MENTAL HEALTH NGO SUBSECTOR COMMISSIONING: DESIGN PHASE

Insights Report

May 2024

ACT Commissioning for Outcomes
2022- 2025

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Acronyms

ACTHD	**ACT Health Directorate**
ACTCOSS	**ACT Council of Social Services**
ACTMHCN	**ACT Mental Health Consumer Network**
AOD	**Alcohol and Other Drugs**
ATOD	**Alcohol, Tobacco, and other Drugs**
CALD	**Culturally and Linguistically Diverse**
CES and YES	**Carer Experience of service and Your Experience of service**
CHN	**Capital Health Network**
CHS	**Canberra Health Services**
CSD	**Community Services Directorate**
IAR	**Initial Assessment and Referral**
JACS	**Justice and Community Safety Directorate**
LGBTIQA+	**Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual +**
MHCC	**Mental Health Community Coalition**
MHCT	**Mental Health Commissioning Team**
MHSPD	**Mental Health and Suicide Prevention Division**
NGO	**Non-Government Organisations**

Introduction

The ACT Government is committed to supporting the mental health and wellbeing of the ACT community and working towards the Territory-wide vision of a kind, connected, and informed community working together to promote and protect the mental health and wellbeing of all. This vision informs all work in the Mental Health and Suicide Prevention Division (MHSPD) of the ACT Health Directorate (ACTHD), including the commissioning of community mental health and suicide prevention services.

The community mental health subsector delivers a range of programs and services across the spectrum of need in the ACT, including mental health promotion, prevention, and early intervention for those with mental health concerns, suicide prevention, and specific interventions, and support for people experiencing mental illness. These services are complemented by programs involving systemic and individual advocacy, capacity building and research.

ACTHD is embarking on a new approach to commissioning community-based Non-Government Organisation (NGO) mental health services in the ACT. This commissioning approach is being rolled out across the ACT Government, and more information can be found about it on the ACT's Commissioning webpage, here. Currently, the Mental Health Commissioning Process is in its Design phase. The Design phase is where essential collaboration with sector partners, service providers, consumers, carers and other stakeholders takes place. The Design phase enables us to examine, shape and involved services, and align key service models and characteristics with health and wellbeing outcomes for the community.

Working in collaboration with the mental health sector, other areas of government and people with lived experience, ACTHD's Mental Health Commissioning Team (MHCT) have been researching and consulting widely during the Design phase of commissioning, building on the work which took place over the Discover and Strategise phases of the commissioning process.

Throughout the Design Phase consultations, the MHCT has heard insightful and meaningful feedback about what the ACT Government funded non-government organisation mental health subsector should look like through story sharing, detailed discussions, research, and examples.

This Insights Report aims to collate feedback received from all consultation opportunities and link key themes with other relevant information and context. This feedback also includes tables and lists of 'possible improvements' that community would like to see in the sector. The MHCT would like to note that this report is not a commitment to these improvements, but rather a discussion paper, and working document for the commissioning process. Additionally, some of the information provided during consultation and discussed in this report are not within the scope of change for the ACTHD commissioning process. However, these points are still highlighted and discussed as they impact the role of the NGO mental health sector.

The MHCT has documented the feedback on each consultation activity in detail. These are attached as an appendix to this Insights Report.

The MHCT would like to thank all those involved throughout this process, and in particular the Commissioning Advisory Group, for the effort that you continue to give to support this process. The ACTHD also acknowledges Capital Health Network's (CHN) role as a commissioner in the ACT. Collaboration between the ACTHD and CHN will help to establish an effective, accessible, and complementary network of services and support for Canberrans.

Design Phase Consultations to date

To start consultations, ACTHD's MHCT published the 'Blueprint for the Design Phase' (the Blueprint)[1]. This document highlights key considerations for the commissioning of an effective mental health system and sector and was hosted on YourSay and the commissioning webpage from 8 May until 7 July 2023.

The MHCT also developed a range of feedback papers, with accompanying discussion guides, to facilitate conversations and input from the ACT community around the needs of priority groups. This included papers on: the Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual and other terms of gender and sexuality (LGBTIQA+) community; Children and Young People; Older People; the Culturally and Linguistically Diverse (CALD) communities; and Carers.

Building on these consultation documents, the MHCT held workshops on a range of topics, including developing an outcomes framework, a workshop for consumers and carers, a focus on prevention and promotion activities, and co-occurring conditions. The MHCT also attended events with Carers ACT and ACTMHCN to speak directly with people with lived experience.

We received 48 written submissions in response to the Blueprint and feedback papers, and there were over 70 attendances across the workshops and outreach consultations.

After reviewing all of the feedback, the MHCT grouped the topics into key themes and ideas. From this grouping, 10 themes emerged. These were:

1. Sector principles
2. Accessibility
3. Navigation
4. Workforce
5. Collaboration
6. Co-occurring conditions and situational complexity
7. Outcomes
8. Funding
9. System structure

10. Priority groups

The rest of this report addresses these themes in detail and includes overviews of the feedback heard, research and contextual information, and potential areas where further consultation will be important during the next section of our Design phase in 2024.

1. Sector Principles

The Blueprint outlined a number of principles that should underpin the mental health service sector. These included the sector being:

- Focused on outcomes;
- Sustainable;
- Collaborative;
- Recovery focused, person-led, holistic and human rights informed;
- Accessible and easy to navigate; and
- Focused on prevention and early intervention.

These principles were spoken about in relation to every priority group and service type in the sector. A number of these such as outcomes, navigation, and collaboration are addressed as separate sections in this report as there was significant discussion around the importance of these in design. However, there were several comments received through consultations that focused on services and the sector upholding the principles of trauma informed, recovery, person centred, and human rights-based care. This section will review each of these areas.

Trauma Informed

Throughout consultations, there was strong recognition of the need to be 'trauma-informed' in our approach to working with consumers and carers, and a desire for this to be a focus for the sector moving forward.

ACTHD understands Trauma is a response to a deeply distressing or disturbing event that overwhelms a person's capacity to cope. Trauma can have a significant and wide-ranging impact on individuals, communities, and society. Trauma-informed practice in service delivery is moving from knowing about trauma to being able to identify, understand and respond to trauma.

Trauma-informed practice recognises that trauma is common and that people accessing and delivering services may be affected by trauma. It is an approach that is holistic, empowering, strengths-focused, collaborative and reflective. This requires an on-going process of organisational change and development. The MHCT recognise that it is important to implement consistent trauma informed practices across commissioned services.

As of November 2023, the ACT Government has created a Position Statement on Trauma Informed Practice for Children and Young People. While it is noted that this position statement is targeted at young people, much of the information and principles within it apply to the general population as well. This may support ACTHD to help guide other sector partners to address their focus on trauma-informed care, noting that this shift will not happen suddenly and will need to be a collaborative step to ensure the best outcomes for the ACT community.

Many examples and resources referenced within the Position Statement are available free of charge and are relevant to a wide range of age cohorts and services. The ACT Position Statement on Trauma Informed Practices for Children and Young people is available here.

Person-centred care

Delivering person-centred care across the service system was a priority highlighted throughout the consultation process. The aim of person-centred care in mental health is to tailor support to the specific circumstances, needs, and goals of the consumer. It involves fostering an authentic partnership between the service and the consumer and it approaches mental health and wellbeing from a holistic point of view. This means working with a consumer as a whole person and looking at all the factors that may impact their life and wellbeing, rather than only treating their diagnosis.

We heard that there are barriers preventing the provision of person-centred care, including:

- Assumptions made about an individual’s background and causes of mental ill health, especially in the case of particular priority groups, such as LGBTIQA+ people;
- Not acknowledging the impact of stigma and discrimination;
- Beliefs by clinicians that they need to ‘know all’ about a person before providing support;
- Assumptions by consumers that clinicians have a ‘complete’ system understanding of community and clinical services, and will know what would provide the greatest, accessible support for an individual; and
- Involuntary treatment in acute inpatient and emergency services as directed under the *Mental Health Act 2015* being in opposition to the principle of person-centred care.

Some suggested ways that the sector might provide a more person-centred care experience are:

- Providing safe and non-judgemental services and care environments;
- Providing choice in the kinds of services that are available;
- Greater collaboration and accessible navigation between services;
- Improving overall awareness of what support is available in the sector;
- Focus on promotion and prevention activities to improve mental health literacy in the sector;
- Providing trauma informed care; and
- Improving cultural and psychological safety within services.

When considering person-centred approaches to a service system it is also important to hear the experience of consumers and those with lived experience. The MHCT heard that it is important to consider the role of lived experience research in creating a person-centred service system. There are both national and local research teams looking at the impacts that

services can have on individuals. This research will be considered in the design of the service system.

Recovery Focused with a Human Rights Lens

Recovery has a different meaning to each individual. It involves identifying what they would like to achieve in their recovery journey. Recovery is underpinned with the values of self-determination and empowerment, and what this looks like to an individual. For some this may be contributing to a community, having meaningful relationships, or making and achieving goals. The concept of recovery as defined in this way was supported through consultations and the Commonwealth Government's Framework for Recovery-Orientated Mental Health[2]. However, through consultations there were some misunderstandings that the term recovery, as written in the Blueprint, was being used in a clinical sense and marks someone 'being recovered'. The design consultations showed a strong preference that commissioned services should focus on the broad and individualised sense of recovery and journey described in the Framework's definition rather than having the deficit-based clinical approach of trying to 'fix' someone's mental health.

The importance of applying a human rights lens across the sector was a strong theme in consultations, with an acknowledgement that mental health concerns are intersectional and inextricably linked with, among other things, systemic disadvantage, racial discrimination, poverty, and trauma. It is vital that our service system prioritises and safeguards the fundamental rights and dignity of people experiencing mental health challenges. Upholding human rights in the sector is also influenced and governed by the United Nations Convention on the Rights of Persons with Disabilities. Under this Convention, Australia has committed to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities as well as promoting respect for their inherent dignity[3].

2. Accessibility

Accessibility is a broad term, but in the mental health sector describes whether, and how easily, an individual can engage with a service. There are a range of accessibility considerations, including, but not limited to, physical accessibility, safety, and location of services, which may impact an individual's engagement with a service.

Consumers, carers, and sector representatives all discussed the importance of ensuring mental health services are accessible. The table below summarises major themes which emerged in this space. These themes were:

- Physical accessibility and location;
- Accessibility of intake and assessment processes; and
- Choice and cultural safety.

Themes:	Possible improvements for the sector:
Physical accessibility and location: Physical facilities, location, and opening hours can be a barrier for accessibility.	• Provide services spread across the ACT, and ensure they are close to transport options • Ensure facilities are suitable for people with disabilities and mobility issues • Ensure gender neutral toilets and facilities are available • Increase the availability of services outside of standard hours • Provide services in home-like environments
Intake and assessment process: Accessing a service for the first time may be difficult. Forms and assessments can be lengthy and re-traumatising.	• Reduce the need for people to retell their stories • Share information between services where possible • Simplify intake systems and reduce use of unnecessary questions • Increase walk-in services
Choice and cultural safety: Not all services are culturally safe. Some branding may be seen as a barrier to access, including religious affiliations or promotion of 'western' mental health practices.	• Provide opportunity for feedback and continuous learning for the workforce relating to cultural safety • Improve connections with diverse consumer groups through greater staff representation • Use of culturally appropriate language in services and documents • Where programs are open to the public, use large venues or community recreation centres for programs, rather than churches or other areas that may not feel welcoming and accepting to all • Increase safety as a design consideration of physical spaces

	• Embrace First Nations culture in the design of care spaces • Remove or limit government branding of mental health services where this may limit uptake • Consider service names and their target group to ensure the name of the service is welcoming and appropriately descriptive • Consider how different services and people may engage with religiously affiliated services

Psychological safety was an important theme raised across all consultation activities. It is important to identify what safety means to the different groups of people with whom the mental health sector works, and specific ways services can support individuals to feel safe and welcomed. Many of these groups, including culturally and linguistically diverse (CALD) communities and First Nations people, are currently the focus of specific projects across ACTHD. The MHCT is working closely with these project teams to ensure findings are integrated into commissioning and where relevant, new and existing services. A large amount of input was also received in relation to the LGBTIQA+ community, which is explored in a dedicated section of this report.

Improving physical accessibility was a common suggestion from across the sector and community. People conveyed that services should be provided in locations with easy access to public transport, or at least with easy access through other forms of transport (e.g., parking). It was also recommended that services should be available in multiple locations to reduce travel times for those in the outer suburbs of Canberra.

The idea of co-locating different services in one place or facility was also raised by the community as a potential solution to a wide range of issues with the sector[5]. Possible benefits of co-location include:

- Improved collaboration between services;
- Offering greater choice between providers;
- Easier transition between services;
- Improved referral pathways; and
- Resource sharing.

The MHCT will be exploring the nuances of service location further through this commissioning cycle, including the need for outreach services that can respond to different areas on different days. The topic of service location will be considered in collaboration with CHN and Canberra Health Services (CHS) to ensure that accessibility of the entire publicly funded mental health care system is part of ACTHD's planning.

3. Navigation

Navigation refers to the process of helping individuals find their way through the complex mental health care system, including providing information about different services and assisting consumers to access appropriate services. For this process, navigation refers to the process of recognising personal mental health needs, identifying the type of care that would be beneficial, and accessing that care. It also includes the administrative complexities associated with accessing multiple streams of support.

Navigation services, professionals, or platforms are additional resources that can assist an individual with the navigation process.

During our consultation many consumers, carers and sector partners shared experiences with difficulties navigating the mental health service system. This included feedback around the fragmentation of the system and limited understanding around current navigation platforms or services, which may not be meeting community expectations due to out-dated or inaccurate information. The MHCT heard that the community wants up-to-date information about services and their wait times, and they would like to access this through a range of formats, including in person, through an app or website, or via the phone.

Common words that might be used in relation to navigation and definitions include:

Intake includes the initial assessment and registration process when an individual seeks mental health services. The decision about appropriate care and support for an individual is based on the information provided in an assessment.

Referral involves directing an individual from one service to another, or from clinicians such as GPs to psychiatrists. Referrals can be ‘cold’ or ‘warm’ referrals. A cold referral usually involves providing information about a service and leaving responsibility to initiate contact with the individual. The current system mostly uses cold referrals which is a risk as people are more likely to fall out of the system. Warm referrals are the preferred options as they include providing active support to facilitate a connection.

Care Coordination is a collaborative and organised effort to manage and integrate various aspects of an individual's mental health care through information sharing and clear communication. Care coordination is particularly important for individuals with complex mental health needs or those receiving services from multiple providers.

Active holding refers to the provision of ongoing support and engagement to individuals placed on a waitlist for services. It could include regular communication and offering interim support to minimize the impact of waiting periods on mental health.

The table below summarises two major issues in this space which were raised over the Design phase: overall awareness of services and where to seek help; and improving connections and referral pathways between services.

