



Government of **Western Australia**
Department of **Health**

Mental Health Network Launch – Supplementary Report

Mental Health Network

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1. Introduction

The Hon. Helen Morton, Minister for Mental Health; Disability and Child Protection officially launched the Mental Health Network during Mental Health Week, Monday 6 October 2014. The event was held at the Pan Pacific Hotel, Perth. The establishment of the Mental Health Network was instigated by Professor Bryant Stokes A/Director General, WA Department of Health in partnership with Mr Timothy Marney, Mental Health Commissioner, Mental Health Commission (MHC).

The launch was attended in person by 280 people from across the mental health sector. Attendees included people with a lived experience, representatives from area health services, government, non-government, not for profit and private organisations, health practitioners and university based academics.

The morning's proceedings were webcast to rural and remote participants, who also had the opportunity to participate in a rural and remote specific workshop via video conference (see section three) Health professionals from the Wheatbelt, Goldfields, Kimberley and Pilbara participated via this method.

On completion of the opening address and presentations, participants took part in three workshops as follows:

- Workshop one – Let us hear your issues across the life-course.
- Workshop two – Identifying the priority issues.
- Workshop three – Setting the Network direction against your priorities.

Prior to the day registrants selected their area of interest from across the life-course consisting of the following domains:

- Maternal (three tables)
- Child (one table)
- Teenage/youth (six tables)
- Adulthood (twelve tables)
- Aged (three tables)

Approximately 250 people participated in the workshop sessions.

This Supplementary Report is a compilation of the information gained from all of the Workshops including the rural and remote video conference material. The information is presented verbatim (corrected for spelling and abbreviations written in full where possible), by table, in order of the life-course as follows:

Workshop one – Issues across the life-course with consideration for:

- Promotion
- Prevention
- Treatment
- Rehabilitation
- Recovery

Tables also considered:

- Aboriginal
- Culturally and Linguistically Diverse (CaLD)
- Disability
- Drug and alcohol
- Rural and remote
- Other issues.

Workshop two – participants were asked to consider all of the issues generated from Workshop one and reach consensus on a single priority issue for their respective table.

Workshop three – during the final metropolitan workshop participants were asked to identify how the Mental Health Network could act on the priority issues identified in Workshop two. Tables brainstormed the Strengths, Opportunities, Aspirations and Results (SOAR).

2. Brainstorming notes

2.1 Maternal

Table 9

Workshop one – issues

Promotion

- A parental/families approach; maternal and paternal Post Natal Depression (PND)
- Accessibility to services; making initial contact
- “Social stigma” mental illness
- Antenatal education in regard to risk factors for PND – do the women want to know?
- Fear associated with Department of Child Protection (DCP) involvement if the women seeks help for mental illness
- Lack of knowledge in regard to prescription medications during pregnancy and breastfeeding
- “Normalising” mental health treatment
- Social networking/media
- Peer group – support network

Prevention

- Pre-conception and antenatal awareness of risk factors
- Continuing professional development of primary care workers
- Community support
- Providing practical and emotional support for women who have no partner or family support
- Education for fathers in regard to PND risks – language and practical
- Prioritising mental health awareness
- Council involvement to support their new family community
- Developing local strategies for families in regional areas

Treatment

- Medication management
- Knowledge in regard to diagnosed condition
- Accurate diagnosis
- Adherence to treatment plan
- Community supports
- Communication between services and care givers – continuity of care
- Employer support; family friendly
- Clinical supervision – knowing scope of practice and when to seek further advice
- Appropriate family involvement
- Lack of resources and funding

Rehabilitation

- Family support – information, knowledge gained
- Community support
- Returning to “normal function” with the support of services

- Provision of a statewide approach to support women returning home
- Continuity of care
- Support services available for family members

Recovery

- Awareness of mental health and wellbeing – loss of stigma
- Integration of diagnosis into their life
- Family support
- Empowerment
- Development of a “skill set” – life skills
- Possible mentorship – giving back to the community

Workshop two – priority issue

- The need for increased community awareness and education.

Workshop three – SOAR

Strengths

- Some existing/available
- Increasing awareness
- Research and evaluation
- On the mental health agenda – more than it used to be
- Relevant – Family focus/systemic (family)/life change/transition/infant mental health
- Valued issue
- Important issue
- Consideration of impact of PND/anxiety on baby and family
- Attachment and bonding awareness

Opportunities

- To address and raise awareness of stigma – reduce stigma
- To increase likelihood of women seeking support/help
- To reduce suicide
- To reduce isolation/increase capacity to find support
- To increase knowledge about risks
- To increase normalisation of the challenge of new motherhood and potential of PND
- To build community support
- To promote parenting/motherhood as a valued role in community
- To promote parenting/motherhood as a rewarding and valuable life experience
- To help with realistic expectations of mothering/parenting
- To help parents to navigate information/resources for suitability/best fit/your baby and your experience and your choices
- To help fathers with education/help/support/resources
- Model of delivery/support – appropriate for clients and service
- Your experience and your choices

Aspiration

- Increasing opportunities, systems, methods, collaboration, development, support, sustainability/for education and awareness which leads to community supported, family focused, empowering framework
- Funding
- Decreased silo/more networking
- Benchmarking of standard framework

Results

- Reduce stigma for women/men/families in order to address prevention and early intervention systems of appropriate/quality support
- Professionals/services competent in designing and delivering support
- Infant mental health and wellbeing benefits as mother/parents seek and gain help/support

Table 10

Workshop one – issues

Promotion

Aboriginal

- Information on smoking, alcohol in pregnancy
- Support networks – translate knowledge into action
- Care close to home when from rural area

CaLD

- Interpreters
- Making people aware of healthy lifestyle

Disability

- Information – given in different format to cater to needs
- Support networks – red cross, social work

Drug and Alcohol

- Information on risks and help harm minimisation

Rural and remote

- Maximising use of local media
- Promotion of financial support available

Prevention

- Early Identification and open communication
- Post traumatic birth experiences
- Shift of culture in communication to patient centred care and a shift in power imbalance
- Encouraging help seeking behaviour
- Normalising mental health

Drug and Alcohol

- Specialised care
- Trauma informed care

Treatment

- Appropriate resources
- Efficiency
- Mothers groups (mother infant groups)
- Supporting family networks with postnatal depression
- Child Health Nurses, not enough nurses and limited postnatal care
- Early detection – Edinburgh Post Natal Depression Scale (EPDS)
- Affordable psychological community services
- Medication– risk versus benefit, discussions
- Women and Newborn Drug and Alcohol Services (WANDAS)
- Childbirth and Mental Illness (CAMI)
- Accessibility to specialised services

Workshop two – priority issue

- Lack of acceptable and accessible social and cultural support networks in the community for mothers, infants and their families.

Workshop three – SOAR

Strengths

- Existing mothers' groups
- Women's health non-government organisations (NGOs)
- Men's groups
- Lots of opportunities for identifying isolated women for referral to support groups
- Rural in-reach (Northbridge Women's Centre)

Opportunities

- Readiness to learn and change (new parents)
- Utilising current infrastructure to expand mother's groups to include perinatal mental health, including vulnerable groups
- New technology and social media enhances access and support

Table 26

Workshop one – issues

Promotion

- Access to information
 - where
 - tailored to needs
 - who delivers information – clinician/peer
 - for – women, carers and family
 - culturally relevant including

- different languages
 - multimedia
 - face-to-face
- For example, information presented in ways that acknowledge the diversity in how women and families engage with services
- Build community and support around the maternal role, for example community centres; family partnerships at schools
- Accessibility
- Allow diverse models and evaluate effectiveness, innovative outcome measures
- Advocacy for importance of maternal mental health
- De-stigmatising
- Not only inform woman but also family/community (broaden focus for health promotion)
- Common language/correct terminology (respectful)
- Educate community/providers
- Easily accessible directory of services for consumers and care providers. Should be co-ordinated with community based services, for example drop in centres
- Resourcing for maternal mental health sustained
- Nurse practitioners

Prevention

- Pre-conception and early pregnancy access to care (community based)
- Early intervention
- University
- Screening – anxiety, psychosocial
- Identification of at risk groups
- Diverse workforce to inform (culturally sensitive)
- Screening needs to be accompanied by pathways to care
- Women with mental health illness have access to sexual health/family planning advice

Treatment

- Issues treatment including foetus, infant, partner, carers – including telehealth
- Inequity in access, for example rural – including telehealth
- Services not equally accessible
- Follow up support post episode of treatment
- Education for community/health professionals in regard to types of treatment
- Treatment – person centred – their values, their goals, include lived experience
- More outreach/community based
- Support/clinicians especially rural and remote
- Coordination and working together between services and agencies – mental health, DCP, Justice and Drug and Alcohol
- Trauma – informed

Rehabilitation

- Rehabilitation connects with prevention
- Maternal mental illness – rehabilitation and recovery
- relationship with partner, infant/children
- family centred

- empowering mother role
- children/infants may need “rehabilitation”
- another baby, fear of relapse
- Rehabilitation connects with prevention
- Support networks – tailored to the women, family and support network

Workshop two – priority issue

- Perinatal and infant (versus maternal) mental health – need for substantive equality in the resourcing of perinatal and infant mental health in its personal/social and cultural context including supporting the healthy development of families.

