 impact as we do not have a time frame for this situation for sustainability. Change management planning.
2	IT support for consumers that is very simplified, where a video link can be accessible and easy to connect with service/support workers. Could we use platforms they are already familiar with for consumers, like Facebook messenger?	This is integral to operating in this new environment with people who may have limited experience with the sharing/conference technologies. Using a platform consumers are already familiar with means the sector is letting the consumer take the lead in managing their wellness.
3	Training and sector development for staff and support workers, including debriefing and self-care support	Because workers are under increasingly more demand and will need support in how to work in this new way and set new professional/self-care boundaries
4	Increase in funding and staffing capacity	More money will mean more adaptability to the new situation and also being able to pay new staff and for their training. More staff will mean more hands on deck to offer the one-on-one supports that we are learning is what consumers require.
5	Reassurance around level of clinical service provision as the COVID-19 situation unfolds	Because it informs the level of care for consumers and will help minimise the level of anxiety around not knowing
6		

Group 6 - Consumers and clients

What changes have you observed in the community and other types of services (e.g. medical etc.)?	How are these changes impacting on non-residential service and staff?
Lot of protocol coming for health/infection control that is overwhelming people within the community and sector.	Creating a lot of work and uncertainty, operating on a day-to-day basis and trying to stay flexible with service delivery
A kind of 'distrust' has emerged with people, "should I be here?"	
People have become friendlier in the community, happier to say hello. As long as people keep their distance!	
Guilt at being out and about – is this essential?	
Clinical services have aspects that are clear about keeping people out of emergency dept, but no clarity on what the other options are. Lack of clarity about what they CAN do, but plenty of clarity about what they CAN'T do.	Anxiety is heightened with consumers and in the sector; there is no clear pathways for serious mental health challenges that would have people traditionally placed in hospital
Families aren't clear about what the avenues for help and support are	Increase in queries and confusion. These services would be trying to find supports that fill the gaps created by families not being able to step in if they are for example isolating. Solution would be better collaboration between the care partners.
People are asking how can we can make this work and are seeking new ways of doing things	Leadership is required from management in these services to make this happen and address the how

There were only five groups created for the top six priority questions.

APPENDIX E: Participant List

Session 1 - Supported Accommodation Services

Organisation/Company	Category
ASeTTS	Service Provider
2 x Representatives from WAAMH	Peak
HelpingMinds	Service Provider
St Barts	Service Provider
Rise Network	Service Provider
Aboriginal Males Healing Centre Strong Spirit Strong Families Strong Culture Inc	Service Provider
2 x Representatives from Vinnies Mental Health Service	Service Provider
Mission Australia	Service Provider
St Barts	Service Provider
Department of Health COVID planning mental health stream	Government
Foundation Housing Ltd	Service Provider
Department of Communities	Government
CoMHWA	Peak
Mental Health Matters 2	Consumer/Family rep
Mental Illness Fellowship of WA	Service Provider
4 x Representatives from Department of Health	Government
Fusion Australia Ltd	Service Provider
4 x Representatives from Roshana group of companies	Service Provider
Life without Barriers	Service Provider
Mind Australia	Service Provider
3 x Representatives from Southern Cross Care group of companies	Service Provider
3 x Representatives from Richmond wellbeing	Service Provider
Mediwest Pty Ltd	
Cana Communities	Service Provider
Access Housing	Service Provider
MHM2	Consumer/Family rep

Session 2 - Workforce

Organisation/Company	Category
ASeTTS	Service Provider
2 x Representatives from WAAMH	Peak
360 Health and Community	Service Provider
Avivo	Service Provider
HelpingMinds	Service Provider
St Bartholomew's House	Service Provider
Rise Network	Service Provider
Aboriginal Males Healing Centre Strong Spirit Strong Families Strong Culture Inc	Service Provider
Mission Australia	Service Provider
3 x Representatives from Department of Health	Government
360 Health + Community	Service Provider
2 x Representatives from Mental Health Matters 2	Consumer rep
Mental Illness Fellowship of WA	Service Provider
Samaritans WA	Service Provider
Youth Focus	Service Provider
4 x Representatives from Roshana Group of companies	Service Provider
5 x Representatives from Richmond Wellbeing	Service Provider
4 x Representatives from Mental Health Commission	Government
Carers WA	Consumer/Family rep
Life without Barriers	Service Provider
Fusion Australia LTD (Geraldton)	Service Provider
Southern Cross Care WA	Service Provider
WANADA	Peak
360 Community Health	Service Provider
Access Housing	Service Provider
St Vincent de Paul	Service Provider
Women's Health and Family Services	Service Provider
WANADA	Peak
Youth Focus	Service Provider
Uniting Care West	Service Provider

Session 3 - Decision Making Support

Organisation/Company	Category
ASeTTS	Service Provider
3 x Representatives from 360 Health + Community	Service Provider
HelpingMinds	Service Provider
Mission Australia	Service Provider
3 x Representatives from Department of Health	Government
2 x Representatives from Foundation Housing Ltd	Service Provider
2 x Representatives from Mental Health Matters 2	Consumer/Family rep
CoMHWA	Peak
Mental Illness Fellowship of WA	Service Provider
MHC	Government
Richmond Wellbeing	Service Provider
4 x Representatives from Roshana Group of Companies	Service Provider
3 x Representatives from Carers WA	Service Provider
Richmond Well being	Service Provider
Life without Barriers	Service Provider
Fusion Australia Ltd (Geraldton)	Service Provider
Access Housing	Service Provider
Vinnies Mental Health Service	Service Provider
WALGA	Peak
Unknown	Unknown
Aboriginal Health Council of WA	Peak
2 x Representatives from Mental Health Advocacy Service	Government
Lamp Inc	Service Provider

Session 4 - Non-residential Services

Organisation/Company	Category
360 Health + Community	Service Provider
HelpingMinds	Service Provider
Rise Network	Service Provider
Aboriginal Males Healing Centre Strong Spirit Strong Families Strong Culture Inc	Service Provider
St Barts	Service Provider
3 x Representatives from Department of Health	Government
360 Health + Community	Service Provider
2 x Representatives from Mental Health Matters 2	Consumer/Family rep
Carers WA	Service Provider
WAAMH	Peak
Mental Illness Fellowship of WA	Service Provider
3 x Representatives from Roshana Group of Companies	Service Provider
2 x Representatives from Richmond Wellbeing	Service Provider
Southern Cross Care	Service Provider
2 x Representatives from UnitingCare West	Service Provider
Lifeline WA	Service Provider
2 x Representatives from ECU Student Guild	Service Provider
Reclink Australia	Service Provider
Life without Barriers	Service Provider
Holyoake	Service Provider
Mission Australia	Service Provider
Access Housing	Service Provider
Mental Health Law Centre	Service Provider
Vinnies Mental Health Service	Service Provider
Chorus Australia Limited	Service Provider
WALGA	Peak
2 x Representatives from Neami National	Service Provider
Womens Health and Family Services	Service Provider
AHCWA	Peak
4 x Representatives from Mental Health Commission	Government

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