Themes:	Possible improvements for the sector:
Service awareness: People do not know what services they need or can access, and are not aware of navigation options that may be able to help direct them to the right place or support them in navigating the system themselves.	• Improve promotion of existing navigation services • Improve education about, and awareness of, non-hospital-based crisis services for staff who support people with mental health concerns • Use technology and online solutions to improve service navigation • Improve support for carers to navigate the system for themselves and the consumers for whom they are caring • Improve referral pathways • Prioritise of cultural safety, including within service navigation • Establish multiple avenues for navigation • Embed navigation throughout the whole system – use the 'no wrong door' approach where people can access the system at any point and be directed to appropriate care • Improve case management and care coordination for individuals with complex health needs • Improve intake and assessment processes in partnership with consumers • Implement peer navigators to support consumers and carers to navigate the system • Introduce flexibility in contracts to allow services to support people in need, even if it is outside of their usual cohort • Improve navigation tools and information available to GPs to support GPs as the first point of call for mental health support
Connections and referral pathways: Lack of strong referral pathways and connections between services leads to fragmented journeys through the sector and a lack of continuity of care. This can also occur at key transition points in a person's journey through	• Increase support for people transitioning between services • Increase care coordination support for people using multiple services • Upskill all service staff in managing consumer pathways

the sector, including transitions between: ○ Primary care and specialist services ○ Youth to adult services ○ Residential and community services ○ Mental health services and other services ○ Acute care and ongoing support ○ Acute and residential services.	• Increase collaboration across sectors to facilitate effective transitions and pathways • Streamline referral procedures to reduce administrative burden on referrers • Implement flexible age-based eligibility criteria for youth and adult mental health services to promote consumer choice and comfort and minimise unsuitable referrals. • Implement warm referrals as standard practice • Increase availability of active holding services • Improve continuity of care, including effective handovers and referrals from existing 24/7 supports or helplines • Establish data sharing agreements between services to facilitate referrals and reduce need for consumers to 'retell' their stories

There have been a range of strategies proposed to help solve the issues stated above. For navigation, many people suggested:

- Creating a single directory of services for navigation platforms to use, ensuring the information is accurate and up-to date;
- Developing an online navigation platform (website or app);
- Providing a centralised point of information that you can call or visit; and
- Using peer navigators.

We note that some of the services above do exist but have some limitations, such as limited target groups and/or capacity. For example, MindMap offers an online navigation platform for young people, while Head to Health offers a national intake and assessment phone service, and a local walk-in centre for adults. Both of these services operate at a high capacity and offer additional supports beyond direct service navigation, including active holding. However, our consultations revealed that there is little awareness around these services. There are also limitations to the extent to which these navigation service can function in an environment with high wait times for service delivery, and with several services (especially private) having their books closed to new clients. Given this, the commissioning process seeks to optimise what already exists in the system and facilitate a whole-of-system approach to navigation, rather than duplicating existing services and risk making the system even more complicated.

General Practitioners (GPs) are usually the first point of call for mental health concerns, and they are promoted as, and expected to be, the gateway to accessing services and providing information on mental health support. Despite this, consumers gave feedback that GPs

often do not know what support is available in the mental health sector in the ACT. While some of the drivers of this issue (such as GP salaries, Medicare Benefits Scheme, GP training) are federal government policy issues and out of scope for commissioning, it may be possible to improve the information that GPs are drawing from and support them to keep up to date with the NGO sector offerings relevant to their patients. CHN are working to support GPs to navigate the NGO sector and make appropriate referrals through the Initial Assessment and Referral (IAR) Training and Support program. While this work falls outside of the scope of commissioning, it impacts the entire sector and needs to be considered.

We heard that there needs to be options for people to seek support and advice in accessible formats with which they are comfortable. For some, this may look like talking to a person with expert knowledge of the service system, either face-to-face or over the phone. Others may wish to avoid talking by using features such as email or online chat, while some will want to remain anonymous through use of online directories and other static resources. As such, a key consideration is providing effective choices to people accessing services and, while the ACT having appropriate platforms and programs to navigate services is a key part of delivering effective mental health support, it is also important that the right services exist and are promoted effectively.

Care coordination for people with more complex mental health concerns was also a common theme raised in consultations. Consumers differentiated this from navigation by describing that care coordination can help when someone needs to move around the system while they are already in it. To support this, carers suggested a ‘personal navigator’ for mental health support. This was described as a person that a consumer could go to, who would listen to their individual story and concerns, and suggest suitable option based on these needs. This navigator would then have the ability to follow and support them through the system, ensuring goals are being met. This idea was echoed by consumers and sector partners, who called for support in navigating the mental health system throughout an individual’s journey. It was suggested that a service like this could use a chat feature and phone line to allow individuals to talk to support staff and find the best options for their personal situation and needs.

Peer mental health workers could be valuable in navigation specific roles and services. Between 2021-2023 the Mental Health Commission of NSW trialled a program where peer navigators were provided for four priority groups to support their access to services, and support existing staff. These groups included individuals in rural and isolated communities, young Aboriginal women in rural NSW, transgender people, and people experiencing complex mental health issues in hospital settings. A subsequent Insights Report[4] written by the NSW Government showed that peer navigators were effective, with consumers reporting that knowing their navigators had lived experience was helpful, demonstrates the potential value that professional using their lived experience can bring to others experiencing mental ill health.

Overall, these consultations have highlighted that the conversation around navigation and care coordination needs to continue. As these continue, it should be acknowledged that there are a range of parties involved in the funding and delivery of mental health services in the ACT, and future conversations will continue to involve these groups.

4. Workforce

Workforce, in the context of this Report, refers to all staff that are required to deliver appropriate services across the mental health sector. This includes:

- Specialist workers, who are typically tertiary trained professionals with dedicated learning in mental health, such as psychologists, social workers, and mental health nurses;
- Generalist workers, who may not have specialised training in mental health, such as those in administrative roles and research personnel; and
- Lived experience and peer workers, who use their lived experience to bring valuable insights into mental health care system through identified positions.

Sector partners have reported difficulties with attracting, recruiting, and retaining staff to provide mental health services. Some of the suggested drivers of these issues affecting the community sector include burn out from high workloads, limited career progression, and opportunities for professional development, low wages, instability of funding, short term contracts, and a limited pool of workers.

For consumers, this has resulted in reduced availability and quality of services. This was echoed in the ACT Mental Health Community Coalition's 2023 Workforce Profile. This showed that, at the time of their research, over half of the NGOs surveyed had vacant positions in their direct support workforce over the past 6 months, while over half of this group said that the positions had been hard to fill[6].

The table below summarises four major themes which emerged in this space during the Design Phase consultations. These themes are:

- Supporting the lived experience workforce;
- Workforce burnout and recruitment challenges;
- Shortages of specialist staff; and
- Professional development opportunities.

Themes:	Possible improvements for the sector:
Lived experience workforce: Peer based services and lived experience workers play a unique part in the mental health sector. An increase in these roles and services would support both consumers and organisations.	• Establish a clear definition across the sector of what an identified lived experience worker is and the scope of their role, and provide education around this • Increase identified lived experience positions in clinical (including hospital) and community-based settings • Increase training opportunities and places available in the ACT for lived experience work qualifications • Improve support for lived experience workers, including:

	○ Ongoing training and support; ○ Increased career progression opportunities; ○ Supervision, both clinical and peer based; and ○ Clear guidance around appropriate pay. • Employ carer lived experience workers to provide targeted support to carers and bring unique insights to the system • Employ peer workers from priority groups, e.g., the LGBTIQA+ and CALD communities, to enable peer-to-peer connections and support culturally safe service provision
Workforce challenges: The mental health sector has seen challenges in the workforce related to burnout and recruitment challenges.	• Implement workforce welfare measures • Improve support and supervision for workforce • Introduce flexible working environments • Align wages in NGO sector to non-NGO systems • Provide mental health supports for all workers • Increase the use of volunteers to support service delivery where appropriate • Explore innovative options for workforce attraction • Provide secure funding to NGOs to ensure they can offer longer term contracts or permanency to staff
Limited access to specialist mental health staff: Limited specialist staff such as psychiatrist in the mental health sector, as well as difficulties accessing these supports cause stress for consumers and put greater strain on the acute system and community services. GP availability and difficulties accessing bulk billing can minimise availability of referrals to specialist staff causing further strain on the system.	• Support increased access to bulk billing GPs and specialists, such as psychiatrists, in the ACT • Increase availability of psychiatrists in the ACT • Explore options to sustainably subsidise more mental health services, both in terms of the amount of services offered and different types of care
Professional development: Providing opportunities for ongoing development and career progression creates a more enticing workplace. Professional development and learning opportunities also allow staff to engage in new	• Improve access to cultural competency training • Provide organised channels for professional development and information sharing. • Increase funding to services for training and workforce development

ways to support individuals and community.	

A strong workforce is an important enabler to ensure that organisations and the public health system can deliver the services that are needed for our community.

While the consultations as part of this commissioning process were focused on the NGO service sector, the MHCT also received input on the broader mental health workforce. This included commentary on the availability of GPs and psychiatrists in the ACT. While this is valuable information, and it is important to consider how NGO services can interface with these elements of the mental health workforce, a number of the suggestions put forward in this area are better addressed through wider government activity. The MHCT has shared this input with the Office for Mental Health and Wellbeing for consideration in their work on the ACT Mental Health Workforce Strategy. The MHCT is also working closely with CHN to explore issues related to the availability of GPs.

Other workforce suggestions that can be supported by commissioning activities include improving access to formal training for lived experience and mental health workers locally, workforce attraction measures, establishing career pathways for those with lived experience, and improving employee wellbeing. Some suggestions for how these can be supported through the commissioning process include:

- Ensuring services are funded appropriately to include professional development and staff training;
- Ensuring services are adequately funded to provide competitive pay rates to staff;
- Facilitating communities of practice and other forums for services and staff to come together and participate in shared professional development; and
- Exploring ways to improve the integration and use of lived experience workers across all services and promoting this through contractual expectations.

ACTHD acknowledges the importance of lived experience workers and their valuable role in the mental health system. According to MHCC's 2023 workforce profile, less than one in 10 staff in the ACT mental health workforce are lived experience workers.[7] Some of the services in which these staff are employed include services for LGBTIQA+ people, promotion programs delivered in schools and workplaces, and some crisis support safe spaces.

5. Collaboration

The term collaboration is being used to describe the way services work together operationally and across referral pathways in the mental health system. This includes work in private, public, and community mental health services, and across sectors including ATOD, housing, justice, and education.

Consumers, carers, and sector representatives have all expressed a desire for improved collaboration across the sector. Improved collaboration between services may lead to improved care pathways for consumers, a reduction in improper referrals, shared values and outcomes for services, and innovative and effective service delivery. It is important to note that when consumers and carers spoke about collaboration between services, they referred to collaboration across the human services sector, as well as within the mental health sector. This captures many of the systems in the ACT that support individuals and communities to function as effectively as possible.

The table below explores three key themes that were raised through consultation relating to collaboration:

- A disconnect between the mental health NGO sector, private and public systems;
- Silos in the human services sector; and
- A lack of information sharing between services.

Themes:	Possible improvements for the sector:
Mental Health System disconnect: There are inherent gaps in the mental health service system formed by funding silos and systemic structures between the NGO sector, private and public systems.	• Increase shared resourcing to support consumer transitions between community and public mental health services • Improve alignment of service values and consumer wellbeing goals between the community and acute sectors • Improve evaluation and feedback mechanisms in public and NGO services • Establish agreements for communication between NGO, public, and private services where possible to support consumer outcomes and allow the sharing of sector data • Increase staff awareness of pathways and community supports • Reduce discharge of consumers from acute care into the community before they are ready or appropriately supported • Share training and education opportunities between public acute services and NGOs

Human services sector silos: Due to systemic structures and funding buckets in government, the human services have distinct and disconnected areas. While these areas are separate on paper, the concerns and issues found are similar and shared and should be consider together.	• Increase funding for organisations to support collaboration activities between sectors • Create communities of practice and sector forums to share information, skills, experience, and learnings • Encourage peak bodies to play key role in leading collaboration and partnership between sectors • Develop joint models of care or innovative service models • Improve support for complex clients and opportunities to discuss complex cases • Increase opportunities to provide warm referrals • Improve professional development opportunities • Increase skill sharing across the sector • Support the co-location and partnership of services across sectors
Information sharing: There are restrictions and limitations in the information shared between services. This is due to a competitive market, privacy concerns and technological availability of data storage.	• Improve information and data sharing • Improve data systems that enable services to share information, including support an ongoing analysis of the demand and capacity of services • Streamline records and intake systems between services so people do not have to repeat their story

We heard that collaboration between services is often reliant on pre-existing relationships and connections. Collaboration built this way can be severely impacted by staff movements, which over the long term can make collaboration difficult. It was suggested by sector partners that while there is a responsibility for services to collaborate, many collaboration activities should be government-led, and that many of the issues relating to collaboration stem from government funding structures and governance. The MHCT is working closely with other project and commissioning teams that relate to mental health, including CHN, to ensure that services are complementary and have opportunities to work together. Joint funding and governance arrangements between relevant agencies and organisations are a future possibility which may help to improve collaboration between mental health and other human services systems.

We are interested in trialling a community of practice, or similar forum, for organisations in the mental health sector. Such a trial would be open to all providers within the sector and serve as would an opportunity to share knowledge, skills between participating organisations. This would also be a chance for organisations to share their insights into what is and isn't working across the mental health system. If successful, this is something the MHCT will continue once newly commissioned services are in place.

Co-locating services is another avenue the MHCT is exploring to improve collaboration. Co-located services could work together to develop shared events, joint models of care, warm referrals processes, and shared care arrangements. The MHCT is looking at the co-location of mental health services commissioned by ACTHD and CHN.

Improvements to the public acute care system and the way it collaborates with the NGO sector were often discussed throughout this consultation period. While making changes to the acute system falls outside the scope of the commissioning project, the role that the acute system plays and relationship it has with government funded NGO services will be considered. As much as possible, the MHCT will aim to improve collaboration with the public system through a range of activities and projects, including service level agreements, opportunities for referrals, and involvement in forums and communities of practice. CHS is a member of the Commissioning Advisory Group and ACTHD will continue to work closely with them to strengthen this connection.

6. Co-occurring conditions and situational complexities

During consultations, the MHCT heard how other intersectional identities and/or life experiences, including health status, disability, ATOD use, housing, employment, education, and justice can interact with mental health and access to services. For the purpose of this report, these are being referred to as co-occurring conditions and situational complexities.

The domains outlined above can significantly impact people's mental health, and vice versa. However, the human services systems and the services operating within them often do not have the time, funding, or capacity to adequately support people with co-occurring conditions or complex situations.

To address this, improved collaboration was noted as the most significant improvement that could be made for supporting individuals with co-occurring conditions or situational complexities. It was noted that different sectors typically work independently of each other and there is a need to reduce silos and support consumers in a holistic way. During consultations, people shared experiences where engagement with one sector inhibited their ability to access support from another. Examples included the use of alcohol, tobacco, and other drugs (ATOD) being an exclusion criterion for mental health services, despite individuals needing mental health support. Various ideas were suggested to support improving collaboration between sectors, which are highlighted in *Section 5: Collaboration* of this report.

As described in *Section 3: Navigation* of this report, case management and care coordination could also help support people with complex needs or co-occurring conditions. A practical example given was the proposal for a role or service that would work with consumers across the human services sector, with the ability to prioritise and escalate issues when required, offer warm referrals, and keep in touch with consumers during their journey to ensure they do not 'fall through the cracks'. Collaboration between various commissioned and public services is something which will be closely considered through this commissioning process.

The paragraphs below outline some specific co-occurring concerns issues that were raised in feedback and information specific to them.