Workshop three – SOAR

Strengths

- Substantive equality – addresses social disadvantage (includes vulnerable and at risk groups), addresses felt need (consumer/carer)
- Cultural/family – broader approach, all family members are included
- A wellness/prevention based/strengths based

Opportunities

- Potential for positive inter-generational impact and trauma reduction
- Potential for growing/building, strengthening communities/schools, multiplier effect
- De-stigmatises difficulties/mental health
- Person centred approach – tailored and outcomes based on individual values

Aspiration

- Resourcing the ultimate early intervention!
- Awareness campaign
- Any woman or family member/carer can access information and services in their community

Results

- Reduction in maternal morbidity and mortality rates
- Improved child/infant –
 - emotional developmental cognitive behavioural health measures,
- Population health measures
- Decreased mental illness and substance abuse
- Longer term reduction in need for government spending in acute and chronic mental health areas
- Reducing burden of disease spending

2.2 Child

Table 8

Workshop one – issues

Promotion

- Definition of age of child
- Community advertising campaign for children's mental health
- State and national plan for children
- Recognising needs of children at different ages
- Promotion needs to be universal
- Advocacy for children's voice and across spectrum
- Promotion to be coupled with recovery model (label not for life)
- Needs of child in adult mental health or alcohol and other drug setting

Prevention

- Consider pre-pregnancy health
- Dialogue able to have things that are not o.k
- Early intervention and identification of high risk children
- Prenatal and infant mental health model (including trauma and neglect)
- Policies and guidelines to support information sharing
 - Escalating confidence
- Continued support of positive and healthy relationships
- Education and information for prevention of trauma
 - Understanding children's vulnerability
- Specific training for communities – universal and targeted
 - Aboriginal
 - CaLD
 - Attention Deficit Disorder
- Better use of social media for program
 - Apps
 - Facebook
- Teaching children self-care using school
 - School health nurses
 - Teachers
 - Leadership
- Children in high risk situations – early programs
- Young carers and support for them

Treatment

- Integrated Model of Care
- Environment of knowing
 - Capacity to be flexible in care
 - Remote
 - Aboriginal and Torres Strait Islanders (ATSI)
 - CaLD
 - Children of parents with mental illness (COPMI)

- When child needs treatment
- How to access
- Identifying barriers
- Availability of periods of assessment for rural and remote
 - Including: lack of housing for families to access metropolitan support
 - Clinicians to access appropriate support whilst remote
- More realistic developmental Model of Care, for example more than 10 sessions
- See child context – family/school/leisure time/peers
- Treating adult – recognition of children
- Specific treatment required for different needs
- Integration of services for treatment – Disability Services Commission and mental health
- Treatment to be sustainable
- Trauma – training and informed care

Rehabilitation

- Adult concept – recovery
- Recovery of normative development path “optimal”
- Embedding support/services to be part of life
 - More services to community areas not just within clinical arena
- Flexibility in what is being offered
- Children in care
 - Access to ongoing mental health services
 - Assessment
 - Ongoing assistance for reunification of children and parents
- Family recovery

Workshop two – priority issue

- Requirement for a Statewide Child and Adolescent Mental Health Plan or Strategic Framework specifically for children and adolescents that articulates the different and specific needs, issues, and approaches to achieve optimal mental health outcomes for children.

Workshop three – SOAR

Strengths

- Focus the passion of people working in the field
- Can dovetail into the state mental health plan
- Shared across different departments – promotes coordination across services
- “State wide” therefore inclusion of rural and remote
- Inclusive of high risk groups
- Comprehensive and integrated and inclusive

Opportunities

- To bring together the findings of various reviews and research, for example Commissioner for Children and Youth People review into mental health and wellbeing/ Australian Early Development Index (AEDI)
- To bring ideas, policies, strategies from other jurisdictions specifically related to children
- To identify gaps in regard to children and the future Mental Health Plan 2015–2025

- To address the needs, access and engage marginalised groups
- To ensure the child's voice is heard and informs the development of child centred strategies
- Statewide plan provides better opportunities to attract funding
- Reduce duplication of services
- Promote integration

Aspiration

- The mental health and wellbeing of all children in WA improves through development, funding and implementation of the new Mental Health Plan 2015-2025
- Development of the Plan should include contributions from child focussed experts, researchers, clinicians, policy makers, agencies, consumers and carers
- Come under the auspices of the Mental Health Network – Child and Adolescent working group, ensuring life course from infancy to childhood to adolescence

Results

- Improved consumer feedback in regard to access and integration of services
- Comprehensive plan that goes beyond what public mental health services provide
- Improved access to services
- Identification of Key Performance Indicators (KPI's)

2.3 Teenage/Youth

Table 6

Workshop one – issues

Promotion

- How to evaluate
- what outcomes
 - how to measure
 - funding
 - time lag between program and outcome
- Who is responsible for doing promotion?
 - Treatment services
 - Population health
- It is in the standards (national)
- Long term funding required
- Online, technology
- Challenges delivering in country areas
- Aboriginal Medical Services (AMS)
 - Social and emotional wellbeing services
- Need for dedicated resources
- Need to be in partnership/messages aligned
 - for example alcohol and other drugs (AOD), dietetics/nutrition
 - PND
 - mental health more linked messages

- Applicability of messages to Youth
 - stigma and shame

Prevention

- Safe places/personal safety
 - for example Youth Centres
 - family mediation
- Catching people at an early stage of illness
- Mental health first aid
- Support and outreach for young carers/children of people with a mental illness very important.
- Large role for NGO sector
- Mistrust between the Health sector and NGOs in regard to the ability to manage risk
 - Continuing existence of older models of care
- Continuity of approach to well-being and promoting resilience over the years
 - continues onto workplace
- Social responses by peer groups can really impact a young person's experience
- Youth ambassadors, mentors, speakers, positive role models
 - role of helping person navigate
 - impact on reducing stigma
- Role for peer supporters in schools
- Confidentiality/discreet people that are well known in schools

Treatment

- Transitioning between child to youth to adult needs to be better
- Transition from correctional facilities
- Individual Placement Services (IPS) – return to work very successful and important for someone's hope and recovery
- Treatment in country and close to home including need for safe places
- Human connection sometimes lost in the reporting on outcomes, for example Activity Based Funding/Management (ABF/ABM) – causing active strain on relationships between carers and consumers
 - Hard to move to recovery oriented services
- How can we value the time and resources to develop collaborative care?
- Need to move to care coordination rather than case management
- Education and treatment can be brought together, for example “understanding ourselves and our story”
 - Sometimes becoming a mental health consumer, you can lose your identity
 - Helps people learn things they didn't learn when they were growing up
- Medication compliance/implications of side effects, self-medication (including AOD use) and how it impacts, impact of AOD use on medication, sharing of medications has complications
- Unclear if Attention Deficit Hyperactivity Disorder (ADHD) is a mental illness or not – has impact
- Access to ADHD medications in Adult Services
- Lack of youth specific facilities – terrifying for young person to be on an adult ward
- Lesbian, Gay, Bisexual, Transsexual and Intersex (LGBTI) services – religion based NGOs – very difficult for a young person

- Trauma informed practice specifically for youth
- Need improved shared decision making with the young person
- Over medication for people with intellectual disability and mental illness – particularly important for youth
- Need better guidelines and training for clinicians
- So many different cultures – how to train people/staff to help
- Stigma in some cultures around mental illness
- Models of service for CaLD groups need to be led by CaLD groups – how can this happen?
- Out of the Shadows Program
 - Refunded?
 - Scope expanded
- Mental Health Access Service – capacity building but not enough (4 FTE metro) funding
- Site Specific Assessment (SSA) Mental Health Service (MHS) not continued funding – hard to build trust, credibility

Recovery

- Hope from the beginning
- De-stigmatising
- Need more peer support workers
 - gives people hope, safety and trust
 - coherent and integrated
- Australian Health Practitioner Regulation Agency (AHPRA) recognition for peer workers and Aboriginal Mental Health workers
- Recovery means something different in AOD
- Recovery versus rehabilitation?
- Recovery in the mental health area encompasses the community (is related to well-being)
- Services in country WA are lacking
- Expectation/hope of recovery for young person – as opposed to hysterical view
- Young People need linkages to other communities/places of safety and trust, for example sports, LGBTI, arts
- Services should not give up on people
 - some people keep coming back
 - need resistance, change what you are doing
 - might work the tenth time!
 - keep the hope!
- Need to support for the workforce
- Freedom to be creative/adapt/change
- Access to employment is really important
 - opportunities for employment or supported access to training
 - help/advocacy to access it
- Collaborative community approach
 - Educating employers about employing people with a mental illness
- Including young people in the broader community, for example cultural connectedness
- Exploiting opportunities to breakdown generational barriers – no “youth” silo
- Movement from treatment to recovery

- You need youth centredness
- Youth co-design
- Cultural specific recovery might be different
- Impact of social media on recovery
 - Can be good or bad
 - Way to engage directly with young people – cheap!
 - Access for country areas

Workshop two – priority issue

- Community collaborative approach, such as through:
 - Supporting communities to support and include youth.
 - Mentors, leadership, peer support that can address issues that are specific for – LGBTI and Aboriginal etc.
 - Improving relationships between young persons and clinicians.
 - Youth co-design of services.