Physical Health

We know that, on average, people diagnosed with a mental illness experience higher rates of health conditions such as obesity, cardiovascular disease, respiratory disease, osteoporosis, and dental problems.[8] To help address this, it was suggested that the mental health sector look to make multidisciplinary care (for example dietetic support) available within services to help reduce the risk of these conditions for mental health consumers.

Conversely, input from consultations also highlighted that people with various chronic conditions may experience increased mental health concerns, because of ongoing health

challenges. This may be due to changes in their home environment or routine, difficulties with accessing services for their physical health concerns, or impacts to their work and social lives reducing an individual's feeling of purpose or increasing isolation. Any of these changes can cause significant impact on an individual's mental health as they seek to rebalance things that have become uncertain or unstable. The MHCT expect that if mental health NGOs can be supported, as outlined in *Section 5: Collaboration*, to consider wider health and wellbeing outcomes and include multidisciplinary care that this will help to better support the overall mental and physical health of clients.

Disability

A large amount of feedback highlighted that the current mental health system is not catering well to the needs of people with disabilities. It was suggested that to improve this element of service delivery, the MHCT should consider:

- Ensuring venues are accessible, with consideration given to how people with mobility impairments can access them, including transport, parking, and toilets;
- Increasing integration of disability and mental health services; and
- Providing case management to people with co-occurring disability and mental health concerns.

Neurodiversity was also raised, particularly in relation to young people and the LGBTIQA+ community, with suggestions to consider the way that services interact and engage with neurodiverse people. The MHCT expect that this will need to be the subject of further consultations during the remainder of the Design phase, which will be done in collaboration with the Disability sector.

Alcohol Tobacco and Other Drugs (ATOD)

ATOD was the focus of the majority of feedback about co-occurring concerns. The feedback showed that there is not enough support for co-occurring ATOD and mental health concerns. There are some mental health services which may exclude people if they consider ATOD use to be someone's primary diagnosis. An induvial under the influence of alcohol or another drug may also be refused entry from a service due to safety concerns for other consumers and staff. This prevents people from seeking mental health support if they are not ready to change their ATOD use. While there is nuance around the need for these restrictions in the current system this results in people being lost between services or receiving inadequate care.

Some proposed ideas to improve support for people with co-occurring mental health and ATOD concerns across NGO services are:

- Improve intake and referral processes in both ATOD and mental health services to ensure that there is a no wrong door approach between the two sectors, regardless of the primary presenting issue;
- Improve sector collaboration with a focus on ATOD and mental health;

- Increase investment in integrated mental health and ATOD services;
- Encourage and foster stronger helping relationships between consumer and health professionals through therapeutic alliances to increase understanding;
- Introduce multidisciplinary models of care; and
- Use a harm reduction approach in mental health services, where a supportive and non-judgemental approach is taken to reduce the harms of ATOD use, while recognising that ATOD use occurs on a continuum and individuals will hold different goals.

Some of the other issues and ideas raised included the importance of sector-wide comorbidity guidelines, eligibility for mental health services for people with ATOD related concerns, and the availability of smoking cessation support for people with mental illness. Collaboration was once again raised regarding ATOD and mental health dual diagnosis centres, and the need for a joint workforce to engage people in holistic recovery. Research suggests that addiction focused treatments on their own are not sufficient to support mental health concerns[9]. It was also highlighted that while dual diagnosis centres may present many benefits, it could reduce an individual's choice in recovery when they may not want to seek support for both mental health and ATOD.

Mental health seems to be more of a prominent focus within ATOD services than ATOD is in mental health services. While the 2018 ATOD services users Census[10] highlighted 73% of ATOD services had a primary objective to improve a client's mental health, mental health service users found ATOD concerns a barrier to access. The ATOD sector currently employ National Sector Wide Comorbidity Guidelines for ATOD and Mental Health in their services[11]. It has been suggested that this is something that should be adopted by the mental health sector in the ACT.

The 2023/24 ACT Government Budget allocated some funding to support the concurrent and integrated treatment of ATOD and mental health concerns. This includes funding to conduct a scoping study investigating how staff in ATOD and Mental health services can be supported to upskill in both areas. Funding was also provided with the aim of improving the relationship between these sectors, by forming an alliance between Mental Health Community Coalition (MHCC) and the Alcohol Tobacco and Other Drug Association ACT (ATODA).

People living with mental health concerns have higher rates of smoking and nicotine dependence and disproportionate financial and health burdens. It was suggested that mental health services look to provide evidence-based tobacco cessation to clients and staff who wish to participate and ensure mental health treatments are provided in supportive smoke free environments.

Justice

Some consumers and carers highlighted that in their experience people engaged with the justice system experience high rates of mental health and ATOD concerns. This could either

be prior to engagement with the justice system, or following experiences within the justice system, or both. It is important that people within the justice system can access support for both of these concerns in a way that is appropriate and effective. Some suggestions that were received in relation to this issue are:

- Increase capacity for services to consider the psychological impact of interacting with the justice system;
- Improve the consideration of therapeutic arrangements as part of sentencing;
- Improve mental health support for people who are currently, or have been involved with the justice system, including care coordination;
- Focus on prevention for people within the mental health system who are at risk of offending or engaging in other behaviours managed by the justice system;
- Focus on promotion for people within the justice system who are at risk of mental illness;
- Continue to offer mental health support for people exiting the justice system;
- Increase family support in justice setting particularly in relation to improving mental health and wellbeing; and
- Consider cognitive impairments and intellectual disability in both the mental health and justice service landscape.

Throughout consultation the MHCT provided some examples of successful interactions between the mental health and justice systems. The Start Court in Western Australia[12] is a mental health magistrates court diversion that offers support and solution focused outcomes for individuals with mental health concerns including ATOD support. The team consists of those in the justice system, as well as mental health clinicians and lived experience workers demonstrating a collaborative approach that was highlighted through consultation. While a program like this is outside the scope of the commissioning process, the MHCT have noted the feedback and aim to work collaboratively with Justice and Community Safety Directorate (JACS) on how mental health NGOs can reach into the legal system.

The MHSPD completed the ACT Detainee Health and Wellbeing Strategy 2023-28 in August 2023[13]. Stakeholders for this project said it was critical to keep enhancing detainees access to care that meets their need when they need it, reflecting what the MHCT has heard through the commissioning processes. It highlighted the importance of detainees knowing what health services, including mental health services, were available and how they can access them, including mental health services. The four strategic priorities for this Strategy were:

- Responsiveness: Improving person-centred care by ensuring culturally and individually responsive service delivery.
- Collaboration: Strengthening integrative responses by establishing collaborative and coordinated support systems for detainees, their families, and staff.

- Workforce: Building staff capability and satisfaction, by enabling confidence and competency, empowering our workforce to deliver safe, high-quality care.
- Governance: Ensuring strong, accountable governance by embedding accountability and supporting mechanisms that continuously improve systems and services.

A large portion of the work within the justice space will fall into a collaborative process with JACS. The MHCT does not have direct influence over the services offered within correctional centres, or how these people may be engaged. However, the MHCT will work to enable services to be fit for individuals who may be in the community and wanting to seek mental health support.

Other socio-economic factors

Some feedback was provided on the impact that a range of other socio-economic factors can have on mental health. Many barriers still exist in these areas, including:

- Stigma and discrimination;
- Not qualifying for financial supports such as the NDIS;
- Personal financial constraints;
- Withdrawal from education and low health literacy;
- Intersectional disparities;
- Housing security; and
- Transport difficulties.

Services commissioned through the mental health commissioning process will be funded by the ACT Government and available for free, or little cost, to those seeking support. The MHCT does not have the ability to change or influence costs associated with services funded outside of this process, or in the private sector. The MHCT will continue to be involved in sector development, work with sector partners, and advocate for accessible services.

Concerns around transport are addressed in accessibility with the MHCT considering the spread of services and availability in all areas, as well as access to different modes of transport. Consideration will also be given to the opening hours and general availability of these services for people who may not be able to access general services during working hours. The accessibility and consideration of the NGO mental health system in a broad perspective will support the mitigation of some of these socio-economic barriers.

7. Outcomes

The Blueprint highlighted outcomes as a key focus of the commissioning process. This means success of commissioned services would be measured by the benefit of the program and the impact they make for community or individuals. This is compared to reporting outputs, which are the raw numbers associated with a program, such as occasions of service or number of referrals.

The MHCT expect that embedding outcomes across the sector will not happen to its full extent immediately. It will likely be implemented slowly across various commissioning cycles and contract review points to ensure smooth transitions and the seamless continuation of delivery and care.

Throughout the written and workshop feedback there was significant discussion around what outcomes the mental health sector should be aiming for, as well as about areas which need further consideration before the sector moves to a shared outcomes focus. Consumers highlighted they were supportive of services measuring outcomes. However, they also noted that there is a need to ensure that the process of reporting on outcomes is appropriate, respectful, and contributes to accountability for service providers.

There was consensus that when mental health services are measuring their outcomes, they should look beyond short-term and surface-level results, such as ‘improved mental health’ or ‘reduced symptoms’. The sector and the community emphasised that it is equally as important to consider mental health outcomes in relation to the social determinants of health. Some areas that were highlighted for potential future inclusion into an outcomes framework included:

- Housing;
- Employment;
- Social Connections;
- Education;
- Physical health;
- Sense of belonging;
- Mental health symptoms;
- Mental health literacy;
- Help seeking behaviour; and
- Overall wellbeing.

There was also a focus on measuring outcomes related to the experience of care that a service provides. These included:

- Psychological and cultural safety;
- Service free from judgement and stigma;
- Feeling supported by service;
- Feeling respected and welcomed by service;

- Access to advocacy;
- Improved support and recognition of carers;
- Access to affirming mental health care; and
- Consumer input into care, pathways, and services.

The MHCT heard from the sector that the implementation of a shared outcomes focus and an increase in outcomes measurement will need to be supported by important system enablers in order to be successful. Suggested system enablers included:

- Capacity building across the government and NGO sector;
- Development of a shared understanding and language around outcomes;
- Development of data systems to collect, store, and analyse data; and
- Investment in appropriate customer relationship management systems.

The MHCT is currently working with the MHCC to co-design an outcomes framework with the NGO mental health sector. This outcomes framework will be used for a wide range of activities, including the commissioning.

Many people across the sector suggested that the MHCT consult existing guidelines and use these as a base for our outcomes framework, such as the:

- National Safety and Quality Health Service Standards;
- National Safety and Quality Mental Health Standards for Community Managed Organisations; and
- Mental Health Statement of Rights and Responsibilities.

The MHCT is speaking to other jurisdictions about how they have implemented their own outcomes frameworks to understand what learnings might be incorporated. The MHCT is also interested in how existing tools and measures of experience such as the YES (Your Experience of Service) and CES (Carer Experience of Service) surveys may be incorporated into NGO services. While outcomes and experience may be different, they are both important to consider to ensure that consumers within the ACT are feeling supported through their journey. Domains around consumer and carer experience are important elements to be considered in the focus on outcomes in mental health commissioning.

8. Funding

Through the commissioning process so far, the MHCT has heard feedback around funding specifically, about how services are funded across the human services sector, and the amount of funding required for the system.

As such, it is important for the ACT Government commissioning processes to consider how services across the human services sector connect. We are interested in exploring joint funding/governance arrangements for certain services in future commissioning cycles.

The MHCT also heard that currently funded services are struggling to effectively meet demand and operating costs, largely due to funding constraints. This challenge was echoed in the 2021 Counting the Costs Report[14], which was commissioned by the ACT Council of Social Services (ACTCOSS) and analyses the costs and funding involved in delivering community services in the ACT. Some of the suggestions raised in consultations included:

- Increase length of contracts to provide greater certainty to NGOs, staff and consumers;
- Consider service startup costs in contracts;
- Ensure services have enough funding for indirect costs, including infrastructure, outcomes measurement, and management;
- Ensure services have enough funding to offer competitive salaries;
- Pilot programs only when there is an avenue for potential ongoing funding;
- Adopt revised approach to indexation;
- Review funding streams and ensure full cost coverage for service provisions;
- Focus on efficiencies to reduce costs where possible– e.g., negotiating discounted rated for service insurances, or customer relationship management systems;
- Improve the mental health sector's use of volunteers, consider funding the volunteer sector to increase workforce capacity; and
- Remove funding silos and competitive approaches to service delivery.

We will ensure that as much as possible, these suggestions are taken into consideration within the current commissioning process, and in new mental health NGO contracts that may commence outside of the commissioning process. While these suggestions and barriers are important to consider, it must be acknowledged that the breadth of these suggestions and concerns around funding are larger than the scope of this commissioning process.

9. System Structure

We heard a range of feedback relating to system structure, which generally fell into two main areas: feedback on the IAR decision support tool; and increasing prevention of mental ill-health and promotion of mental wellbeing.

Initial Assessment and Referral (IAR) framework and Levels of Care

In the Blueprint, the IAR Levels of Care were used as a way to identify different needs across the mental health system[15]. This initiative of the Australian Government Department of Health and Aged Care outlines five broad levels of mental health care needs, ranging from self-management to acute and specialist community mental health services, with the intent of sector staff being able to use this framework to categorise individual needs and refer effectively across the sector. ACTHD has made a commitment through the Mental Health and Suicide Prevention Bilateral Agreement[16] to start the use of the IAR as a common assessment tool to address the needs of consumers seeking and accessing care. The IAR is already being used in some services in the ACT which were commissioned by CHN. This was a major factor in the decision to adapt the IAR Levels of Care for commissioning to show the spectrum of need the mental health NGO system must cover.

We received some feedback that this was not the way the community would like the system represented and that the IAR was not fit for this purpose, as it is an assessment and referral tool for use with individuals, and not applicable for system mapping and navigation. To reflect this feedback, the MHCT will continue to explore various alternative approaches to viewing the system throughout the remainder of the commissioning process, while ensuring all these levels of care are being addressed. It is noted that the IAR is just one of many ways through which individual need might be assessed and the MHCT recognise that people accessing mental health services may not necessarily fit neatly into any one 'box' or level of care.

Prevention of Mental Ill Health and Mental Health Promotion

There was wide support for increases in the amount of promotion and prevention services offered across the ACT, with a view to decrease the burden on acute and crisis supports over time and help ensure less people 'fall through the cracks' while trying to access care.

The Royal Commission into Victoria's Mental Health System[17] identified a number of priorities for prevention and promotion which align with feedback heard during the Design phase. The report arising from the Royal Commission noted that funding should be sufficient to support universal and long-term strategies, as well as supporting activity that aligns with more immediate priorities. This report presented evidence that prevention and promotion should form at least 5% of a mental health budget, including hospital community and NGO programs. This will continue to be explored both within and outside of commissioning through further research and discussion in ACTHD.

Prevention of mental ill health can be targeted at those early in life, illness, or episode. There are several projects currently underway in the MHSPD which will help contribute to

increasing prevention early in life, including the Head to Health Kids and the Youth at Risk projects, which are outlined in the Bilateral Agreement. The MHCT will be considering how it can increase prevention activities early in illness and episode as well as mental wellbeing promotion supports, without having major impacts on other services within current budget constraints.