Workshop three – SOAR

Strengths

- Community Collaborative Approach
- Most of the community is there, for example “workforce is there”
- Includes consumers and their values in their care
- Tangible programs that can be delivered
- Already a government policy on this
- Avoids duplication, pools resources (include from outside mental health funding)
- Is safe
- Gives purpose, meaning and can assist recovery of the people providing support to others
- Reduces isolation therefore prevent crisis/manages it better

Opportunities

- Catch people who would otherwise fall through gaps
- Can help change attitudes/break down stigma
- Break the cycle if intervening early
- Can fill knowledge gaps for service providers
 - Two-way information/knowledge sharing
 - Break down barriers
- Can get creative
- Identifies future leaders
- Engage, skill and inspire existing communities to support the recovery journey

Aspiration

- Cohesive service delivery
- People involved with a person with mental illness can talk openly and safely about mental health without fear, shame, or judgement
- Healthy, happy inclusive with or without mental illness
- People looking out for each other

Table 7

Workshop one – issues

Promotion

- Increased focus on life-skill/coping skill development in schools, for example resilience-building programs/adaptability skills
- Systemic/familial approach – supporting effective parenting
- Youth education in regard to responses, for example ability to critically analyse messages portrayed in social media and media in general

Prevention

- 1% of health expenditure used for picking up on possible emerging mental health issues and responding at earliest instance
- Increasing mental health literacy of young people and outlining options for early treatment
- De-stigmatisation – encouraging young people to seek support
- Aboriginal promotion information not reaching these populations due to poor school attendance, decreased exposure to media
- Disability – lowered access to information. Various delivery formats of information to cater for audience
- CaLD – Working with families
- Rural and remote – harder to access services – isolation issues
- Workforce support required in this area due to isolation
- Creating mentally healthy workplaces
- Education/up-skilling employers

Treatment

- Engagement issues – young people unwilling/unmotivated to engage
- Empowering young people to direct their treatment
- Collaborative approach
- Asking young people what they want
- Family barriers to engagement
- Co-morbidity challenges
- Need for continuous evaluation
- Aboriginal – not presenting until too late – mistrusting of mainstream services
- CaLD – Cultural beliefs in regard to mental health. Stigma

Rehabilitation

- Linking to community supports
- Stability issues – holistic approach required
- Financial issues
- Skills to counteract/make-up for delayed emotional development
- Endorsing recovery and relapse prevention

Workshop two – priority issue

Increased youth education required, for example life and coping skills (resilience building), increasing capacity to critically analyse messages portrayed in the media and social media.

Workshop three – SOAR

Strengths

- Some services/programs already in place – embedded in school curriculums however not compulsory for schools to deliver
- Foundations of material available
- Some services outreaching to schools

Opportunities

- Increased collaboration between health and education
- Utilising skills of existing services experienced in area
- Social media – building upon mediums already in place to support healthy well-being and coping, for example apps
 - Developing games promoting healthy messages, for example DOA and bullying

Aspiration

- Cultural change within schools – embedding resilience-building in all aspects
- Increased outreach and partnerships with early intervention mental health services, for example going into schools
- Mental Health Network role – advocating for programs, researching best-practice models, program development, implementation and ‘train the trainer’
- 2%– 3% education facilities delivery
- Targeting sporting clubs to spread and encourage messages. Using high-profile ‘champions’ to help with de-stigmatisation

Results

- Increased self-management of difficulties resulting in decreased youth requiring services
- Increased well-being indicators in schools
- Increased service utilisation for those who need it
- Increased functioning – vocational
- Decreased acute presentations, for example emergency department admissions
- Decreased youth suicide

Table 12

Workshop one – issues

Promotion

- Engage, belong
- System framework
- Developmental perspective
- Role modelling/peers/leaders
- Sporadic/gaps in regions

- Need consistency in regions
- Funding models
- How to access information
- Accessing the information for professionals to support youth
- How to get young people involved in consumer involvement (different ways)
- Parent support
- “Informed”
- Low (scandal) level investment
- Culturally appropriate
- Sport/Exercise/Physical activity – disability
- Funding is guided by evidence based practice (EBP) and governance
- Education
- Family Involvement (parent role)
- State versus Commonwealth mismatch
- Arts/recreation
- Ongoing process

Prevention

- Treatment factors.
- Attachment/carers support
- Developmental perspective
- Resilience building – COPMI
- Systems framework
- Targeted intervention
- School based Intervention
- WA regional versus metro
- Decreased resources and adapted, and ongoing consistency
- Culturally appropriate/sensitive
- Indigenous health workers
- Pathways/navigation of system and responsiveness

Treatment

- Abuse
- AOD
- Drug talk
- Warm transfer/handover of referrals/transition
- System too complicated – not designed for young people
- Timeliness to respond and access to get to services
- Complex (multiple) needs
- Private/state/Commonwealth system
- Shame/stigma
- Youth mental health stream – silos
- ABF – Multiple models on integration of intervention
- Relapse prevention
- Education of clinicians – workforce development
- Family inclusive
- Working relationships within and across health and other sectors (non-government/GPs)

- 24/7 response
- 1% rural and remote
- Financial incentives and mining business for infrastructure
- Case planning

Recovery

- Hope and self-determination especially regarding youth
- How to get the meaning relevant for mental health
- Under-resourced
- National Disability Insurance Scheme (NDIS) not encouraged
- Intersectoral framework

Priority Issue: Nil recorded

Workshop three – SOAR

Strengths

- Big bang for dollars
 - Work within best practice
 - Human capital
 - Stokes Review 2012, Mental Health Plan 2015-2025 and *Mental Health Bill 2013*
 - Builds on existing platform
 - Cultural change
 - Governance framework

Opportunities

- Save money
- Decrease vicarious trauma
- Integration across sectors
- Inclusive model (carers, workers, families, GPs)
- Improve services to consumer
- Staff morale and value staff which leads to staff retention
- Multiple areas into one strategy
- Bring reform to grass roots level
- Embark on cultural change
- Include peer support workers

Aspiration

- Consistency in service provision, action and research
- Co-worker case management cross services and sectors. Consumer lived experience is included
- Consumers get best outcome
- Centre of excellence (mentality)
- Workforce development strategic flow
- No silos
- Evidence based practice
- Research

- Clinicians
- Consumers/carers
- Feedback loop
- Improved inductions, mentoring, supervision, leadership
- “Safe systems”
- Culturally
- Occupational health and safety
- Governance

Results

- Decreased suicide and self-harm
- Endorsement of International declaration on youth, mental health
- People are ‘trained’ across all services to be youth friendly and family/carer sensitive
- Youth mental health competencies defined
- Have peer support workers
- Feedback evaluation

Teen/Youth-Table 23

Workshop one – issues

Promotion

- Drugs and their effects/impacts – education
- Relevant and at their level; youth
- Lead
- Driven
- Getting youth involved in positive activities
- Drug awareness; synthetic street drugs; pharmaceuticals
- Creating the spaces for youth to come together
- Make it fun
- Peer leaders
- Integrate services into their activities and areas of interest
- Social networking
- Leading by example
- Act, Belong, Commit
- Family, parents, community and societal
- Support
- Connections
- Camaraderie
- Empowerment
- Promoting adventure, physical activity, culturally relevant and appropriate and accessible
- Funding

Prevention

- Age appropriate strategies

- Know better do better
- Active listening
- Mentors and champions and positive role models
- Peer leaders
- School and community environment
- Early Childhood screening
- Protective behaviours
- Teaching resilience, coping strategies
- Keep pace with how young people communicate and using those avenues to get information to them
- Education programs for parents
- Domestic violence
- Prevention
- Empowerment
- Open discussion
- De-stigmatising
- Strong Families

Treatment

- Over-diagnosis and over treatment
- Mind the language that professionals use
- Person-centred treatment and collaboration
- Accessibility to services and treatment
- Alternative treatments
- Respecting cultural and spiritual beliefs
- “One-stop-shop”: Services and treatments under one roof
- Information sharing
- Lack of assertive case-management

Rehabilitation

- Step up, Step down
- Post code based treatment does not work
- Building relationships and rapport with supports
- Youth-based mental illness recovery
- Clinical workforce
- Training and education
- Interaction with peer support workers
- Holistic approach
- “Looking after and encouraging the autonomous citizen by respecting ordinary feeling and minding our language” (Dr John Juridini)

Recovery

- Person-centred: “I am the most important part of my recovery.”
- Family and community
- Integration, wrap-around services and supports
- Networks
- Not working in silence

- Looking at the whole person not just their illness
- Consistency
- Follow-up
- Building genuine relationships
- Rapport with clients
- Trust
- Addressing staff burn-out and rapid job changes

Workshop two – priority issue

Person-centred, holistic, individualised care (scaffolded).

- Making sure the connections are there for people
- Building a relationship and rapport between client and practitioner; integration of services; central record; transparency; continuity of care
- Collaborative health planning
- Empowerment of the patient, for example peer support or big brother/sister
- Scaffolding of care
- Person-centred, individualised care
- Holistic care
- Preventative care/programs
- Suicide prevention
- Drug and alcohol Issues

Workshop three – SOAR

Strengths

- Person-centred, holistic, individualised care (scaffolded)
- Better compliance (trust) with treatment
- Developing and maintaining connections especially those teens/youth that don't have family and community (natural) supports
- Building self-esteem; empowers self-responsibility in their own treatment and recovery
- Consistent commitment on the part of the teen/youth
- Treating the whole person (not labelling)
- Maintaining functionality and improving quality of life (as opposed to just seeing a set of symptoms and labelling).
- Teen/youth knows that they are not alone
- Information given to empower them
- Flexibility around their care

Opportunities

- Public awareness initiatives
- Support through a range of activities for teen/youth that promote connections and camaraderie; physical activity, for example Tough Mudder, camps, fun runs, trekking, music festivals, boot camps
- Social Networking, use of technology, chat forums
- Training, education and upskilling of practitioners
- Chaplaincy and pastoral care in schools. Staff in student services
- Multi-generational family centres within communities

Aspiration

- Counteracting disconnection and disempowerment
- Peer support and mentoring
- Challenging our society's "alcohol culture"
- Strong Families; a family-friendly society; family-friendly work places
- De-stigmatising mental health issues

Results

- Lifetime empowerment on pathway to recovery
- Consumer-based treatment

Teen/Youth – table 24

Workshop one – issues

Promotion

- The connect groups, CaLD, Aboriginal – families
- Refugee experience
- Define promotion – holistic (prevention and intervention), multi (Universal) and their particular strategies
- Need more research and evidence, for example 'Mind Matters' built on Cognitive Behavioural Therapy, does not work at present?
- How to use it for good? More Positive messages, 'Reach Out'
- Mind Matters and Sensibilities - 38% Aboriginal?
- Knowledge in the community... to inform?
- Personal Relationship and network
- Support Communications
- Priority
 - Collaborative approach including community and stakeholder participation especially young people

Prevention

- Infancy and early/primary intervention
- Emotional psychological informing services data?
- Data – base line measures
- How is it collected?
- How is it used?
- Follow up data
- Working services – all services together
- Mental health workers in school settings together
- Educational Psychological – Risk management and clinical
- Students do not always feel safe!
- Mental health and psychology first aid secondary prevention level
- We don't have enough services to offer!
- Schools are Fiefdoms!
- Target education principals and teachers

- Schools and future capacity?
- Under Graduate teachers and training
- Youth up to 21–25
- Self-harming and suicide – clubs in seniors
- Texting and sexting
- Better preventative measures for youth
- School structure and transition points
- Technical and Further Education (TAFE) – more emphasis on resilience
- Cultural/principle in schools
- Organisational risk management – School Psychologists
- Continuity
- If screen – lack services to refer to
- Youth services in community – intervention
- Build relationships in schools
- Provide a good environment, better
- Social determinants
- Opportunities
- Co-morbidity of chronic diseases

Treatment

- Key issues for treatment
- Youth and people do not know! Can be discouraging
- Treatment and waiting times
- Child and Adolescent Mental Health Services (CAMHS) go to 16–18 – Bentley Adolescent Unit (BAU) developments?
- Fiona Stanley Hospital
- Youth present at Princess Margaret Hospital (PMH) – support?
- Mission Australia and Child and Youth services, empowering and educating?
- Tier I, II and III
- CAMHS and funding?
- Siege Mentality
- Side-effects of medication
- Need for follow-up - Coordinate and navigate services
- Introduce people rather than systems
- 16–18years – Gap

Rehabilitation

- BAU – Funding and recovery orientated community services
- The service context
- Community support communication and relationships, drug and alcohol?
- Recovery
- Looking for opportunities
- Holistic, social determinants
- How do we help the person recover?
- Integration and Navigation
- Schools and mental health – the workforce development, cohesive model behaviour focus

- Culture and mental health – the workforce development, cohesive model behaviour focus
- Go outside school settings
- Community – boundaries, supervision, Youth Affairs Council of Western Australia (YACWA) and ethics
- Key issues – guiding principals
- Training and child and adolescent health!
- Peer work, Perceptions
- Dads and basic mental health
- Key questions/family dynamics, community services, person centred
- Use of language
- Education and mental health and workforce focussed
- Drug and alcohol – rehabilitation
- Mental health – recovery
- Opt for joint work with T3/4 services and with NGOs
- Positive youth developmental directory
- Co-occurrence with adolescent
- Recovery or rehabilitation?
- Key things? Encourage?
- Lack of government commitment and funding
- Terminology/consistent language

Workshop two – priority issue

Creating youth friendly contexts that are responsive and flexible to the individual and collective needs across the continuum of care – for example social model of care versus medical model.

- A good discussion around prevention – definitions and thoughts, treatment, client led (focussed), homelessness
- Primary
- Secondary
- Tertiary
- Education and clinicians
- Whole of community
- Educate the system – The networks and approach, schools provides opportunity, marginalised children – school is a nexus point!
- There is a risk of pathologising things
- Medical Model – screening – labelling
- Developmental delays
- Finalise the level of need based on need
- Social model of care/health
- A system that is responsive to need
- Consumer literate
- The flexibility of delivering mental health including prevention
- A responsive system across the continuum of care
- A system that is flexible
- Prevention through to recovery/co-morbidity!
- Relationship - society
- Creating contexts – environments – government and community

- Grass roots level
- Creating contexts that (promote) – not just recommend
- Individually focussed- Holistic
- Responsive to individual and collective
- Across the continuum of care

Workshop three – SOAR

Strengths

- Timing is right for commitment?
- Motivation for change
 - possibility of local group gatherings
 - service mapping
- How do we empower services
- It depends on the organisation
- A partnership approach

Opportunities

- Partnership approach
- Sharing: Memorandums of Understanding (MOU)
- Developing partnerships
- Community participation

Aspirations

- Ideal model vision
- Person centred and responsive
- Social model of care versus medical KPIs
- Youth to take responsibility

Results

- What will it look like
- Outcome?
- Resilience in youth and families
- Capacity building
- Self-efficacy
- Measuring Success - Achievement of Goals – resilience

Teen/Youth – Table 25

Workshop one – issues

Promotion

- Awareness
- Technological Innovation, for example Facebook
- Right material for age groups – target groups – language
- Knowing what works with young people and implementing it

- Education and training for people who work in the sector about things that attract young people
- Balance between acknowledgment of stigma of mental health amongst young people and adults towards what the young people should know (protecting young people from information)
- Knowledge of what works with young people including addressing stigma

Prevention

- Using common language and processes
- Appropriate and genuine language
- Youth engagement – reference group. Representative over the key areas, for example aboriginal, CaLD
- Addressing stigma
- Funding issues for young people
- Social media engagement
- Facebook
- Twitter
- 24/7 service delivery
- Lack of role models

Treatment

- Stigma if going into tertiary care
- 24/7 not hours of support
- 16–18 consent versus service policy
- Mature minor assessment
- Addressing cultural difference
- Specific cultural differences
- Service providers have different intake criteria for different age groups
- 16/18 age group
- Referrals to CAMHS at 17
- Young people ending up in adult facilities
- Lack of services
- Youth specific
- Onward referrals are slow
- Parental support
- Being treated by GPs and medicated – not proper assessment/referral

Rehabilitation

- Youth friendly integrated service
- AOD
- Mental Health
- Trauma informed care
- Repairing relationships with significant people
- More rehabilitation and respite services
- Early and ongoing re-engagement into services
- Empathy for setbacks
- Access to psychiatry input without having to go back through the system

- Education on their own treatment
- Specialty GPs – more – funding to ensure continuation of services
- Being conscious of person centred approach and what it actually means
- Being genuine and authentic
- Consent issues
- Ensuring choice/options are presented
- Funding for private services
- NDIS funding impacts recovery services
- Gap in funding and delivery services
- “Time out from services”
- Can engage back when need to
- Flexibility of services
- Communication between regional services and interstate

Workshop two – priority issue

Determining and implementing up-to-date ways to better engage young people, for example innovative technology and common language across services, including culture

Workshop three – SOAR

Strengths

- Headspace
- Promotion of current programs – Act Belong Commit
- Current resourcing
- More awareness – school programs

Opportunities

- Leveraging off current programs that are affective – Headspace
- Increase access to resources, for example social media (these need to be managed due to online bullying (Facebook) – positive versus risks – social media
- Better system navigation
- 24/7 service access
- Promote common language
- Improving access

Aspiration

- Driven by the young person
- Managing the risk
- Co-production
- Reference groups
- Youth network
- Well resourced
- Political support
- Adaptable to the unique need of diverse community groups, for example Aboriginal, CaLD, AOD
 - Agencies working co-operatively and collaboratively
 - Well connected system

- Prevention – tertiary treatment – Life transitions

Results

- Increase the use of technologies to prevent/promote
- Reduce incidences of youth in crisis
- Increase use of youth programs
- Common language protocol/policy
- Decrease all levels of stigma
- Increase level of funding
- Increase diversity in services
- Youth input into the development of new programs
- Change in models of service so young people do not fall through the cracks

Teen/Youth – Table 33

Workshop one – issues

Promotion

- Aboriginal
- Event
- Social medias and technologies
- Sports
- Music: Creative arts, for example painting
- Application development appropriate to group
- Youth centres/Youth groups/schools
- Engagement with community
- AOD
- Events, for example leavers
- Alcohol - take responsibility for binge drinking culture
- Safer ways to explore AOD – cultural change, for example “friends role”
- Disability
- Begin at schools

Prevention

- Critical
- Has the most potential to make significant change
- Resilience increased, vulnerability decreased
- Strength-based approach
- Timeliness – act ‘now’/response that is ‘hopeful’ whilst with you
- School Programs (evaluated regularly for impact and social changes), for example healthy eating programmes
- Unintended consequences from broad programs, for example smoking, healthy eating/balance
- Positive capacity of service providers
- Evaluate well – existing/long-term contracts
- Are they still effective

- Contract management
- Corporate social responsibility
- Media – Critical!
- Hear about achievement of young people
- Positive stories
- Prevention approach to youth suicide
- Honest/vulnerable – good and bad stories – “having the conversation”
- Start a lot younger 10/11 years
- Families and communities – attachment theories

Treatment

- Youth friendly co-located (with youth sector/services) mental health services
- Self-awareness – tools
- Not just reliant on a system, their psychiatrist
- Build personal resilience too
- Exploring self-awareness early
- Involvement of family and carer
- Balanced approach
- Young person – needs to be able to decide but not alone
- Whole case management model
- Get back into life and full-recovery
- Bridging gap youth and young adult
- Interface between services more integrated
- Outreach-based
- Go to where they are

Rehabilitation

- Young veterans
- Current supports ‘older’ system / and impact of veterans on families
- More examples of “Headspace”
- Peers – co-managers
- Language – scary for young
- Main-stream services also more appropriate and accessible for youth
- Identified youth workers/staff in different sectors – for example youth appropriate GPs
- Why not psychiatrists
- Professions – additional training/interest for youth
- Case management model – best outcome
- Co-production with young people and supports

Recovery

- Language ‘recovery’ needs to be youth appropriate - promotion
- Critical to invest in young people – part of normal life – promotion
- CaLD “recovery!” – what does it mean
- Strength-based model
- Starting early – “everyone goes through sad time”
- Long-term plan
- Leave clinical supports

- Good, good continued support
- Youth mental health network explore? Promotion
- Getting more young people in health Promotion
- Recruitment and retaining – Promotion

Workshop two – priority issue

Reduce Youth Suicide

- Language – Recovery – what does it mean to young people.
- Access – removing stigma, changing language, youth friendly. How can you start a conversation if you don't have the right language?
- Other young people, peer support, different context, background, employed with background, Youth Liaison Officers