Some general suggestions for improving mental health promotion and prevention programs in the ACT include:

- Creating programs at individual, group and universal levels;
- Focusing on positive behaviours, relationship building, resilience, coping skills, and reducing stigma;
- Expanding current programs to capture a broader audience;
- Facilitating access to clinical intervention, when needed, to prevent the progression or worsening of more severe mental ill health symptoms;
- Providing more specialised clinical interventions focused at preventing onset of more severe symptoms, such as DBT;
- Targeting promotion and prevention activities to at-risk groups such as people under financial stress, those exiting the criminal justice system, those within child protection care, people with disabilities, and ATOD users;
- Using digital campaigns to increase scope and engagement; and
- Developing programs involving lived experience and lived experience workers.

Psychosocial Support

The MHCT heard a wide range of feedback on how people can be provided with psychosocial supports for ongoing mental health concerns. Psychosocial support services aim to help people with various conditions, including severe mental illness, who may need extra support with their day-to-day activities. These services support people in domains beyond just their direct mental health, for example, community services to help people strengthen their social, educational and vocational skills.

This feedback largely followed the experiences of people who were unsuccessful or ineligible to receive support through the NDIS. The MHCT acknowledges the NDIS Review Final report as published on 7 December 2023[18] and will continue to work with the MHSPD and Commonwealth partners to ensure that any actions and recommendations impacting psychosocial support services in the ACT are considered in the Design phase.

Crisis

Through consultation there was feedback provided on how to support people experiencing a mental health crisis and what opportunities there are within community to support these individuals. Experiences shared by consumers highlighted that the Emergency Department and other clinical environments can exacerbate an already stressful time. The community highlighted that a key strategy to reduce the need for mental health presentations to the Emergency Department is a system design focused on prevention and early intervention.

We heard that there were a number of crisis services and programs in communities that are supporting individuals. Community and organisations raised the positive impacts that Safe Haven and Step-Up Step-Down programs can have on people. Having the opportunity for these safe spaces expands the choices available to individuals. These types of service models often involve peer workers, operate in home-like environments, and follow the principles of person-centred care and recovery. It was also highlighted that these models have a greater understanding of carers and what supports are needed for them.

Community based crisis supports are an ongoing focus for the MHSPD. The 2023/34 ACT Budget announced further funding for a hospital-based Safe Haven. This service will ensure that people have a choice in seeking support and help bridge the gap traditionally found between acute hospital services and safe spaces for mental health. The importance of these safe spaces and community based acute crisis supports, as well as any findings of the Co-Creating Safe Spaces Research Project[19], will be considered in the Design phase.

Suicide Prevention

Suicide prevention was a strong focus of some submissions, who were seeking an increase in suicide prevention and aftercare services across the ACT. The Suicide Prevention Team in the MHSPD is continuing its priority focus on multifaceted approaches to suicide prevention and in the ACT. This includes supporting the ongoing provision of suicide prevention programs (e.g., Question Persuade Refer, the Youth Aware of Mental Health program, Connecting with People and the Wesley LifeForce Aboriginal and Torres Strait Islander Suicide Prevention Training), and strengthening the resources available to people across the ACT. This team works in partnership with individuals and organisations across community and government to develop initiatives that are within the scope of the sector and respond to any gaps that are identified during ongoing co-design, consultation, and collaboration.

Key current initiatives include:

- The new ACT culturally appropriate Aboriginal and Torres Strait Islander suicide prevention, aftercare, and postvention service which commenced operations in 2023. This service is operated by Thirrili, who developed the service model through extensive co-design work with members from across the ACT Aboriginal and Torres Strait Islander communities;
- The Universal Aftercare Project - this project is funded through the Mental Health and Suicide Prevention National Agreement and Bilateral Schedule and is enhancing and expanding the ACT services available to individuals and carers following a suicide attempt and/or who have experienced a suicidal crisis; and
- The Tertiary Education Sector Suicide Prevention Partnership Group – this newly established group will provide collaborative leadership and promote partnerships between ACT-based tertiary education service providers and other ACT-based service providers to enhance the mental health and suicide prevention supports available to students in the ACT.

10. Priority groups

The MHCT received a large amount of feedback on several priority groups. These groups were:

- Carers;
- CALD communities;
- Aboriginal and Torres Strait Islander people;
- People in the perinatal period;
- Children and Young people; and
- LGBTIQA+.

The MHCT acknowledges that this is not an extensive list of all priority groups to consider within service design. Any groups that have not been identified through this or previous reports will continue to be explored and discussed as the Design phase continues. The MHCT works closely with a number of other commissioning and project teams undertaking work that intersects with these priority groups.

Carers

According to the ACT *Mental Health Act 2015*[20], a mental health carer provides personal care, support or assistance to an individual person who has a mental disorder or mental illness. The *Carers Recognition Act 2021*[21] defines a carer as someone who provides care to another person in a 'care relationship'. This does not include paid carers, care provided through volunteer organisations, or as part of education or training. Anyone can be a carer, including family members, partners, friends, or neighbours. There are also a number of people who may meet this definition of being a carer or are providing the main care for an individual, but who will not identify with or use the title 'carer'.

We heard that carers, families, and other support people for individuals with mental health concerns need access to greater support for themselves, and need to be included in the recovery of the person they are caring for.

Carers shared their experiences of being excluded from services and treatment for their loved ones and highlighted that they would like to see:

- Carer-inclusive language used in documents and service provision, noting that not all carers identify as carers;
- Relevant information and documents shared with carers wherever possible and with consent, even if general in nature;
- Consumers informed about Nominated Person, Advance Agreement and Advance Care Directive forms to nominate their carers;
- Respectful communication from service providers to carers in all settings;
- The family situation of an individual taken into account when considering treatment;

- Policies developed around providing updates on the consumer's care and guidance for how the carer can support their loved one;
- Stronger alignment of services with the *Carers Recognition Act 2021;*
- More support to understand what options are available to assist carers, including peer navigators;
- More support to understand elements of mental health care, such as types of services, medications, and legal arrangements that may need to be considered as a carer; and
- Carer experience surveys to measure and support strong outcomes at services.

All suggestions provided around supporting carers aligned closely to the Triangle of Care model and support the use of this theory in commissioned services. *The Triangle of Care*[22], as discussed in the Carer's Discussion Paper, recommends how carers should be included in holistic models of care for consumers. This model identifies how inclusion of carers should be focused on safety, supporting communication, and sustaining wellbeing all of which were, desired outcomes raised by consumers and carers through the commissioning consultation process.

We also heard that there are complexities surrounding legislation (for example, the *Privacy Act 1988*) preventing carers from being involved in their loved one's care, unless clearly consented to. While this is not an area managed through the commissioning cycle, it has been noted and will be raised with the Community Services Directorate (CSD) who have oversight of the *Carers Recognition Act 2021*.

Carers also spoke about the need to access their own support in their caring role. It is important for carers to maintain their own mental health and wellbeing and feel comfortable seeking support when they need it. Carers suggested there should be more:

- Promotion and education programs about supporting others and improving carer wellbeing; and
- Carer respite services, including at-home respite, short term residential care, and social activity initiatives.

The MHCT will continue to collaborate with Carers ACT to support the voices of carers being considered in the commissioning process.

Culturally and Linguistically Diverse (CALD) people

A small amount of feedback was received relating to the mental health needs and outcomes for culturally and linguistically diverse communities and individuals living in the ACT. The main ideas raised were:

- Government and services should consider the differences in values and perspectives between cultures;
- Focus on specialised prevention and promotion activities by engaging with influential people within CALD communities;

- Increase diversity of workers within the mental health sector to help people feel safe and comfortable; and
- Consider culturally specific programs which may be more appropriate or preferred by individuals and may operate outside of typical Western mental health care practices.

The Office for Mental Health and Wellbeing is collaborating with community leaders on the Mental Health Support for Multicultural Canberrans project. This project has recently commenced and will be an important resource to inform future investments in this space, including decisions made in the commissioning process. The MHCT will be working closely with the Office for Mental Health and Wellbeing, and their stakeholders in the community, to further assess the gaps and opportunities for proving support to this priority population group.

For more information on this project please email:
mentalhealthsuicidepreventiondivision@act.gov.au

Aboriginal and Torres Strait Islander People

The needs of Aboriginal and Torres Strait Islander people were highlighted as a priority in the Blueprint. However, a specific Discussion Paper or Consultation Workshop was not conducted during these initial Design consultations so as not to over-consult the community in the ACT who were in significant demand for consultation at the time. Instead, the MHCT will be analysing feedback and input that has been provided previously for a range of different mental health consultations and processes. Where appropriate, further information may also be the subject of future targeted consultation processes over the rest of the Design phase.

However, there was a small amount of feedback relating to Aboriginal and Torres Strait Islander mental health service needs submitted through the Design phase. This feedback conveyed that:

- Not all services are culturally safe, and effort must be directed to educating providers to deliver culturally responsive services;
- The community is interested in ensuring that there is a First Nations led service to work directly with community members; and
- There should be an identified First Nations workforce in mental health service delivery, in both clinical and non-clinical services.

Alongside commissioning, ACTHD is currently working with Yulang Indigenous Evaluation, an Aboriginal-led consultancy group, to undertake a review of ACT Government-funded mental health services for Aboriginal and Torres Strait Islander people and provide recommendations for future direction in the ACT.

This ongoing work will continue to inform the mental health commissioning project on gaps, barriers and options for support for our First Nations people.

People in the Perinatal Period

The perinatal period was not raised as a particular priority group in the Blueprint and was instead combined with children and young people. However, The MHCT heard a significant amount of feedback through the Design phase about the unique needs for expecting and new mothers (and birthing parents), other new parents, and families. ACTHD has defined the perinatal period as anytime from conception until 12 months following pregnancy or birth. This definition is consistent with the definition used by the Commonwealth under the National Mental Health and Suicide Prevention Agreement.

The perinatal period is an important opportunity for prevention and early intervention. Intervention for parental mental health concerns during pregnancy and early parenthood provides an opportunity to improve outcomes for the family and child. It can also be a period of significant changes in life circumstances and mental health needs, where those already accessing supports might need new, different, or adjusted approaches to care.

Through the National Mental Health and Suicide Prevention Agreement and the ACT Maternity in Focus Strategy, ACTHD is currently working on a Perinatal Mental Health Project. The MHSPD are leading this Project, which is progressing the commitments made in the National Mental Health and Suicide Prevention Agreement – ACT Bilateral Schedule and the ACTHD Maternity in Focus - First Action Plan 2022-2025[23]: Goal 5 – Improve access to mental health and wellbeing support.

This work will be progressed over the next two to three years via the following three streams of work:

1. Delivering a residential mental health service for the mother/birth person and baby unit following an initial scoping study and model of care development;
2. Initiating universal perinatal mental health screening; and
3. Improving referral pathways, including from primary care to mental health services and NGO provider perinatal mental health supports.

This project includes the scoping and establishment of a needs-based service for this group. The MHCT is working closely with this project team to ensure that the information gathered through this project is considered through commissioning, and vice versa.

For further details please contact the Perinatal Mental Health Project team on PMHP@act.gov.au

Children and Young People

The ACT recognises children and young people as anyone from birth until the age of 25. This group has several distinct cohorts with their own identified needs, which require their own approaches to care. These approaches may be delivered within the same or different services. For example, supports for children will differ from those of adolescents and young adults. This report refers to the group as a whole however, the unique needs of children and young people will also be considered separately through the commissioning process.

Several services, advocacy groups, consumers, and carers spoke about the needs of children and young people. Some of the barriers to accessing services for this group include:

- Limited availability of services and long waitlists;
- Exclusion criteria around age or co-occurring conditions;
- Navigation, intake, assessment, and active holding supports not being available or easily understood by young people;
- Limited information given to family members and carers to help them understand how to appropriately support the young person;
- Services not being trauma informed;
- Services not being inclusive or gender-affirming;
- Services being time-limited; and
- Confusion when transitioning between youth and adult services.

Some of the other themes which emerged were the importance of considering intersectionality, for children, young people, and their families, particularly in relation to the justice system or housing.

Consultation also raised the need to continue the discussion around the 'missing middle' for children and young people. This refers to children and young people who are not able to access the care they require through the primary mental health system alone, but are not unwell enough or do not meet the eligibility criteria to receive support provided by specialised tertiary mental health services[24]. People in the missing middle may have accessed services in the past, but did not have their needs met whether through the duration of care or level of specialist care to respond to the complexity of their needs[25]. The need to increase these supports for moderate to severe conditions for young people has been an ongoing discussion at a national level.

Additionally, there may be a cohort a group of children and young people with mental health support needs that constitute a separate subgroup of those that have not been consulted with due to lack of engagement in the system. This may be due to limited system understanding, barriers with navigation, reduced mental health awareness, or different cultural beliefs. Both of these groups have needs that are not being met within the current system and need to be considered as gaps in commissioning and future work.

There was also strong discussion around the need to increase the availability of mental illness prevention and mental health promotion supports for young people as a key way to reduce potential impacts of poor mental health. It was recommended that mental health education should focus on promoting positive behaviours, building relationship skills, fostering resilience, and developing healthy coping skills.

The location of services and accessibility for children and young people who do not have awareness of the system or who are without support networks was raised as a consideration for future services. Suggestions to address this included providing outreach services that can meet children and young people where they are, such as engagement within educational settings.

It was suggested that the MHCT connect with existing governance groups for child and youth mental health to learn more about the needs of this cohort. In partnership with the Youth Coalition of the ACT and CHN, the Office for Mental Health and Wellbeing has established an ACT Child and Youth Mental Health Sector Alliance. This Alliance contains representation from NGOs, community, government, private services, and young people with lived experience. This Alliance will enhance collaboration and connections and will work to progress key priorities associated with the mental health and wellbeing of children and young people. Members of the Alliance also support key projects in youth mental health to improve transparency across the sector. Engaging with this group will help to ensure that consultation is not being repeated.

In addition, the MHCT is working closely with the Youth at Risk and Head to Health Kids projects that are currently underway under the National Mental Health and Suicide Prevention Agreement. The Head to Health Kids service will include a multidisciplinary team to improve mental health access for children up to 12 years old, and the Youth at Risk project aims to provide a coordinated response to trauma for young people with complex needs who are at risk of developing mental illness. Both of these projects use existing networks, whose members are experts in different cohorts of young people. All information gathered through these projects will be leveraged to inform commissioning, and vice versa.

Given the focus of these services through the National Agreement, the commissioning of mental health services for children and young people will look to complement these services, rather than duplicating their scope, target groups, and models of care.

LGBTIQA+

The LGBTIQA+ community is a broad and ever-changing cohort. It is inclusive of all individuals who are lesbian, gay, bisexual, transgender, intersex, queer, and asexual, while the ‘+’ (plus) refers to other marginalised identities and expressions of sexuality or gender. Consultation has highlighted the need for inclusive services that can support LGBTIQA+ Canberrans.

We have heard that people from the LGBTIQA+ community struggle to access services due to:

- Stigma, fear of experiencing discrimination, or lack of safety within services;
- Inaccurate referrals that do not reflect their identity or require repeating their story;
- Short term or minimally resourced LGBTIQA+-focused programs; and
- Privacy concerns.

The community identified several improvements that could help alleviate these barriers. These include workforce development, improved connections between LGBTIQA+ services and mainstream services, improved education opportunities across the sector about the LGBTIQA+ community, data and intake process improvements, and targeted mental health promotion programs.

In addition to the general workforce development already spoken about in this report, the LGBTIQA+ community has advocated strongly for increased peer-based services and identified positions for staff in mainstream care. The community said that this could increase safety and trust within services.