Workshop three – SOAR

Opportunities

- Existing services and infrastructure can be built upon for collective impact – develop framework
- Build upon existing sense of belonging within communities
- Increase investment in wellness
- Build into funding and procurement – strategic procurement, intelligent investment.
- Growth funding and reinvestment strategy
- Evaluation of current investment and reinvestment strategy
- Evaluation of current investment and reinvest in success
- Shared common language
- Survivor stories
- Build youth peer support workforce Youth Liaison Officers. Walking beside the young person
- Recovery includes education, employment, accommodation, friends, meaningful life

Aspiration

- Suicide rate reduced to zero
- Remove all barriers to service provision (access to follow up)
- Collective uniform approach to achieve major social change
- Strategies/interventions will be tailored to unique needs – developed by gaining understanding, knowledge and building on that

Results

- Significant reduction in death by suicide in young people
- Significant reduction in self-inflicted injury
- Ongoing funding based on analysis of existing programs and reinvestment into successful programs
- Increased investment
- Reduced incidence of serious mental illness (side-effect of strategies)

2.4 Adulthood

Table 2

Workshop one – issues

Promotion

- Reduction of stigma
- Identifying and using champions, for example ABC's Mental As
- Coordinating the range of community and media events, for example during Mental Health Week
- Going beyond Mental Health week where possible
- Value for money through activities
- Personal stories count
- Using local communities to drive things, for example local government
- Directing programs towards groups such as men, defence personnel, fly in fly out
- Using more online resources – people can access privately. But also remembering some groups do not relate to this. Some need more 'sideways' approach to raise the issues – for example rural older men
- Open days at hospitals, for example Graylands
- Promote range of activities for Mindfulness, for example groups for gardening. Good for the whole community
- Building networks, connecting in with community groups, families, friends
- Involving family networks in the person's support, and helping families avoid isolation
- Recognising that there is risk in living, but not being too risk averse in promotion, for example support staff by not being too punitive
- Helping staff recognise what they might be able to do creatively/differently

Prevention

- Connectedness, promoting people's networks and relationship building. Celebrities speaking out help this.
- Education, for example about risks of drugs.
- Early intervention, for example in primary school.
- Resilience and self-care programs, for example people knowing to go early to their GP.
- Education about different roles, services, options in the mental health system. People don't know who does what
- Early wraparound services
- Lack of services/uneven spread of services, for example more community follow up makes a lot of difference
- Work/life balance. Incorporating meaningful activities into one's life
- Research into what is working well for people
- Respite activities
- Working out what is a normal response to life and what is a mental illness, for example need to recognise that life should have a range of emotions. It's normal not to always be happy. Recognising that life events have an impact and this is often normal.

Treatment

- Involving families in the conversation

- Inform families how they can help the individual
- Issue – permission by consumer to involve family members
- Education to families to help them know they are not alone and what they can do
- Be mindful that in some cases family behaviour can be detrimental
- Look at international best practice, for example Open Dialogue in Finland.
- Promoting choice in treatment alternatives
- Difficulties in navigating system. Lack of knowledge about accessing services, especially knowing prior to getting very unwell. Particular difficulties for people accessing public services and getting labelled ‘non-compliant’
- Personal control of recovery can make a difference, for example people having access to funds to buy services
- Wait list for specialised services, for example eating disorders, sub-acute
- Some beds are occupied by people who could live in community if the right support was available
- Support services are not currently always frequent enough/well enough resourced to give continuity
- More integrated access to a mix of public and private services, for example Occupational Therapists, Social Workers and Physiotherapists
- Sometimes programs have stopped, for example Living Well.
- Gaps in workforce puts limits on service delivery and causes problems in continuity
- Uncertainty of short term contracts (NGOs) causes difficulties for staff

Rehabilitation

- Consistency of everything! Programs uncertainty exacerbates anxiety, for example for peer workers
- Systems that encourage family and friends to support a person reintegrating into society
- Particular pragmatic needs of forensic patients – they have often limited family and friends and need to sort food, accommodation before rehabilitation. Physical rehabilitation can also bring up a lot of other issues otherwise neglected
- Incentives to self-sabotage – to stay institutionalised
- Need to give after care. Good discharge planning

Recovery

- Is ongoing, not a linear process.
- Needs to be goal-directed (by the person)
- Will vary for individuals
- Important to have varied and different ways of supporting recovery – better for the diversity
- Relies on good communication between the person and service
 - Needs time to develop relationship and trust
 - Allows tough stuff to then be said
- Rapport-building is important to work out what is meaningful for the person
- Recovery workers need good training in separating their own values and preferences
- Good training for recovery staff
- Recognition that sometimes clinicians should provide pathways
 - A person sometimes has no insight, needs to support them

- Family can help in those times, for example there can be activities the person can do for connects
- Recovery includes a type of ‘family recovery’.
 - The choices by the person impact the family
- A person with insight can still be supported to do activities that help their mental health – for example choir, but a person will need help to do that
- Importance of networking to know who’s out there – important for recovery

Priority Issue

Stigma

Workshop three – SOAR

Strengths

- Benefits of addressing stigma
 - Openness of discussions
 - Encourages individuals and families to seek help
 - Reduces isolation
 - Normalises mental health issues and brings them into the mainstream of life.
 - Reduction of stigma supports early intervention
 - Increased understanding/awareness within the general community

Opportunities

- Cross sector networking to provide diverse opportunities to engage in community activities
- Corporate sponsorship
- Education in the corporate sector to promote good work practices to support mental health and wellbeing

Aspirations

- Supported housing dispersed throughout the community and not in clusters of enclosed blocks.
- Integrated services - easy access.
- Consumer driven
- Mental health and wellbeing
- Being a normal part of everyday conversation everywhere

Table 3

Workshop one – issues

Promotion

- Lack of funding for prevention/promotion
- Promotion focus on “sexy” areas
- Use promotion to reduce stigma
- ABC’s Mental As program this week has been very positive
- Changing the Royal Show item positive

- Increase consumer/promotion of lived experience voice
- De-Stigmatise by Normalising as Wellbeing/Health Issue
- Use learning from disability sector, i.e. marketing strategy (see the person not disability campaign)

Prevention

- Research
- Education
- GP Prevention – issues re mental health knowledge
- Develop programs
- More community
- Workplace
- Schools
- Education for community
- Early intervention
- Options?
- Phone lines?
- Change to “prevention and early intervention”
- Promotion should start at schools
- Change societal attitudes/cultural change for example school education on depression, gender roles
- New society pressures re work and family/work-life balance
- Increased risk mental health increasing
- Decreased labelling (medical model) – de-stigmatization
- CaLD Interpreter services
- available and cost
- understand culture-bound syndromes

Treatment

- (Group crossed out treatment and wrote Intervention and Rehabilitation)
- Term treatment and rehabilitation reflects medical model
- Be recovery focused
- Change language to recovery language to change culture
- Increased choices for consumers: with support re options
- Take strategies from Aged Care packages/sector
- Intervention -
- Language: Recovery/Rehabilitation
- Funding frameworks language conflicts with person-centred care/recovery model
- Change “evaluation” methods too and insurance issues/language
- See Disability frameworks
- Dependency – culture shift re long term clients, training changes
- Relationship with consumers/carers can change at low cost. Risk sharing/dignity of risk
- Power differentials
- Recognise and address
- Manage these
- Co-production strategy
- Support consumer choice

- Respect and support to think beyond dependency
- Do no further harm – transition period from dependent – recovery pathway. Avoid cruelty of imposing models on client
- Validate person's experience
- Disability models reform
- Lived experience used
- Promotion – develop joint understandings of recovery/wellness
- Other domains needing development:
- Accommodation/Housing options
- Employment and meaningful activity options
- Health
- Inclusion and family and relationships and connectedness
- Income
- Resource poverty

Rehabilitation

- (Rehabilitation crossed out)
- Child protection
- Trauma on child and family history
- Child protection support – COPMI
- Child carers/young carers
- DCP system assumptions about ability to parent/system collisions – educate child protection workers to shared learnings
- Protection, for example elder/consumer abuse (vulnerability – easily exploited re \$/across cultures
- Be culturally sensitive – extended family
- Workforce supervision – retain in context of ABF \$
- Impact of ABF will cut beds
- Impact of NDIS – Personal Helpers and Mentors (PHaMS) going, Partners in Recovery (PIR)
- Support workforce

Workshop two – priority issue

Shared understanding of conceptual language across sectors

Workshop three – SOAR

Strengths

- Common language
- Common service modelling
- Common care plans
- Common policies (generic)
- Referral pathways
- Better engagement with everybody
- Inclusive

Opportunities

- Shared language
- Genuine cross sector partnerships
- Streamlined communication
- Genuine co-production
- Training – review for health professionals
- Reduced cost training
- Opportunity for health promotion
- Opportunity to create seamless services for consumers

Aspiration

- Reduced tension
- Reduced misunderstanding
- Reduced miscommunication
- Reduced costs/duplication
- Best Practice
- Improved outcomes for individual/community
- Reduce STIGMA
- Reduce amount time in acute services
- Person centred seamless wrap around services (including housing, health, welfare etc.)
- Easier for consumer to engage in services
- Creating a contemporary mental health culture
- User friendly/consumer owns the process
- Joint responsibility/accountability for outcome

Results

- Decreased time in system
- Cheaper mental health system
- More integrated service
- More consumer focused
- More recovery focused
- Wellness driven not illness driven
- Positive strength based system
- Life span approach
- Applicable to all vulnerable and minority groups
- Holistic
- One care plan/one case manager
- Plain language for all
- Easier care coordination
- Clearer partnership between Health and the community

Table 4

Workshop one – issues

Promotion

- Drug education for users
- Education is accessible to everyone
- Accessibility of education
- De-stigmatisation of mental health
- Multiple adverse life events
- Multimedia pursuit of information provision
- Using the correct mode of communication
- Safe/secure childhood enhancement
- Over reliance on formal education mechanisms
- Lack of parental skills/ability/opportunity
- Cultural change in parenting and services
- Rural/remote – no internet
- Resource poor area of mental health
- Culturally secure promotion of issues
- Holistic and selective promotion

Prevention

- Lack of acknowledgement of developmental causes (inter-generational)/traumatic experiences
- Awareness of suicide occurrence in rural communities
- Social determinants – poverty, lack of quality education
- Information dissemination around suicide prevalence
- Abuse within community
- Education of drugs for young people
- Early identification of issues
- Lack of mental health literacy
- De-stigmatisation of mental health
- Education of GPs
- Parental discord
- Child abuse prevention campaign – children and adults target
- Person-centred funding preference

Treatment

- Lack of choice for treatment
- Access – waiting list, mismatched needs to services provided, reduced funding from Federal through GP
- Different pathways to treatment
- Transparent education of research
- Dominance of pharmaceuticals within treatment
- Need for variety of treatments
- Anti-depressant reliance
- Resources within treatment

- Development of services – co-production
- Lived experience
 - lip services
 - families involved
- Holistic approach to treatment – support structures
- Individuals choice to include family in treatment or not
- Counselling
- Complex care needs – bridging service silos
- Lack of supported housing
- More doctors, nurses, dentists in rural areas

Rehabilitation

- Allowing rehab to be a journey
 - Able to make mistakes and learn
- Over reliance on medication
- Over use of medication
- Risk associated with being in rehabilitation
- Availability of treatment options
- Lack of rehabilitation services everywhere
- Low expectations of rehabilitation
- Low resources in services
- Need for discharge planning from hospital
- No rehabilitation associated with tertiary hospitals
- Discharge to early
 - Results from lack of beds and over demand
- Poor connect with NGO services and community
- Cultural education for rehabilitation services

Recovery

- Return to workforce recovery support – ongoing
- Lifelong need for recovery – support available over the long term
- Community understanding of language for mental health, for example remission versus recovery
- Recovery as a term – is this appropriate?
- Individual differences in recovery
- Empowerment
 - lack of
 - for the consumer and families
- Clinician understanding of mental health recovery
- Mental health versus mental illness – understanding in the community
- Safe, stable, secure housing not available for recovery
- Poor education
- Poverty associated with poor health and mental health outcomes
- Transport to services – family and carers unable to join

Workshop two – priority issue

To enable recovery – safe, secure, stable housing with proper planning is essential

Strengths

- Housing safe, stable, secure is on the radar of the sectors
- Housing is recognised as a human right
- Safe, stable, secure housing is a requirement of recovery
- Ability to plan
- Supported housing model is being utilised in AOD services

Opportunities

- Education of the sector on the importance of the safe, secure, stable nature of the housing. Not just a roof over the head
- Supported housing will enable the recovery
- Cross sector engagement and collaboration
- Coordinated planning for supported accommodation
- Social return on investment for meeting the tenants recovery needs (additional to housing asset value)
- NGO involvement in housing provision

Aspiration

- NGO/partnership
- Benevolent landlord
- Housing that is tailored to the individual's needs. Additional support services that assist the tenant to maintain safe, secure and stable housing

Results

- Social capital measurement increased
- Homelessness decreased
- Hopelessness decreased
- Employment increased

Table 13

Workshop one – issues

Promotion

- Stigma reduction/elimination
- Discrimination
- Education – parents – children
- Resourcing for programs
- Whole of life
- Holistic
- Promoting to target populations
- Getting people's stories 'out there'
- Tailoring programs to specific audiences including regional, rural and remote
- Trauma
- Homeless
- Think outside the box, be innovative (Mary G Adverts)

- Promotion as whole of life, not explicitly mental health

Prevention

- Developing awareness of symptoms of mental health issues/problems
- Increased in holistic community programs
- One stop shop 'navigation of services'
- Educating GPs about programs and services
- Warm-lines (for system navigation, prevention)
- Peer workers staffing programs
- Programs in workplaces – Mental Health first aiders and peers
- Family centred programs

Treatment

- (Treatment crossed out and supports written)
- Recovery and person centred
- Appropriate, relevant, affordable and accessible
- Educating GPs and doctors
- Therapeutic/live in communities
- Programs for dual diagnosis
- Utilizing the peer workforce
- Integrating families in supports
- Supports for rural and remote (\$\$\$, tailored models, local people. Regular contact)
- Moving away from medical and hospital 'treatment' and environments
- Multi-disciplinary supports (including family)
- Trauma orientated supports

Recovery

- Recovery colleges to support recovery
- Consumer led education for workforce design and development
- Inclusive of drug and alcohol issues
- Inclusive of families and supporters
- Peer support programs
- Sharing our stories
- What worked, build strategies
- Build confidence and personal value
- Developing networks and keeping connected to others
- Active community engagement
- Recovery 'centres', person focussed
- Support groups programs
- Department of Education and Training Peer workforce
- Diverse
- Training – accessible
- Career pathways
- Jobs!

Workshop two – priority issue

Developing a peer (consumer and family) workforce skilled in recovery orientated trauma-informed, family-centred practices based on national mental health competency standards. Holistic, whole of family, whole of life approach.

Workshop three – SOAR

Strengths

- Peer support workforce
- Workforce reform
- Helps address power imbalance
- Improve quality of services
- Increase recovery rates
- Helps individual family functioning
- Consistency of best practice
- Changes culture of practice (medical to holistic)
- Normalises madness

Opportunities

- Better outcomes
 - individuals
 - families
 - community
- More accessible and timely services
- True cultural reform
- Increased awareness and understanding
- Peer workers bring hope
- Better engagement
- Better opportunities to access CaLD and marginalised groups
- People with lived experience model overcoming adversity

Aspiration

- Holistic, 'whole of family', 'whole of life', person centred
- Predicated on developing peer workforce
- In order not to discourage people with lived experience from various backgrounds, alternative entry level pathways to workforce development are required

Results

- Better outcomes; versatile and improved workforce

Table 14

Workshop one – issues

Promotion

- Language – need common language, for example medical versus consumer/carer movement

- Hearing from consumers and carers
- Demystify mental illness
- Need to provide culturally sensitive services, for example CaLD Training
- Act – Belong – Commit campaign
- Clarity about what mental illness is

Prevention

- Educate about mental illness/symptoms
- Tailor to CaLD community
- Pathway to better treatment
- Increased GP awareness training
- Workplace education, for example decreased bullying
- Start at schools

Treatment

- Non-medical treatments can be just as affected, for example art therapy, allied health
- Too much emphasis on medication
- Co-location to address 'silo-ing'?
- Collegial work between NGOs and government
- Move professional information sharing (with consent)
- Peer support workers – change culture – genuine involvement!
- Awareness and referral to community supports
- Service mapping is essential!

Rehabilitation

- Step up/step down
- Accountability
- Practice guidelines
- Localised
- 'One size fits all' doesn't work

Recovery

- Looks different for everyone
- Leading a contributing life
- Recovery training needed
- Genuine consumer and carer engagement
- Mental Health Network: Executive Advisory Group
- Person centred
- Cultural change – instil hope and optimism
- Education essential – recovery is possible

Workshop two – priority issue

Collegial collaboration that will decrease silos of care and improve professional information sharing and provide better service mapping.

Strengths

- Will have shared language

- Demystify what mental illness is
- Encourage discussion – spread education
- Better utilisation of resources
- Less duplication
- More empowered workforce
- Higher retention
- Less confusion re services
- More systemic changes
- More efficient pathways to recovery
- More effective support to/from colleagues
- Sharing lived experience
 - professionals
 - consumers

Opportunities

- PIR – good example
- Joint networking opportunities
- Shared professional development
- Case reviews/conferences
- Open space forums
- Multi model collaborations
- ‘Super clinics’ – all share building/services
- Share throughout services
- Mobile team

Aspiration

- One mental health system
 - Not divided into various parts, for example public/NGO/private
 - One language one service
 - More efficient and productive system
 - Flexible system
 - “Nothing about us without us”

Results

- No gaps in system/no overlaps
- Fluid service
- Available for all
- Better self-care for professionals
- Improved care for consumers/carer/family – ‘recovery’
- Equity – no matter what
 - Age
 - Cultural group
 - Post code
- Culture change
- Focus on what’s needed not what’s funded
- Psychiatrists will listen
- Sustainable funding

Table 15

Workshop one – issues

Promotion

- Families do not know what is available
- People not given information when they have contact with the systems
- Peers are a great way to share and give information
- Establish support systems for long term changes
- Supporting GPs and setting up partnerships with GPs
- Self-assessments available
- Information provided at school
- First episode teams
- Get young people to shape services
- Care coordination

Prevention

- (Prevention crossed out and Across all types written)
- Information Technology (IT) – across all areas:
 - sharing information
 - helping people access their own information and using it to provide
- Crisis plan – should be shared and clients/individuals to be involved
- Confidentially needs to be expected but also simplified
- Out of hours contacts?