LGBTIQA+ mental health service providers have reinforced their desire to connect with other mental health services across the sector. Options to improve connections and collaboration between dedicated LGBTIQA+ services and other mental health services could include colocation, co-branding, or partnerships. This could improve capacity and capability for staff working with LGBTIQA+ communities, as well as provide more holistic support for consumers. There are also opportunities for LGBTIQA+ services to share their knowledge through communities of practice or other professional development opportunities.

Feedback highlighted that the format of forms and intake data relating to sex and gender can contribute to transgender, gender diverse, and intersex people feeling excluded or unsafe in services. It is important that forms and data collected by services provide adequate choice for individuals to identify as they wish. This will be something that the MHCT will consider moving forward to ensure it can be built into standard reporting and data entry expectations in contracts.

Consultation with representatives from the LGBTIQA+ community empathised a number of disproportionate barriers to accessing services that are experienced by this community. This included stories and experiences of situational complexities surrounding disability, housing issues, interactions with the justice system and neurodivergence creating further difficulties in accessing traditional mental health services.

The LGBTIQA+ community identified prevention and promotion programs as a key gap in service provision. These programs, when delivered across the population could reduce discrimination towards groups such as the LGBTIQA+ community, therefore promoting acceptance and increasing understanding of the burden discrimination has on mental health. Alternatively, prevention and promotion programs specially designed for the needs of the LGBTIQA+ community could build help to build trust in the mental health system and encourage help seeking behaviour when needed.

The Office for Mental Health and Wellbeing, in partnership with A Gender Agenda and Meridian, produced the *Guidance to support gender affirming care for mental health*[26] guidelines. These guidelines were developed to encourage and enable mental health care providers to be able to deliver their services in a gender-affirming way and support the needs of trans and gender diverse people. However, it is important that the MHCT continues to ensure that these guidelines are being met and services are adequately supported and trained to deliver this care. How this can be achieved at a service level will be an ongoing conversation with sector partners, as well as with the Office of LGBTIQA+ Affairs, and the ACTHD LGBTIQA+ and Social Inclusion Team.

The ACT Government Office of LGBTIQA+ Affairs also completes a number of initiatives each year supporting a range of outcomes for this cohort, which includes mental health outcomes. Some of these initiatives include work around protecting the rights of people with variations in sex characteristics in medical settings and the Capital of Equality Strategy, which sets out how the ACT Government will continue to make Canberra the most welcoming and inclusive city in Australia. More information about this work and initiatives can be found on their website here.

Conclusion and next steps

As demonstrated throughout this report, the MHCT received a wide range of feedback on a broad range of themes and topics through this consultation period. The MHCT would like to thank each individual, organisation, carer, consumer, and government representative who has engaged with us through this process.

The information that has been gathered through this process has answered many of the MHCT's questions, but raised a number of others. Therefore, as indicated throughout the report, there will be some further targeted consultation activities throughout early 2024. The MHCT will also be reaching out to consumers, carers, and organisations as needed to hear what support and details they think are needed in certain areas to support an effective and cohesive system.

Updates about any further consultation activities and progress can be found on the Mental Health Commissioning Website here.

Please feel to provide feedback directly to MentalHealthCommissioning@act.gov.au on any aspect of this document or areas of interest as the Design phase continues.

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APPENDIX: SUMMARY OF ALL FEEDBACK

Through the Design Phase of Mental Health Commissioning, the ACT Heath Directorate released 5 feedback papers, held four public facing workshops, and released the Mental Health Subsector Commissioning Blueprint. This Appendix presents a summary of the feedback for each of these consultation activities as it was heard. This means that readers may notice repetition of themes or content throughout sections, or there may be information raised in some sections that you may expect to be raised at different points. This Appendix does not attempt to synthesise and categorise this information and simply presents it as it was heard.

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1. The Commissioning Blueprint

The Blueprint was the first consultation piece developed for the Design Phase of the Mental Health Non-Government Organisation (NGO) Commissioning Process, and it laid out many of the key concepts ACTHD wanted to explore for the future sector. To explore these, the Blueprint included three sections that broke down key elements for the design of a mental health system and sector, including:

1. The underpinning principles of the sector, which we want to uphold to help us deliver effective services and outcomes for the community;
2. Service categories, which describes the various levels of acuity of services required across the whole sector, as we want to ensure that people have access to appropriate services at any stage of mental health and wellbeing; and
3. The unique needs and contexts of population groups who are either at higher risk of poor mental health, or who need specific considerations for service provision, which we must recognise to ensure we can have welcoming and inclusive services.

ACTHD published the Blueprint on YourSay and the Commissioning Webpage. YourSay is the ACT Government's formal consultation platform and has a wide reach across the community. The YourSay platform provided an opportunity for everyone in community to have input into this process, including those who had not or could not attend any workshops. This opportunity was important, given the scope of the Commissioning Project is that all Canberrans have an opportunity to engage in discussion and provide input around the prevention, support and treatment of mental ill health and wellbeing promotion in the ACT.

In response to the Blueprint, ACTHD received 35 responses (this does not include responses received for feedback papers which are highlighted separately in this Report). 18 of these were in response to the survey hosted on YourSay, and 17 were received as email submissions. This input is summarised below.

Sector Principles

The sector will be focused on outcomes

- Outcomes statements should be developed in partnership with people with lived experience, and connect to the principles of recovery, person-led, holistic and uphold human rights.
- When developing the outcomes framework government should minimise use of clinically worded outcome measures.
- Outcomes frameworks should focus on generating beneficial knowledge for sector and community and on evaluating and demonstrating the impact of programs.
- Outcomes should have a long-term focus on care, even up to 6 to 18 months. This is particularly true for people with complex needs, such as those who are involved in the justice system.

- There was some feedback that using a framework to define successful outcomes is not meaningful.
- Conversely, there was also feedback that using a framework would better help maintain consistent evaluation.
- Outcomes should consider a wide range of mental health conditions including severity and presentations, especially across different genders or cultural understandings. They should also take on a broader definition of mental health than the clinical definition to be inclusive for everyone in the ACT community. This includes accommodating for intersectionality.
- Mental health outcomes should look at social determinants of health, this includes factors across other human services, such as education, employment, housing, food security, and more.
- The sector requires sufficient funding to undertake outcomes measurement.
- Smaller organisations may need support to develop skills in outcome measurement and reporting.
- Some organisations in the ACT self-identified strengths in outcomes measurement and have developed specific tools to measure their programs already.
- ACTHD should invest in capacity building internally to make sure that outcomes measures and frameworks for the sector are appropriate.
- ACTHD should establish an advisory group with participation of government, mental health community organisations and people with lived experience, to ensure accountability and transparency on the development of, and effectiveness of an outcomes and performance framework.
- Possible tools identified for measuring outcomes were:
  - DASS (indicator for mental health but difficult to use to measure the success of a program); and
  - Outcomes Star methods.
- The following barriers need to be considered regarding outcomes measurement:
  - Language barriers that affect ability to complete surveys;
  - Cultural taboos in relation to speaking about mental illness;
  - Privacy and the storage of data, particularly individual survey responses;
  - Lengthy processes – consumers can be burdened or reluctant to support data processes that are time consuming or seem unhelpful. Similarly, organisations may not have the capacity to complete lengthy processes and collection;
  - Consistency and accuracy – there is currently no consistent and clear way that outcomes are collected across different services, such as a data management system for all funded NGOs, making the process confusing for consumers and service providers; and
  - Retelling of stories – consumers do not want to repeat information multiple times or share information that may appear unnecessary, consider a way of data collection and management that would avoid this. Consumers don't want to repeat information multiple times – is there a way this can be avoided.

The sector will be sustainable

- More funding is needed for the overall sustainability of the mental health sector.
- ACT Government should lengthen contracts and manage the contracts effectively against any agreed performance indicators. Any underperformance or delivery issues should be addressed directly with organisations to give them the opportunity to manage and address underperformance.
- ACT Government should fund the mental health sector adequately to deliver well-resourced and timely services to community, including to become registered for NDIS or provide services to NDIS participants.
- The competitive nature of funding NGOs may contribute to a more siloed sector.
- ACTHD should increase support and resourcing for smaller organisations to develop tender/grant writing skills, and to cost services effectively.
- Services which already have high demand and waitlists should have increased funding.
- More prevention and early intervention style programs should be invested in.
- Programs should only be piloted if there is a plan to fund the program after the pilot phase ends.
- The ACT Government should adopt a revised approach to indexation that covers cost increases adequately.
- ACTHD should focus on efficiencies across the sector that can reduce cost pressures. For example, the sector could collectively negotiate discounted rates for necessary services like insurances.
- The volunteer sector could be funded to support mental health services.
- Increase investment in peer worker positions and workforce.

The sector will be collaborative

- Collaboration is essential between agencies, people with mental illness, and their carers.
- Providers should ensure referrals are appropriate, especially when working with marginalised groups.
- ACTHD should explore opportunities for care coordination.
- ACT should establish a shared understanding and language for mental health to support collaboration and effective referral. Shared educational initiatives and cultural competency training for sector could support this.
- Collaborations and partnerships require additional resourcing, including employing people with the skills and experience, sufficient time to maintain connections, and developing and implementing systems.
- Co-location of services is a good option to support collaboration between services. It can:
  - enable working together;
  - increase incidental engagement;

  - reduce disruption for people who need multiple services;
  - increase warm referrals;
  - reduce risk of disengagement;
  - reduce disruption for young people.
- Given the close link between Alcohol, Tobacco and Other Drug (ATOD) use and mental health, mental health community services should undertake training to increase knowledge of co-occurring ATOD and mental health issues.
- A central coordination function could be useful as part of the service system to ensure there is respectful, meaningful and ongoing engagement and collaboration across the sector.
- ACTHD should provide options for organisations to apply for funding in consortium or partnership.
- Collaboration between ACT Government Directorates and mental health services was identified as a major issue.
- Consumers recommend the use of 'service navigators' to assist mental health consumers to navigate between the various Federal, Territory, NGO and private services that are available.
- Communication, dedicated case workers and involving the family, can all help acute services work better with commissioned services.
- A central database for storing and sharing data between stakeholders should be developed to enable efficient communication and information exchange, facilitating coordination among service providers, government agencies, and other relevant parties. This will empower stakeholders to access and utilise data effectively, leading to improved decision-making and service delivery.
- ACTHD should lead regular meetings, workshops, and forums to enable stakeholders to exchange ideas, share best practice, and collaborate on initiatives.
- Peak Bodies for mental health in the ACT should play a role in partnership for helping communication and capability building activities. In this context the Peaks have no stake in final service delivery, they are enablers and facilitators.
- ACTHD should collaborate cross-Directorate more to consider joint commissioning for accessibility and transition in services.
- Explore opportunities to improve collaboration and information sharing with General Practitioners (GPs). GPs are the face of preventative treatment and require education on what services are available for people in the ACT.

Services will be recovery focused, person-led, holistic, and human rights informed

- Services should operate with honesty and humility, with a lens of defensible practice that empowers clinicians to use clinical judgement, rather than defensive practice.
- There were varying understandings of the word 'recovery' – some did not like the use of the word as it implied that a person will 'recover' and be symptom free from their mental illness.

- Barriers to effective delivery of recovery focused services identified by consumers included:
  - Services that look to 'fix' people, which is a deficit-based view of mental ill health;
  - Services assuming that 'recovery' means that a traumatic event has occurred that you must unpack before moving to recovery focused approaches;
  - Risk – services a have duty of care but this should not come at detriment of person's right to decision making;
  - Standardised interventions that do not recognise individuality;
  - Lack of focus on self-management and self-determination;
  - Clinician and services misunderstanding that you must know everything to provide support on any level;
  - Directive, oppressive and coercive correction therapies that do not support the client in collaborative decision making; and
  - Internalised heteronormativity.
- We also heard that enablers for services to deliver holistic care include:
  - Being culturally accessible and having cultural competency training for all staff;
  - Have a cultural diversity lens in recruitment;
  - Using a human rights lens to see individual client needs;
  - Ensure services are affordable or free;
  - Be trauma informed and incorporate trauma competence into the design and delivery of services, especially ATOD and mental health services; and
  - Operate with a ‘no blame’ culture – and not force on unwanted goals or objectives to consumers.

Services will be accessible and easy to navigate

- There are numerous accessibility barriers for people with co-occurring needs, most notably for people with co-occurring ATOD and mental health concerns.
- There are currently issues relating to transitions between services, particularly in relation to youth services, transitions from acute care, and transitions across the human services sector. ACTHD should consider ensuring eligibility criteria for services are flexible, and there are supports for transition periods.
- Options for service model changes, such as co-location of services or multidisciplinary teams, should be considered.
- Opening hours of services are currently limited – through commissioning, ACTHD should explore services operating outside of business hours.
- Service intake criteria can be limiting – this includes age, severity of mental illness, and exclusion criteria surrounding ATOD use.
- ACTHD should consider the spread of services geographically across the ACT, while also exploring co-location of services where appropriate.
- Services must be culturally appropriate.

- Consider language barriers in the delivery and promotion of services. This should also include production of easy read documents and information for services, as well as accessible websites and, potentially, translation services.

The sector will focus on prevention and early intervention

- Quality supports should be available in schools from early primary years.
- ACTHD should explore various models for early intervention, prevention, and promotion programs in schools, including models not currently being used.
- Services in this space are underfunded and need to be funded appropriately to be sustainable.
- Lived experience and peer support are important elements of prevention and early intervention.
- There are early intervention options that can promote wellbeing in all aspects of life that are not typically seen as mental health programs, for example, public health campaigns promoting healthy eating or sleep hygiene practices.

Service Categories

- The Intake, Assessment Referral (IAR) levels used in the Blueprint have a clinical focus and do not leave room for mild to moderate life-long mental illness – ACTHD should consider alternative or additional options for categorising services, such as a clinical staging model.
- ACTHD should ensure there is support for services that work across all levels of the IAR, including Safe Havens.
- The IAR should be adapted specifically for a youth mental health cohort as their needs are different.
- There should be an understanding of other health and social impacts on mental health (such as physical health, alcohol and other drug use, and neurodiversity).

Priority Groups

Children and Young people

- There are informal barriers to accessing mental health services for children, young, people and families who are culturally and linguistically diverse, Aboriginal and Torres Strait Islander, gender diverse or have disabilities. Mainstream services should be able to collaborate effectively to support these individuals and improve accessibility.
- It is critical to consider how the sector can support children and young people who experience moderate to severe mental health issues and are unable to access other services due to limiting criteria, or demand.
- Consider family therapy options, including Functional Family Therapy and Multi-Systemic Therapy. These could be provided as a level of early intervention.

- Parents and care givers for children need to be able to build their skills and capability to support children. This may reduce demand on some services if families are equipped to help themselves.
- Community NGO outreach services for children and young people with complex needs may need to be expanded, with current specialist services operating with limited resources and high demand.
- There are service gaps for young people who are neurodivergent.

Culturally and Linguistically Diverse (CALD) Communities

- CALD communities may require culture-specific services – not all mainstream services will be appropriate.
- ACTHD should consider commissioning services run by organisations who are embedded within target cultural groups, as they may be more culturally safe.