Prevention

- Skills for teachers to spot those kids who need extra support

Treatment

- Accessibility
- Out of hours?
- Some accessibility for acute services after hours
- Client engagement is sometimes difficult
- Increase engagement in community so that end up in hospital
- Mental Health Emergency Response Line (MHERL) – it is not a free number so hard to call
- Co-location is important – we're still too isolated. Have more services in the same building
- Services here to break out if silos
- Shared measurement system, for example all share system and NGO
- It's about partnerships and sharing that information

Recovery

- Lack of support and services for young men in early 20s – 30s don't fit in youth or 'adult'
- Less formal services
- Definition is not always shared
- Diet and exercise – support network

- Choice – a range of supports
- It has to be about a person's own definition of recovery

Workshop two – priority issue

It is time to concentrate on action as a priority

- Action – choose an initiative and do it!
- Framework to reduce no governing bodies
- MHC, DCP, North Metropolitan Health Service Mental Health (NMHSMH), CAMHS, OMH, Mental Policy Research, South Metropolitan Mental Health Service (SMMHS), WA Country Health Service (WACHS)
- Champions of change – find the good and disseminate, for example co-location, care coordination, networking and sharing information
- New voices on committees
- IT
- Strong leadership – decision making- use of good practices that are already happening
- Use champions of change who are already there

Workshop three – SOAR

Strengths

- Use existing proven services/strategies
 - National recovery framework

Opportunities

- Embedding champions of change within daily activities
 - clinicians
 - service users – individuals and carers
- Building capacity with educational/shared knowledge to bring about change and monitor

Aspiration

- Reduce duplication of services with common language
- Strong leadership especially decision making
- Time frames to ensure change occurs – reasonable but a defined (no extensions without a good reason)
- Ensure committees/working parties have diverse range of members and not duplicated in other sites i.e. one working party for one action/change across network
- Framework for all mental health (MH)
- Recommendations implemented from stokes report
- Regular progress reports
- Accountability
- Recognition that extra funding is needed to drive program. Resources stretched already. Not dependent on political change or party in power

Results

- Audit against framework/stokes
- Consumer feedback and surveys

Table 16

Workshop one – issues

Promotion

- Co-occurring
 - disability/mental illness
 - acceptance it can occur
 - vice versa
- Awareness of complexities
- Raise understanding of issues
- Stigma – destigmatising
- Raising community awareness
- Act, Belong, Commit
 - Still important

Prevention

- Early psychosis programs implemented
- Access to 'good' care
- Training of Applications
- Communication between services
- Levels of prevention
 - early and timely access to services
 - for example pathways to recovery – Medicare Locals initiative
 - prevention of relapse
- Co-occurring
 - disability
 - funding issues
 - AOD
- Cultural impact on mental illness
 - cultural norms
 - do not recognise mental illness
- Currently appropriate education
- Gender bias
- Diversity in programs

Treatment

- Workforce development training
- GPs training (stigma)
 - Knowledge of services available
 - Appropriate referrals
 - Treatment available
 - Tend to medicate first
 - Talking therapies
- Access to treatment services
 - Especially rural and remote
- Less restrictive
- Person-centred

- Diagnosed – labelled – treatment
- To risk averse
 - Staying on medications
 - Shared decision making on medications
 - Side effects of medication worse than condition
- Carer involvement
 - Need to predictability on what is happening next
 - And time to think about it
- Treatment and discharge
 - Plans continuity
- More research into medications available
 - Less side effects
 - Alternative meds
- Research on off label use of meds
- Holistic treatment
- Focus on relationships rather than just treatment
- Lack of crisis assistance
 - after hours number

Rehabilitation

- Lack of a range of places to go
- Places for co-occurring AOD/MH issues limited
- Misunderstanding about the length of treatment
 - Medications affect people differently and for different lengths of time
- Person-centred, holistic
- Consider social Departments of health in the context of MH

Recovery

- Pre-existing conditions being a deterrent to employment
- Definition of recovery – not cure
- NDIS implications
 - Funding
- Medicare locals
 - PIR
- Co-ordination of care
 - AOD – disability
 - MH
 - Case management
- Service providers have large case loads
- Having a workforce that is suitably trained and supported
- Need for more realistic, positive stories

Workshop two – priority issue

Coordinated, person-centred, holistic approach requiring consideration of co-occurring issues.

- Coordinated, person centred, holistic approach requiring consideration of co-occurring issues, for example AOD, MH, Disability, cultural diversity
- Developing a culture

- Developing a workforce that is capable and supported to...
- Using a co-production framework to develop coordinated, person centred, holistic approach taking into consideration co-occurring (for example)

Workshop three – SOAR

Strengths

- Amalgamation of the Drug and Alcohol Office (DAO) and MHC – address co-occurring
- The sector is commencing to embrace a contemporary recovery principles according to international standards
- Workforce Development is focusing on the above (NGOs and Government)
- Partners in recovery program

Aspirations

- Coordinated services with flexible funding to decrease silos
- Least restrictive practice/alternative to enhance the persons dignity and choice (dignity of risk)
- Involvement of consumers/carers/family – care planning

Opportunities

- Utilising co-production framework to create cultural change within service delivery

Results

- The person receiving the best possible care and support to support their personal recovery in a timely and effective manner
- Treatment, discharge, care plans – consumer/carers involved in development

Table 19

Workshop one – issues

Promotion

- Delayed referrals/self-referrals due to other crisis pressing issues (for example housing, ASeTTS clients (torture and trauma) not presenting until 1-3 years post arrival in Australia.
- Providing mental health services concurrent with other needs, for example housing
- Slow shifts in culture and tolerance regarding mental health issues leading to increase in people 'coming out' with mental health issues.
- Need more information (facts) to back up stories
- Stigma
- Not a great sense about 'what is possible'. 'Can do' attitude needs promotion across all communities and populations.
- Youth is promoted greatly but not consistent campaigning for adulthood. There appears to be more promotion for mental health in childhood which disappears for adulthood.
- Diversity in promotion messages is needed.
- Frontline of support should be with GPs – but it's hard to find a GP who is knowledgeable.

- Incorporate mental health knowledge into education system to combat negative messages from media. For example what will happen when receive treatment.
- Media messages are improving though need increased encouragement and knowledge by GPs.

Prevention

- Bringing mental health knowledge into curriculum in education system will help increase skills, knowledge to identify early signs of mental illness and treatment knowledge.
- Peers/young people go into schools and talk about lived experience with mental illness to raise awareness would be a more powerful way to connect with young people and influence young people's views of mental illness
- Tertiary students need to build mental health knowledge into tertiary educations
- Health support systems at universities are useful.
- Media, websites to disseminate information regarding mental health.
- Monitoring programs for tertiary students to assist retainment of people at education systems.
- Life events. For example redundancy
- Broader social determinants. For instance, engage broader government departments as services can only do so much. Partnerships with other government departments.
- Flexible working hours plus healthy workplaces shifting to expectation of constant availability. Need to build resilience, self-care, family. Provide a toolbox for responding to these workplace demands.
- Recognise the fact I can't fit on my own, where I go to get support.
- Prevention of condition and prevention of escalation of mental illness.
- Incorporate personal responsibility and understanding of mental illness of/for recovery process. 'What can I do to maintain my wellbeing?'
- Treatment should incorporate prevention!

Treatment

- Accommodation for people with mental illness, vulnerable groups such as ethnic/non English background.
- Training in mental health professionals. Greater incorporation of mental health into medicine and physical health.
- Referral to health services for people with comorbidity (mental health + physical health).
- Inclusion criteria for services, should be consumer focused.
- Funding for services, availability of services to consumers.
- The concerns of treatment (pharmacological) as a fix, no structured multifaceted approach.
- Value for money with services, assessment and efficiency in mental health services.
- Delivery of services in rural areas, helping people navigate through the health system.
- Continuity of care. For example transferring services when changing address. Files not being transferred.

Rehabilitation

- Relationship is crucial to ASSETTS care/treatment model. Invest time and energy in building relationship with people before reaching 'treatment' stage.
- Rehab concept not really embedded in mental health setting and services.

- What is difference between rehab and recovery (I hope I can live a good life)?
- What is the aim of rehab? Participating in the community.
- Choice is necessary to recovery. Personal choice central to recovery.
- Navigation of mental services is very difficult for consumers and carers.
- Postcode systems catchment systems problematic
- Inclusion criteria is problematic where people excluded.
- Label of rehab not used anymore
- Inequalities of support for disadvantaged groups.

Recovery

- Peer support so important – some models of this but not enough.
- Small peer support workforce – expansion of this is needed.
- Where is personal health worker? Usually carers fill these roles of navigation.
- Not-for-profit plus government systems – both sectors.
- Identifying personal needs, individual planning.
- Don't do recovery by diagnosis but by individual needs.
- Recovery needs to occupy 'promotion' space to foster hope in promotion stage.
- Is recovery sitting more in a community setting? Or a state issue? A commonwealth issue? Hospital setting needs to be viewed as a component of system, not THE system.
- Services have to meet outputs for funding.
- Quality measurement is divorced from people's recovery but married to outputs of services (contradictory).
- Mindfulness
- Resources available during recover from a mental illness.
- Recovery is an individual plan, not a blanket process.

Workshop two – priority issue

Client chosen recovery goal drives the aim and design of treatment.

- Care-coordination consumer focused (person)
- Self-investment in mental wellbeing (connectivity)
- Quality and value of services (breadth of services)
- Client chosen recovery goal drives the aim and design of treatment.
- Culture
- Concurrence
- Undergrad courses should have mental health care capabilities
- Awareness of what information is out there (access + navigation)
- Access points: Where to seek support
- Increased contribution, economically, socially, financially

Workshop three – SOAR

Strengths

- Enables individual choice (only doing what is identified as necessary)
- Efficiency
- Empowers consumer
- Shared responsibility and ownership

- Reduces 'silo' with mental health
- Assessing the needs of the consumer

Opportunities

- Consumer to store input on treatment
- Increased effectiveness in utilisation of resources
- Creates space for consumer voice to be heard
- Increased effectiveness in achieving chosen outcomes
- Self-management, better quality of health and wellbeing

Aspirations

- Clinicians/service providers renouncing power
- Early, effective treatment
- Better access to services (eliminating restrictions due to comorbidity)

Results

- Sustained health and wellbeing sooner in alignment with goals set by6 consumer.
- Community acceptability, shifting of cultural norms, greater understanding
- Improved overall functionality in life
- Increased contribution, economically, socially and financially.