LGBTIQA+

- It is essential that all services for LGBTIQA+ communities have a co-design process including a reference group with people with lived experience of mental health.
- Stigma should be addressed. Training should be provided to the sector by peer-led community-controlled organisations.
- There is a misunderstanding that a person will likely have mental ill health as a product of identifying as LGBTIQA+ - this is not always the case.
- Internalised heteronormativity is an issue in a number of services and is a barrier for safety for LGBTIQA+ people.
- All services should have gender inclusive bathrooms.
- There are a number of key transition points to consider for LGBTIQA+ communities, including transitioning from primary care to LGBTIQA+ services, from youth services, away from schools, TAFE, or university services, acute/crisis to coordinated care, and between services for co-occurring issues.
- There are also several barriers to referrals for LGBTIQA+ people, including:
  - fear/lack of safety because people feel that their needs will not be understood; and
  - incomplete or inaccurate referrals that mistakenly assume that their gender/sexuality is the major issue, when really it could be many other things.
- LGBTIQA+ services should be provided by peer-led and community-controlled organisations. Specific services should include a comprehensive mix of peer-navigation, social support, case management and professional counselling, psychology, and care coordination.
- Mental health care for LGBTIQA+ people needs to focus on a person centred, resilience building, recovery-focused approach.
- Mental health services and Government should use inclusive language and practices to ensure that all individuals, regardless of their gender identity or sexual orientation, feel included and represented.

- There should be more resourcing for gender affirming mental and primary health care with a focus on Hormone Replacement Therapy and surgery.

Aboriginal and Torres Strait Islander people

- Cultural safety should be a sector principle.
- More individualised, culturally safe and continuous support is needed. Services provided by Aboriginal Community Controlled Organisations (ACCO's) or Aboriginal and Torres Strait Islander led services may be more culturally safe.
- There needs to be more focus on early recognition of mental health concerns for Aboriginal and Torres Strait Islander young people through the education system.
- An ideal service would be one that observes, follows and supports individuals through their life. Ideally, a First Nations led service that is trusted, which works within community to provide family support from birth and can identify needs early would go a long way to addressing these deep-rooted inequities.

Perinatal/expecting/new parents

- Expectant and new parents should be a priority group considered through commissioning.
- Working with expectant and new parents is an effective early intervention strategy, as issues for parents can translate into lifelong problems for their children and ongoing high costs to the health system.
- Children of parents with perinatal mental health issues are affected in both the short and long term, with a number of impacts including, increased risk of low birth weight/premature birth, mental health issues, physical health issues; childhood trauma and neurodevelopmental issues.
- Similarly, parents with perinatal mental health issues not only face a lower overall quality of life and increased health system use, but are also impacted by perinatal mental health problems in their personal and work lives.

Other comments:

Some responses were more closely related to the private sector, services which fall under Commonwealth responsibility, or Canberra Health Services (CHS) acute services.

These included:

- Cost barriers in accessing:
  - Private psychiatrists;
  - Private psychologists;
  - General Practitioners; and
  - Dieticians.
- Lack of access to private mental health supports, in particular, long waitlists.
- Concerns around mental health involuntary treatment.

- Privacy laws and their impact on mental health supports – in particular the need for flexibility in some cases.
- Feedback that the CHS' Home Assessment and Acute Response Team could improve interactions with providers, carers and general practitioners.

2. Feedback and Discussion Papers

LGBTIQA+ Feedback and Discussion Papers:

We asked several questions to find out what inclusivity and safety looks like in community mental health services for LGBTIQA+ people and how our community sector can be best supported to provide this.

We received three responses from key LGBTIQA+ community organisations and policy teams in ACT Health Directorate. This input is summarised below.

The commissioning process should consider funding services that offer the following:

- LGBTIQA+ affirming and competent bulk billing GPs;
- Case management, including peer-led case management;
- Trauma-informed counsellors and psychologists;
- Child psychologists/counsellors; and
- LGBTIQA+-friendly psychiatrists, particularly trans-competent psychiatrists for affirmation procedures.

Services should provide safe and inclusive environments for LGBTIQA+, some ways that this can be facilitated are to:

- Ensure intake forms and surveys provide space for LGBTIQA+ people to accurately record their identity. For example, demographic questions include a diverse range of options and/or provide space for consumers to use their own terms.
- Provide options for consumers to provide information confidentially, and not just to receptionists or front desks of services.
- Staff trained to engage and affirm LGBTIQA+ community, including leading interactions with pronouns when meeting people and including pronouns on staff badges or emails.
- Mainstream services should work with identified LGBTIQA+ organisations to ensure services are designed to be inclusive.
- Services should have policies and procedures for working with the Trans, Gender Diverse and Intersex Community, and having these policies reviewed by organisations who support the community.
- While pride flags and other welcoming symbols are beneficial, these need to be supported by staff training to make sure services are truly safe and inclusive before using these symbols.
- Have staff in service from the LGBTIQA+ community to increase visibility and perception of safety.
- Encouraging development and usage of queer resources for LGBTIQA+ community.
- LGBTIQA+ awareness and visibility should not just be a focus for pride month, needs to be all year round, otherwise can appear as tokenism.
- Provide safe place to go to the toilet (non-gendered bathrooms).
- Services that are delivered by and located within peer-led organisations.

- Holistic and integrated care for LGBTIQA+ people under one roof or in a central location. This would prevent them from going through the stress of accessing multiple services, and from needing to retell their stories.
- One submission completed a survey asking individuals to choose what services they would like to see included in an integrated model. The top three responses were:
  - Counselling (89%);
  - GPs (88%); and
  - Psychologists (74%).

Barriers experienced by the LGBTIQA+ community:

- Fear to engage with community due to fear of stigma and discrimination;
- Casual transphobia;
- Location: ensure there are multiple – consider NGO Hubs at walk in centres to increase access and locations;
- 'I' (Intersex) is invisible;
- Services lacking competency regarding intersecting identities and issues that overlap with the queer community (e.g., homelessness, sex work);
- Financial barriers;
- Lack of material and services in other languages;
- Absence of service or limited community knowledge of pathways to access services or access self-directed resources;
- Lack of affordable mental health services in the ACT;
- Mental health treatment plans – GPs aren't always safe; and
- Trans people have to see a GP then psychiatrist to have gender affirming surgery.

Feedback relating to outcomes and recording data:

- Government and services should actively record LGBTIQA+ population data accurately (e.g., census, Primary mental health minimum data set);
- Provide exit surveys once leaving the service;
- Possible indicators to measure: wait times, client retention, sector referrals;
- Limited staff understanding and training of recording data, including outdated terminology, or failing to use inclusive gender options.

Lived experience workforce:

- All services should be employing LGBTIQA+ lived experience workers, good models include AGA, Safe Haven, Meridian, YWCA, and Headspace Canberra City;
  - Support these workers through paid placement, supervision, Employee Assistance Programs, scholarships, financial aid, safe work environments,
  - Have practices in place to prevent burnout such as leave or boundaries, flexible working environments and additional mental health supports.
- A 2019 Evaluation by Thorne Harbour Health of the Equinox Gender diverse health centre indicates that peer counselling and support services are effective for

promoting positive health and wellbeing outcomes for LGBTIQA+[1]. The peer connectedness elements of these services enhance the resilience of local LGBTIQA+ communities and promote further and more regular access to community supports.

Older People Feedback and Discussion Papers:

We asked several questions to find out what older people need when accessing community mental health services, what the priorities should be and how our community sector can be best supported to provide this. We received no direct feedback on these papers and will continue to work with community throughout the rest of the Design Phase to ensure that these questions are answered, and the specific mental health and wellbeing needs of older people are considered.

Children and Young People Feedback and Discussion Papers:

We asked several questions to find out what children and young people need when accessing community mental health services, what the priorities should be and how our community sector can be best supported to provide this.

We received three extensive responses from key community organisations across the ACT that focus on or provide distinct support for children and young people. This input is summarised below.

- Stigma continues to be identified as a barrier for young people and children, as well as their families, seeking mental health support.
- There is value in mental health promotion and education programs within school and community setting for families and individuals; Government should consider expanding these to young adult settings such as universities.
- Programs need to support families including prior to emergence of symptoms. Consider capacity building of parents to support children and young people effectively such as Triple P Parenting programs.
- Waitlists are long and families and children and young people need ongoing support while on these lists.
- It is important to note that many people do not characterise their neurodivergence as a disability, this may be because of:
  - Identity affirmation;
  - Social model of disability;
  - Overlapping identities;
  - Self-advocacy and empowerment; and
  - Evolving perspectives around neurodivergence.

Barriers faced by children, young people, and their families:

- Services have limited capacity to provide active holding, deliver services in outreach models, and responding to young people and families with complex needs.

[1] https://equinox.org.au/wp-content/uploads/2019/06/equinox-evaluation-report.pdf

- Parental consent – Sometimes young people do not want to share information with their parents, or may not be linked to a family network, which can prevent services from working with them.
- The Office for Mental Health and Wellbeing Missing Middle Report outlined several formal and informal barriers to accessing services, include the voluntary nature of mental health services, limited child, or youth-friendly engagement strategies, limited inclusive trauma informed practices, exclusion and eligibility criteria, and long wait times to access services.

Lived experience workforce for children and young people:

- There is a need to define lived experience workforce in relation to child and youth services.
- Lived experience workers have a place in clinical and non-clinical programs.
- The National Mental Health Commission have produced lived experience guidelines which have identified barriers including lack of valuing of lived experience by management, lack of preparedness for integrating lived experience workforce into programs, insufficient funding, and challenges establishing career pathways.
- Organisations should provide training for lived experience workers to share their stories safely using frameworks such as the 'Do No Harm Framework'.

Trauma informed services for young people:

- These services work with young people experiencing complex and co-occurring needs, this cohort of young people are often excluded from other services.
- Priorities to consider:
  - Expanding community supports for children and young people with moderate to severe mental health issues through different service delivery modalities;
  - Improving and streamlining navigation, intake, and assessment for young people;
  - Addressing service system gaps related to child trauma services, early intervention DBT programs, and active holding;
  - Universal promotion and education programs to support increase mental health literacy and help seeking behaviour;
  - Family support such as parenting programs, especially aligned to transition points in a child's life; and
  - Service integration and cross service collaboration to enable easier and more coherent service access.

Promotion and prevention:

- For universal promotion there is an importance in building positive behaviours, relationship skills, resilience and developing coping skills. Government should also consider stigma reduction and improving service pathways.
- Focus of promotion and prevention should be on early primary years through to 25.
- Schools are a great capture point for providing services.

- Digital campaigns could also be effective outreach.
- Consider equipping young people with skills to support themselves and how to safely respond to a person experiencing mental health concerns, while at the same time ensuring young people know they do not have to deal with the issues on their own and there are avenues for support.
- For health promotion programs, simple post program surveys don't always capture effective results, and instead capture if the presenter was convincing and whether participants felt like they were learning, not the actual matter of learning.
- For promotion and prevention programs, providers should collect qualitative feedback on experience as it allows for the efficacy of a program to be seen and whether the individuals are likely to engage in the help seeking behaviour they have learnt.
- Other measurement areas for prevention and promotion programs should include knowledge of mental illness, understanding of how to maintain good mental health, knowledge of effective self-care strategies, awareness of help seeking option, understanding of stigma and self-stigma.

LGBTIQA+ Children and Young people:

- There is an increase in young individuals from 12 to 15 seeking gender affirming psychological care.
- There needs to be a level of mental health and education support for the parents, carers, or chosen family of young people who may identify as trans, gender diverse or non-binary to help them support the young person.
- Gender dysphoria is not captured in main data sets, however there is an increase in young people despite the data not being able to show this.
- Trauma experienced by young people differs to older individuals especially for the LGBTIQA+ community - the developmental stage that many young people are in has potential to continue into unique forms of trauma.
- While young people may not experience the criminalisation of homosexuality, they have experienced discrimination in other ways, including through the use of technology.
- There are many young LGBTIQA+ people who also identify as neurodivergent. It is important for services to recognise and understand this.

Culturally and Linguistically Diverse (CALD) Feedback and Discussion Papers:

In these papers, we asked several questions to find out what support services people from culturally and linguistically diverse communities need, how the sector can be best supported to provide this and what barriers exist for people in these communities.

We received two responses from individuals across the ACT in response to these papers. This feedback is summarised below:

- Information ACTHD provided in the blueprint and other commissioning documents lean towards fitting CALD people into western concepts of mental health service but there also needs to be consideration given to the different values and views of CALD people.
- Competing values in CALD communities is a main barrier to accessing mental health services and making assumptions about people's cultural preferences is not always effective.
- Increase the number of CALD workers and increase their involvement in design and delivery of services.
- There are some CALD focused mental health programs in the ACT such as 'My Mind My Voice'. These programs allow space for people to express themselves in a safe environment.
- Prevention/ promotion programs in CALD communities could be done by working with CALD individuals to share their lived experience stories in whatever way the community identify as appropriate.
- Engagement methods needs to be unique to each community and only work when fully informed, directed, and led by members of that community.
- Online programs are unlikely to be utilised by CALD communities– however videos featuring people from CALD backgrounds might be appropriate.

Due to the low response rate, we received for this cohort, we will be looking into options for further consultation opportunities.

Carers Feedback and Discussion Papers:

In these papers, we asked a number of questions to find out how community mental health services can best support carers, and how can services best connect and work with formal and informal carers.

We received two responses to these papers; both provide a lived experience perspective on how to include and support carers in the mental health sector. This feedback is summarised below:

- Services should involve carers in the planning, delivery, and evaluation of their service. This can be done in a variety of ways (including the use of the Mental Health Carer Experience Survey) and should align with the *Carers Recognition Act 2021*.
- Safety for the carer and for the person they are caring for is often the key concern for carers in relation to seeking mental health support.
- Carers and families often need support when a family member is going through the justice and mental health system. This could be provided as in-reach or out-reach support by community services. This could include:
    - Establishing and funding communities of practice associated with the justice system and mental health;
    - Ensuring timely referrals for physical health and social support activities for those with co-occurring conditions and those involved with the justice system; and

  - Interjurisdictional examples include the Start Court in WA.
- More collaboration is needed between carers and services in mental health and psychosocial disability services.
- Carers acknowledged that placing consumers in crisis into restrictive service settings does not always align to human rights requirements. However, it is important that the safety and wellbeing of carers is appropriately supported to ensure a safe environment for both the carer and the consumer.
- Funding should be allocated for NGO staff to learn how to identify potential carers. Carer Awareness Training Programs exist online and in-person.
- Prioritise a standard protocol for staff to regularly update carers about treatment plan, progress, and any changes in condition. If consent by a consumer is not provided, the protocol should stipulate that the carer still be provided with general information, advice, and support.
- Upskill mental health staff to understand the context, content and need for Positive Behaviour Support referral to help reduce behaviours of concern for those with an intellectual or cognitive disability.
- There should be a single care plan with multiple objectives, services, and accountability with lead agency for complex care.
- There needs to be multiple avenues for identifying available services to support access including apps, websites, flyers at mental health and justice services, and Centrelink/Access Canberra.
- Co-location of services would support carers and the people they care for.
- People with co-occurring conditions would benefit from concurrent treatment, Example services include Anglicare Victoria’s Alcohol and Other Drugs Services.
- Use more inclusive carers language to distinguish between paid and unpaid carers or volunteers.
- Carer supports should be targeted at anyone who is involved with a person experiencing mental ill health rather than targeted specifically at carers.
- ACTHD should explore respite style services to give carers a break from their caring role – particularly for those caring for people over 65 or people who require long term support. These could be delivered both at home and externally. There is also a specific need for these services for people not eligible for NDIS.
- Specialised emergency response would allow the care recipient to receive mental health care while allowing carers opportunity to distance themselves from crisis and recuperate. Examples include Safe Haven, Crisis House (UK) and HOME in Queanbeyan.
- Mental Health Carers Voice have heard that supports for family postvention are sparse in the ACT.
- Services should employ carer lived experience workers who can bring their unique insights and experiences. Examples include Mildura Mental Health Service ‘Care Consultant’ and WCS Carer Support Worker.
- Carers can be supported to pursue and engage with lived experience work through:

    - Scholarships for training and education;
    - Flexible paid arrangements to support time poor carers;
    - Incentives such as wage equivalent to allied health professions, including superannuation;
    - Part-time working arrangements; and
    - Peer work framework with opportunities for supervision and ongoing training.
- Carers ACT top priority is carer support roles to embed the Triangle of Care Framework in services.
- Outcomes measures to consider for carers include:
    - Carer health and wellbeing;
    - Carer involvement;
    - Social inclusion and participation;
    - Mental health literacy; and
    - Satisfaction, experience, and recovery.

3. Workshops

Outcomes Workshop – Monday 2 June 2023

The workshop focused on defining outcomes and starting to explore what outcomes the NGO funded mental health sector in the ACT should focus on.

20 people attended the workshop, they were a mix of people with lived experience, NGO representatives, and ACT Government representatives.

For the purposes of the workshop, we used the following definitions:

- **Outcome:** A desired end-state of wellbeing for the person (or community) (e.g., "I have meaningful social connections")
- **Indicator:** Quantification of progress towards an Outcome - directional (e.g., increase in social connections)
- **Measure:** Quantification of the size, amount or degree of change achieved (e.g., validated psychological tool result, survey results, or other proxy)

The feedback from this workshop is summarised in the table below.

Activity	Feedback
Activity 1: Identifying outcomes for people using NGO mental health services. Participants worked in small groups to brainstorm the kinds of outcomes they felt that mental health services should be aiming for	*In alphabetical order, the outcomes noted for consideration for mental health services were:* • Access to affirming mental health care • Access to individual advocacy • Access to initial support • Access to stable housing • Autonomy in making own mental health decisions • Communication between carers and consumers (and services) • Confidence to seek help • Coordination of care • Engagement with education • Feel validated, safe, understood, and free from stigma • Focus on early intervention • Good service navigation • Holistic services • Improved physical health • Improved quality of life • Increased social connections • Job satisfaction and stability • Mental Health Literacy • People feel respected and welcomed • Person centred • Person has knowledge of services available • Reduction in gambling • Service referrals

	• Services are accessible and affordable • Support and recognition of carers • Supported decision making framework • Trauma informed services and systems • Understanding dignity of risk

Activity 2 and 3: Grouping outcomes and developing indicators.
After looking at the outcomes listed above, the group identified 4 key themes which were emerging.
 	
These included: good mental wellbeing; good mental health literacy and awareness; social and community connection; and a well-connected system that is easy to navigate.
 	
In small groups participants brainstormed possible indicators that could be used to measure outcomes in this area.
	• Good mental wellbeing:
	  ○ Reduced work absenteeism
	  ○ Reduction in health services strain
	  ○ Reduced ATOD use
	  ○ Improved security of housing
	  ○ Accessibility to health professionals timely
	  ○ Mental health improvements from Intake to exiting service
	  ○ Consumer satisfaction/narrative;
	  ○ Referrals
	  ○ Suicide rate
	  ○ Expressed wish and feeling heard
	• Good mental health literacy and awareness:
	  ○ Increase in people engaging in services earlier
	  ○ People accessing the right services at the right time
	  ○ Population mental health literacy
	  ○ Decrease in stigmatisation of mental health in particular population groups
	  ○ Increased inclusion of mental health across other human services
	  ○ Increased referrals
	  ○ Decreased ED presentations
	• Social and community connection:
	  ○ Increase in participation in community activities
	  ○ Increased sense of belonging
	  ○ Feeling of being empowered to seek connection
	  ○ Able to access safe and affirming spaces
	  ○ Report feeling respected by services and staff
	  ○ Reduction in loneliness
	  ○ Consumers are supported to set own community/social goals.
	• A well-connected system that is easy to navigate:
	  ○ Includes GP, community services, CHS run services, Private services, and CHN funded services
	  ○ Look at: Consumer, Carer, and Staff experience
	  ○ Ensure funding is available to support activities in this space
	  ○ Leadership group developed

	○ Referrals should be acted upon, added into practice (e.g., for discharge), receiving service encouraged to provide feedback ○ Multiple options for consumers ○ Care coordinator
Activity 4: Challenges, barriers, and enablers to outcomes measurement. In small groups, this activity explored challenges, barriers, enablers, and possible ideas to help make measuring outcomes and capturing data easier.	*Barriers/challenges* • Burden of data collection and analysis on NGOs • Systems are 'out of step' and limited • National coordination through the Commonwealth can pose challenges with clashing reporting requirements • Resources, both financial and human • Organisational culture • Management of different outcomes tools • Political appetite • Legal requirements around data integrity *Enablers and ideas* • Incorporating data and indicators into practice to streamline and enhance service delivery • Increase use of data in service planning and operation • Contracts should reflect demand and quality of service being delivered • Sophisticated storytelling as a mechanism for evaluation • Greater cross-sector data access/visibility • Focus on system and service communication – outcomes are considered holistically • Ongoing funded Consumer Relationship Management system (CRM) across the sector to support safe collection and storage of data – at scale this would be significantly cheaper than each organisation purchasing their own. • Alignment with the ACT Wellbeing Framework

Prevention and Promotion Workshop – Thursday 15 June 2023

The workshop focused on exploring ideas for increasing prevention and promotion activities to support mental health early in life, illness, and episode through the NGO funded mental health sector in the ACT.

14 people attended the workshop, they were a mix of people with lived experience, NGO representatives, and ACT Government representatives.

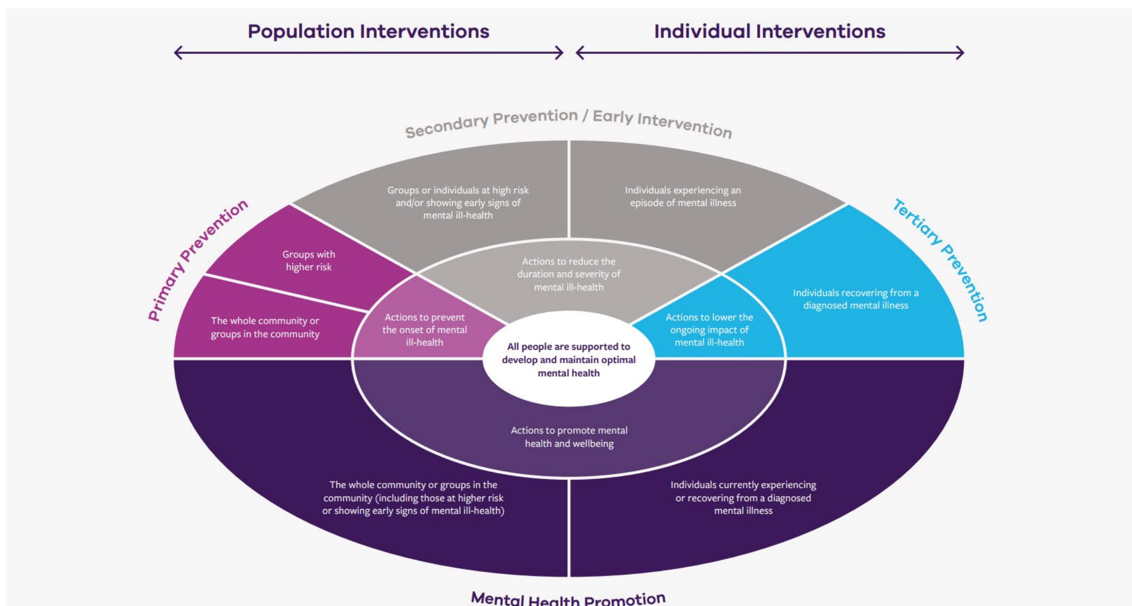
Promotion of Mental Health:

- Seeks to enhance and optimise protective factors for mental health, including social and emotional wellbeing and quality of life.
- Initiatives can target entire populations, groups of people or even individuals and can occur in any setting.
- Applicable to all people, including those currently experiencing or recovering from diagnosed mental illness.

Prevention of Mental Ill-Health:

- Focuses on reducing and minimising risk factors for mental ill-health. This can occur:
    - prior to onset of illness (primary prevention);
    - during an episode (secondary prevention); or
    - after an episode (tertiary prevention).

Promotion and prevention can also be delivered individually, or on a population level. The diagram below created by Everymind (2015) illustrates this, and this diagram was used and referenced throughout this workshop. [2]



[2] https://everymind.imgix.net/assets/Uploads/Everymind-Prevention-First-Adapted-Framework.pdf

The feedback from this workshop is summarised in the table below.

Activity 1: Identifying priorities:
In small groups, participants brainstormed priorities for prevention and promotion for population and individuals.
	For population prevention and promotion
	• Consider different groups including:
	    ○ CALD communities
	    ○ Carers and families
	    ○ Aboriginal and Torres Strait Islander people
	    ○ LGBTIQA+
	    ○ Older people
	    ○ People with complexity or co-occurring conditions
	    ○ At risk groups such as Fly-in/fly-out workers
	• Priorities should look at:
	    ○ Social media campaigns
	    ○ Design embedded with lived experience
	    ○ Accessible information
	    ○ Community programs
	    ○ Workplace and school activities
	
	For individual prevention and promotion
	• Consider people that:
	    ○ Are not eligible for the NDIS
	    ○ Experiencing regular or frequent episodes of mental ill-health
	    ○ Have chronic suicidality
	    ○ Have co-occurring mental health and ATOD issues
	• Priorities should include:
	    ○ Service mapping
	    ○ Coping and problem-solving skills
	    ○ Intersectionality support including education, employment, and housing
	    ○ Every service having a no wrong door approach
	    ○ Services that offer affirming preventive care

Activity 2: Deep diving into priority groups:
In small groups, participants considered population or individual level services for prevention and promotion, what they should look like, and discussed how we would know if these were making a difference.
	Promotion/prevention for older people
	• Should provide education to older people surrounding:
	    ○ retirement as a major stage of life change, which can lead to a loss of independence
	    ○ cooccurring needs and the consequences on mental health

	• Should provide education to GP's and other health professionals surrounding:
	  ○ signs of poor mental health
	  ○ healthy aging
	  ○ identification of protective factors and support networks
	• Group programs could be run in settings such as aged care facilities or retirement homes
	• Individuals should continue to be able to receive supports in the community despite their age or whether they are in an aged care facility
	• Care coordination for older people should be improved to include mental health support
	• There should be seamless transitions between aged care and mental health services
	
	Promotion/prevention for all Canberrans
	• Should promote healthy relationships as a protective factor for mental health
	• Should try to improve visibility of the sector for everyone
	• Engage with sporting organisations to engage with groups that may not typically access mental health support and to reach a large number of people
	• Should focus on human rights
	• Support parents, carers, families, and community groups
	
	Promotion/Prevention for LGBTIQA+ people
	• All services should all have cultural competency and awareness
	• Services should focus on improving advocacy for LGBTIQA+ rights in all settings, not just in services, as this would have flow-on effects for wellbeing
	• All services should be gender affirming
	• Services could be delivered to community groups and events
	• Improve case management services
	• Increase the number of LGBTIQA+ safe spaces
	• Increase investment in promotion and prevention for LGBTIQA+ people

	Promotion/prevention for the mental health workforce
	• Run workplace programs looking at mental health issue identification, wellbeing, and empowerment
	• Expand capacity for workers to attend promotion and wellbeing related activities
	• Workplaces should address burnout
	• Workplaces should ensure that people feel supported in prioritising wellbeing
	• Workplace policies should reflect mental wellbeing
	
	Children, young people, and families
	• Programs for families should focus on:
	    ○ reduction in isolation
	    ○ Increase in coping, resilience, and help-seeking skills
	    ○ problem-solving
	    ○ mental health literacy
	    ○ Connection to support groups including family unit, wellbeing groups and peers
	    ○ Education and guidance for family units to focus on improved family dynamics
	• Create a website that promoted services and supports, providing an opportunity for individualised care
	• Implement skills based therapy programs for parents
	• Implement multidisciplinary services for perinatal support following a 6 day, 6 weeks, and 6 months format, as well as individualised support for those people not joining groups or seeking support
	• Inclusion of lived experience and story sharing as a part pf program models
	• Seamless referrals and support
	
	Promotion/prevention for Aboriginal and Torres Strait Islander people
	• There is a need to upskill other services to improve cultural safety across the sector
	• There was support to develop a specific promotion and prevention service designed and

	led by the Aboriginal and Torres-Strait Islander community
	• To better support Aboriginal and Torres-Strait Islander people, the sector should focus on:
	  ○ No wrong door approaches
	  ○ Cultural competency
	  ○ Choice
	  ○ Understanding of family structure and kin
	
	Promotion/prevention for Culturally and linguistically diverse (CALD) people
	• All services should offer information and services in accessible language option
	• Promotion and prevention Services should focus on reduction in stigma and improving cultural understanding in the community
	• Ideas for initiatives include:
	  ○ Social media campaign with stories relating to individuals from different communities
	  ○ Increased training on cultural competency in other services to recognise mental health issues
	  ○ Consider a CALD peak body
	  ○ Safe Places – understanding there are different for different groups
	• When delivering services, providers should consider:
	  ○ Engaging with different generation in different ways
	  ○ Partnering with cultural alliances or trusted groups
	  ○ Ensuring those offering support are trusted by community
	  ○ Considering each group and their outcomes separately

Activity 3: Golden ticket:
Participants were asked to nominate what they would implement if there was only one change they could make for mental health promotion and the prevention of mental ill-health.
	• Education programs to:
	  ○ Improve mental health literacy
	  ○ reduce or address stigma
	  ○ respectful relationships for schools and community
	  ○ improve understanding of neurodiversity and cognitive impairments

	• Broad based community awareness raising programs, including:
	  ○ Perinatal Mental Health Week
	  ○ Lived experience story sharing (adult/community settings)
	• Perinatal wellbeing programs:
	  ○ This would involve embedding a wellbeing service at a whole-of-population level, reaching all women experiencing pregnancy and childbirth in the ACT
	  ○ A whole of pregnant population multidisciplinary antenatal wellbeing program
	  ○ Support and guidance for parents and caregivers to improve family dynamics and healthy coping strategies
	• LGBTIQA+ supports:
	  ○ All services are affirming and inclusive
	  ○ More investment in the current inclusive pathways program at meridian that provides safe, inclusive, and affirming psychological support that is peer-led and supports LGBTIQA+ people
	• Supports for young people:
	  ○ Centre for early intervention for youth and parents
	  ○ Mentoring
	• For older people:
	  ○ Improved care coordination
	  ○ continuity of support
	  ○ Assertive outreach psychosocial support
	• Subacute support for people with:
	  ○ Disabilities
	  ○ LGBTIQA+
	  ○ Aging population
	• Peer support groups
	• Early intervention programs, focusing on priority groups who wouldn’t normally access mental health services or need support immediately

Final discussion: Measuring outcomes in prevention and promotion	• The Office for Mental Health and Wellbeing conducted a presentation on outcomes measures in mental health, including in prevention and promotion, noting that there

	were many ways of looking at outcomes for promotion programs and currently no agreed methods between the commonwealth and ACT Government • There was strong agreement from the group that there should be a shift towards focusing on prevention and promotion services to improve early outcomes and reduce strain on the later part of the system • It was also collectively noted that a shift toward outcomes measurements for these types of services would be difficult, and there would be a large amount of work required to ensure that measurements are capturing the correct outcomes effectively

Complex and Co-occurring Needs Workshop – Tuesday, 27 June 2023

The workshop focused on how ACTHD should commission for people with co-occurring conditions or complexity.

15 people attended the workshop, who were a mix of people with lived experience, NGO representatives, and representatives from ACT Health's Alcohol, Tobacco, and Other Drugs (ATOD) team.

The group explored:

- Service challenges regarding access;
- Outcomes and how to consider them across different sectors; and
- Opportunities and concepts for design of commissioned services.

Our conversations focused on co-occurring conditions and complexity, noting that intersectionality and discrimination associated with identities and experiences are important to consider as a barrier when addressing service delivery.

We defined **co-occurring conditions** as when individuals have more than one health condition or concern, for example someone who has chronic health problems, in addition to their mental health concerns.

We defined **complexity** as situational, where someone may experience complexities across numerous human services areas outside of health, such as difficulties in accessing secure housing, in addition to their mental health concerns.

The feedback from this workshop is summarised in the table below.

Activity 1 and 2: How to make services work for people with complex presentations by reducing barriers. These activities were delivered in small groups, where participants were asked to discuss barriers to care for people with co-occurring and complex needs, and ideas to help better support people with these needs.	*Barriers highlighted by participants included:* • Siloing and compartmentalisation of services • Consumer lack of self-awareness of complex issues • Complexities are becoming more prevalent at a younger age than historically recognised • Services have their own perception of an individual's 'readiness to 'recover' which may not be aligned to the consumers goals • Not all services are trauma informed • Services are not multidisciplinary and primarily work towards short term outcomes • Housing difficulties including affordability, unsafe conditions, and access impact people's ability to access mental health support • Inadequate disability accessibility measures • Lack of involuntary treatment for ATOD in the ACT meaning that people fall through the cracks

	• Workforce capability, capacity and understanding of other conditions across sectors is hard to measure • ATOD, mental health, and housing cross over can sometimes lead to inappropriate risk management of clients, so people are excluded from access to services because one of their issues makes them ineligible for other services • Long wait times for services • Privacy and information sharing limits • Consent for sharing of information and to engage in treatment can be complex for services to navigate *Ideas for supporting people included:* • Creating and using detailed care plans and discharge plans for mental health services • Creating exit plans especially for people from the justice system using a bespoke process • ACTHD to support flexible contracts to give services opportunity to adjust their practice, including flexible age ranges, removing limitations for working with single cohorts, and give services opportunity to pivot when identifying emerging gaps • Improving community support structures for people with mental illness, including drop-in groups and safe spaces • Improve navigation support for staff, carers, and consumers systems • Improved resources to support services to make appropriate referrals and continuity of care • Ensure a 'no wrong door' and warm referrals approach; • Increase 'ownership' of cases so people do not fall through the gaps or float between sectors • Promoting the ACT Mental Health Consumer Network's My Rights, My Decisions tool kit[3] to support consumers and services to understand rights under the *Mental Health Act 2015* • Championing lived experience • Workforce resilience training and supervision • Shared definitions across the sector, including meaning of 'complex' • Sharing data and information across services
Activity 3: Exploring models of care.	*Multipurpose Service: involved combining multidisciplinary supports into a single service to meet the immediate and*

[3] https://actmhcn.org.au/my-rights-my-decisions/

<table>
<tr>
<td>In this activity each group was given an example of a service model that could help to support people with co-occurring conditions and complexity.

Groups were asked to unpack how each model could work in the ACT, what would be needed to support access to the service, and what outcomes the service should be aiming for.</td>
<td>extended health and community care needs of a particular client cohort.
• How to make it work in the ACT:
o Consider the place of peer workers
o No-wrong door approach
o Stepping through care with a person, i.e. supporting people to complete paperwork for housing; and
o Create government partnerships to support model, including co-commissioning between sectors
• What is needed to support success:
o Working across sectors, including shared case management and coordination
o Increasing funding
o Trust building with providers
o Awareness that this service will not be the correct choice for everyone
• Successful Outcomes:
o Consumer experience improved
o Less people experiencing crisis across the ACT

Service networks: This model involves creating networks between services from different human services systems to facilitate linking clients and to enable shared learning and partnerships.
• How to make it work in the ACT:
o Needs to be solution focused
o Need to ensure funding for services includes funding specifically for engaging with these networks
o Utilise existing networks where possible
• What is needed to support success:
o Different levels of network connection including communities of practice, shared training, service directories, and service level agreements
o Case conferencing and facilitating referrals between systems
o Focus on individuals, relationships, and alliance of networks
o Awareness of staffing and capacity needs
• Successful outcomes:
o Increased system capacity to hold and support individuals
o Improved transitions between services</td>
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	○ Improved service navigation and awareness of service offerings across sector *Service Hub: grouping different services by different providers in a shared location, however the providers work as an integrated unit.* • How to make it work in the ACT: ○ These are already starting to form in an ad hoc way ○ Ensure neutral branding to appeal to various cohorts ○ Use language appropriate to each cohort ○ Consider including GP, nurse practitioners, clinical and non-clinical staff, CBT coaching, and support or community groups ○ Ensure it does not exclude people by targeting single cohorts, e.g. homelessness, ATOD • What is needed to support success: ○ Design hub around broad outcomes rather than specific target areas ○ Consider which agencies would support each other ○ Consider various age services to support transition and other needs ○ Offer broad services including self-help and psychosocial supports ○ Consider a case manager in the hub ○ Consider resourcing requirements, including burden of rent and who will pay ○ Multiple locations needed across ACT i.e. north, south, and central ○ Outreach to other locations in similar ways to 'Chat to Pat' ○ Pair with communities of practice • Successful outcomes: ○ Increased access and availability of services ○ Warm referrals and handovers between services in hub ○ Shared performance measures and goals *Case Management Navigation: A coordinated process where an agency coordinates and supports navigation of the system for an individual across different services* • How to make it work in the ACT: ○ Ensure the service is goal focused and holistic

	◦ Broader understanding of all services, including across sectors • What is needed to support success: ◦ Need to address mistrust between NGOs, CHS and consumers ◦ Ensuring the consumer is decision maker of the care planning ◦ Ensuring involvement with carers • Successful Outcomes: ◦ Address all concerns and have wrap-around approach; ◦ Support for carers ◦ Active navigation, personalised care
Activity 4: Golden Ticket Participants were asked to nominate what they would implement if there was only one change they could make for this cohort.	• Designated mother and baby beds at the mental health unit • Supported seclusion decision making principles • More high intensity Cognitive Behavioural Therapy coaching • Increased availability of GPs/ primary care on range of community sector services and referral pathways • Involuntary drug and alcohol treatment review for young people in the ACT • Service sector supported by clinical supervision, as well as availability of an Employee Assistance Program • More training in guidelines for co-occurring support, trauma informed care and respite for workforce • Safe, supportive, and affirming care, which is accessible, and trauma informed • Access to a mental health advocate (independent and trauma informed)

Carers and Consumers Workshops

We ran several workshops and engagements with carers and consumers directly during the Design Phase. We held an online workshop with carers and consumers together on 8 June 2023, we attended the Carers ACT "Carers Collective" meeting on 16 June 2023 and attended the ACT Mental Health Consumer Network Drop-in on 29 June 2023. Across these engagements, there were 23 attendances.

The feedback from these engagements is summarised in the tables below.

Workshop 1: Online, 8 June, 8 participants

This workshop was facilitated as an online group discussion. Each question was posed to the group for discussion.

Activity 1: What do you think is missing from the mental health service system?	• GPs are a significant partner for mental health support, but some have no idea of services available in the community and usually funnel people to private psychologists with long waitlists • Culturally appropriate responses to Aboriginal and Torres-Strait Islander people, including trauma, cultural ways, etc. across the board • Opportunities for social connection for people with mental illness • Ensure that social determinants of health are included as outcomes with less focus on clinical outcomes • Ensure that outcomes measurement is focused on impact with minimal unnecessary reporting and bureaucracy, this will help smaller organisations

Activity 2: What makes an NGO mental health service good, what needs improvement?	• ACTHD should use existing tools and measures of what makes a service good, such as the 'Your Experience of Service (YES)' survey and other examples of national work that has been developed with people with lived experience
	• Services being trauma informed, safe, respectful, culturally appropriate
	• Consumers collaborating with services on what the service can provide, rather than having services done 'to you'
	• People have choice
	• Examples of good programs:
	  ○ Recovery College
	  ○ ACT Mental Health Consumer Network (particularly their education offerings)
	• Improve community sector linkages with GPs and private psychology
	• Intake processes are currently difficult. Requirements for documentation as an intake procedure is challenging especially for young people in out of home care in particular

	• Pathways to help must be improved - difficult to know where to look for help • People are reliant on organisations (e.g., specific organisations for Aboriginal and Torres Strait Islander people) to help them navigate however, this is not accessible to everyone • It is important that services are available out of hours and in accessible locations • CHS community outreach services, like PACER or the ACCESS phone line, do not treat carers well • More services without intake/bureaucracy, such as the Safe Haven and walk in services • Some people won't access government services or services that have 'mental health' in the name, due to stigma, lack of self-identification, or lack of trust • More promotion of NGO services so community know they exist. • Equity of response between physical and mental health • Services in other areas, like housing or poverty, need to be functioning well because they impact on mental health • Stigma is still an issue
Activity 3.1: Unpacking different kinds of services. Participants were presented with a hypothetical service model and asked to discuss. The service model was: A safe place for short-term mental health support: for individuals experiencing distress and in need of respite and support.	• Length of time, opening hours, setting locations should be customised depending on target group • Adjacent to complementary services or activities that are relevant to the target group • Home-like settings, community recreation centres, large venues, proper resources • Suggested models include recovery colleges, social hubs or neighbourhood houses • 24/7 and multiple locations, walk in, no paperwork, peers plus clinical – but mainly just a choice • Services may not need a fixed physical location - think outside the box e.g., BMX riders making their own spaces, pop up programs. • May be better if ACTHD funds the service and leaves it alone, sometimes the association with government is off-putting • Consider targeted audiences for messaging and services
Activity 3.2: Unpacking different kinds of services. Participants were presented with a hypothetical service model and asked to discuss. The service	• Be consistent with what is out there and don't duplicate • Some kind of one-stop shop or care coordinator to support people to access services • Case workers in government and public mental health services currently don't refer to NGO services as often as they should • Use people with lived experience to do service navigation

model was: Mental health coordination and service navigation for people facing mental health related challenges, including navigating the mental health system and accessing the right services.	• Research units, like ACACIA at the Australian National University, do not fit into the IAR used in the Commissioning Blueprint but are important for sector development and they also have many connections

Workshop 2: Carers Collective, 16 June 2023, 10 participants

This workshop was hosted as part of the June 2023 Carers Collective meeting. The questions were posed to the group as a group discussion, and participants could provide feedback verbally or in writing, which was collected at the end of the session.

What can NGO funded Mental Health services do to better support carers?
 	
What mental health services are missing or could be provided by the NGO sector to support carers?
	• More services that people (especially neurodivergent young people) can go to connect with other people and feel ‘normal’ - these kinds of places provide respite for carers and provide social connection for young people (which can help prevent mental health issues from progressing)
	• Involve carers more in service delivery to consumers
	• More promotion of services - navigation is difficult
	• Support with service navigation
	    ○ One participant described wanting a “big hero 6” for service navigation –someone you can go to and ask for help and explain the issues and they will tell you everything available
	    ○ An app could work but so would human interaction
	• Carers were not aware of the online MindMap youth portal even though they had young people who use mental health services
	• Lots of emphasis on social connection both for carers and for people they care for
	• Support in educational settings – young people are there for so long it is a good environment to provide support and opportunities

Workshop 3: ACT Mental Health Consumer Network (ACTHMHCN) Drop in, 29 June 2023, 5 participants

This workshop was facilitated as part of the ACTMHCN network drop-in session. Participants were both online and in person, and all questions were posed to the group and discussed together.

Do the ACT's NGO mental health services meet all your needs?	• Access to services is challenging because of things like waitlists, age restrictions on services, strict eligibility criteria, time availability (many services only operate 9-5) • Service continuity is an issue – within and between different services • Recovery coaches and peer workers are great • Transition periods in life are challenging, especially for young people transitioning from primary to high school. Services should focus in these areas • Program ideas: outreach suicide prevention team - to support people at home to prevent them from worsening to a point where they need emergency care • Create 24/7 access centres, not just for suicide but also for psychosis • Program idea: Peer led house services - there is one of these in New Zealand, a place where people can go for as long as they need to. Could be a few hours, overnight, or a few days • Walk in programs should be like walking into a warm cosy home - look at models such as Safe spaces, and the Urgent Mental Health Care Centre operated by Neami national in Adelaide[4] • Consumers have heard that the colonial divide has created more problems than good - would prefer integrated but culturally sensitive services
What kinds of services would you like to see in the ACT?	• More social media presence – explore how technology can be used to support people and advertise services available • Service like MindMap but for adults • Active hold as a standard • Centralised platform for accessing all services, including those in across the human services sector • A temporary case management service or service that provides support workers for short periods ○ This could help with advocacy and support with daily tasks, like making appointments, and could prevent mental health from worsening by alleviating stress • Partners in Recovery: these kinds of services are great - they sit with people while they wait for services • Recovery Colleges: Government should look at efficacy of recovery colleges and reviews, they provide networking and educational opportunities • Services should be sustainable - fund for longer than 12 months or be very upfront about it being a trial only

[4] https://www.neaminational.org.au/services/urgent-mental-health-care-centre/

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Arts based programming should be more widely considered – there is lots of evidence to support social prescribing and arts by prescription
A peer led trauma service, which also does psychoeducation
One consumer asked if it was possible to have an ACT Mental Health Commission
Mental health justice clinic
Advocacy service for when complaints are not being handled appropriately

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<tr><td>General comments</td><td>

There was strong support by participants for the organisation Mental Illness Education ACT (MIEACT)
Education should include parents, teachers, and young people, including university students
Look at other existing education programs, such as Be You or headspace and how services can work with these
Upskill CIT to run mental health and peer work certifications – the lack of a course in the ACT is a huge barrier to increasing the peer workforce
Create space for peer work and clinical placements in contracts
Expand funding support for safe havens
Diagnosis is a barrier to accessing services
The old recovery college was not accessible geographically, and future recovery colleges should be in a more accessible location
Part of the function of the recovery college (or another service could be to give education to services and provide a platform for info-sharing
Co-location was supported. Feedback included:

Use walk-in centres
Be close to public transport

There was less support for multidisciplinary services than service hubs
It was perceived that multidisciplinary services offered by a single provider can limit consumer agency and choice about the services being given to them
Focus more on 'step up programs' from the community and less on 'step down' from acute services

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