Table 20 and 22 combined

Workshop one – issues

Promotion

- Homelessness and mental health
- Media
 - Facebook
- Domestic violence and MH
- Finance and MH
- Local and MH
- Undergraduate health promotion
- Education
 - provide positive message
- Music
- TV
 - roles, storylines regarding mental health
- Criminal Justice and MH
- Celebrity
- Social media
- Other technology

Prevention

- Education
- Network and promotion

- Social determinants
- Social and environmental
- Early diagnosis
- Narrative
 - changing the conversation
- Employer awareness
 - mental health first aid
- Changing government
- St Johns First aid v mental health first aid
- Promote services to all people in community
- Training in all staff levels
 - in mental health first aid
- Dominant services
 - health care professionals
- Difficulty in applying for funding
- Cultural appropriately promoted
 - advisory groups
- Identify vulnerable target groups
- Cost effective practice
- Isolation

Treatment

- Waiting lists
 - early intervention
 - fall through gaps
- Costs
- Funding
 - for more than one year
- Stigma
- Fear
- Registrations and regulations getting more strict
- Lack of 24 hour care
 - lack of rural response teams
- Capacity wait lists
- Large case loads
- Interaction between private and public
- Collaboration
- Tele-health not used enough
- More effective use of funding
- Culturally appropriate response from law enforcement
- Bigger focus on quality outcomes
- Lack of wrap around services
- Establishment of crisis teams
- Interprofessional communication
- Police engagement
- Programs not in place

Rehabilitation

- Trust between services and elders
- Lack of education for GPs – continuing professional development (CPD)
- Clearer communication between clinical and community
 - no community support
- Culturally appropriate places to go (country)
- Training
- Over emphasis on acute care
- Availability of infrastructure
- Workers
- More support workers
- Volunteers to work in community
- Stigma
 - normalise treatment
- Lack of family support
- Do not have an appropriate place to stay
- A confusing system
- Labels
- Competition between services
- Limited support in the community

Recovery

- Organisational recovery
- Lack of Aboriginal voice/representation
- Discussions
- Dignity of risk
- Stigma within the system
- Funding to go back into re-engagement
- Miscommunication
 - clinical recovery
 - personal recovery
 - social recovery
- Family support systems
- Limited housing
- Professionals
 - re-traumatised
- Re-access services
- Once people are discharged they should be able to reconnect

Workshop two – priority issue

Addressing social exclusion in mental health through creating more positive conversations about mental health rather than illness, for example through education, awareness, understanding and collaboration and a commitment to address stigma.

- Address all five issues (below) together:
 - Whole of population focus, not just health, include community

- Collaborative approach, holistic health and wellbeing, at all levels involving consumers, carers and families
- Develop relationships; ensure all services work together collaboratively and in an integrated way; culture shift
- Ensure sustainability; increase community capability, assist individuals to manage themselves and achieve independence; overloaded clinicians managing crisis means there is no time for person-centred approach
- Person-centred recovery approach at all levels of care; adopt a recovery approach, ensure person-centred care, work collaboratively, build service relationships

Workshop three – SOAR

Strengths

- Evidence based
- Existing service providers are fantastic
- The conversation has started
- Social media is available, cheap and in use
- Traditional media is becoming more constructive and effective
- Community talk is positive, promoting communication and discussion and not as taboo anymore
- Representatives from minority groups are available
- Lived experience learnings
- Technology is available, use it
- Strengthen the consumer voice and participation
- A shift has started to include and respect the consumer voice
- Moving away from the medical model
- The right message is out there but not fully implemented
- Dedicated and highly skilled professionals are available
- More training exists
- There is recognition that training is needed
- Care support becomes part of the workforce and the team
- Good models of recovery exist and are being acknowledged in policy

Opportunities

- Training is being rolled out in public mental health services in collaborative care planning in collaboration with consumers
- Organisations exist that are using collaborative care planning and demonstrating effectiveness
- Consumer advisory groups are being set up
- Consumers are being involved in providing training

Aspirations

- Fully integrated services where everyone (community care services) is working together, including carers
- Unified care plan across services; commission agencies agree that it is acceptable to have unified care plan

- Recognition of non-pharmacological treatments and more inclusion of psycho social interventions
- Better balance of power across the team (including carers and consumers)
- Increased retention of staff and increased staff satisfaction
- Outcome measures for documentation is meaningful and helpful for the individual
- Mental health facilities are inviting, comfortable, safe environments; designs are improved
- Consumer leads the care planning; the capacity of consumers is develop to achieve this

Results

- Working party to look at care planning approach; look at requirements at different services
- Involuntary treatment isn't traumatic for the person
- Better prevention across all programs
- Reduced use of acute services
- Reduced time/ readmissions to acute services
- Crisis care is better managed so the individual spends less time in acute services
- Admissions are planned

Table 21

Workshop one – issues

- Recovery is strength based
 - need to focus on this – maintain identity
- Need more emphasis on trauma informed care
- Needs to be all about the consumer
- Services need to be working more collaboratively together
 - not just health but wider
- Find ways to prevent people falling between the cracks
- When services work collaboratively, greater capacity to work with more complex consumers – improved outcomes/engagement/experiences
- Cuts down on duplication
- Services need to be willing to work with the consumer where their “problem” is not their core business, to help link them in properly
- Need a more integrated model – MH, ACD, youth, NGO – one service
- Needs focus on public MHS changing culture to be recovery based – collaborative working will follow

Promotion

- Gaps in service- need to start early
 - Schools
 - parenting/attachment perinatal
- Needs to be at ALL levels and for whole population
- Positive – how good *beyondblue* info is
 - excellent resource
 - current

- right balance of consumer focus and clinician
- Focus on holistic wellbeing – not just MH
- Changing culture – making it acceptable to seek help
- Important not to reinvent things
- Online communities
 - provide helpful resources
 - opens up information to wider/younger population
- Need to involve all partners
- Falls outside public Mental health (MH) services
 - NGO sector
 - ? role for MHS to be doing more promotion
 - both to public
 - more within their consumer population
- Needs to be pitched at appropriate level
- Mixed interest from GPs
 - some fantastic
 - some not interested
 - GPs key awareness area for promotion (1st line)
- Recognise well-being is necessary to good mental health

Prevention

- Need for range of previous approaches to meet needs of wide population
- Targeting the most disadvantaged
 - “75% of MH issues are preventable”
 - relate to trauma
- Need for services which are responsive and culturally appropriate
- Aboriginal and Torres Strait Islander
 - missing how to link c̣ them
- Prevention needs to happen at the start, links to promotion
- Prevention stems from good promotion
- Investing in community – community investment
 - not MH specific, for example community gardens
 - cheaper than hospital
- Public MHS
 - not engaging people who could benefit from brief intervention to prevent longer term involvement with services
 - 16-25 year age group – people fall through cracks
- Lack of clarity re: diagnosis to do preventative work

Treatment

- If prevention nor working then primary care needs to know how to refer on
- ? Treatment is the easy part
- Medication debate
 - how helpful is this?
- Not good at collaborative treatment planning
 - not engaging the consumer in making choices
 - focus on symptom control
- Inconsistency in pathway/experience consumers have in navigating service

- Depends on clinician/Dr, how articulate person/carer is
- Infrastructure needs culture shake up
 - Graylands
 - facilities old
 - not conducive to care
 - culture shift – entrenched
 - needs to be blown up
 - need a new site
- Diagnosis is key

Rehabilitation

- Public MH does not prioritise rehab
 - not seen as their responsibility
- Funding for NGOs is restricted
 - long waiting lists
 - staff turnover
- Pay in NGOs prevent skilled clinicians applying for roles
 - rely heavily on support workers
 - not funded for specialist skilled workers/clinicians to do work with very complex cases
- People with complex issues needing long term rehab treatment
 - long term intensive treatment not available
 - borderline personality disorder – don't get service
- Need overarching plan to direct rehabilitation services to best meet needs

Recovery

- Collaborative care and coordination approach is better accepted in public Mental Health Services than NGO is presenting more respect
- Put participant first – make them own it
 - helps to build responsibility
 - ownership builds recovery
- Recovery star – useful tool
 - NGO services working recovery oriented way
- Public MHS mindset
 - they do treatment and NGOs “do recovery”
 - think it's asking the person what they want
- Recovery needs to be at every level of promotion, prevention, treatment, rehabilitation
- Recovery not just activities and people re-engaging with their community
 - everyone looking after each other
- Mental health recovery not just responsibility of MHS
 - housing, local community, wider health
 - how to engage those communities
 - how do mental health issues impact wider life
 - employment, relationships, access, housing
 - “broken leg – not just broken leg – impacts all areas of life”
- Services tailored to meet needs of someone with MH needs and other issues
- Not making adjustments to properly engage people and provide services in a way that meets their needs

Workshop two – priority issue

Whole of population focus

- Not just health, for example community
- Collaborative approach. Holistic health and wellbeing – at all levels involving consumers, carers and family
- Develop relationships – all services working collaborative and in an integrated way – culture shift
- Sustainable – overloaded clinicians managing ‘crisis’ – no time for client centred approach
- Community capacity
- Manage themselves
- Independence
- Person centred approach – time not spent on preventative. Recovery approach at all levels of care – person at centre of care – collaborative
- Service relationships

Workshop three – SOAR

Strengths

- Strengthen – consumer voice and participation
- A shift has started to include and respect the consumer voice
- Moving away from medical model
- The right message is out there but not fully implemented
- Dedicated and highly skilled professionals
- More training exists
- Recognition that training is needed
- Care support become part of workforce and the team
- Good models (recovery) exist and are being acknowledged in policy

Opportunities

- Opportunity in public mental health
 - training being rolled out in collaborative care planning
 - collaboration with consumer
- Organisations exist that are using collaborative care planning and demonstrating effectiveness
- Consumer advisory groups are being set up
 - consumers being involved in providing training

Aspiration

- Fully integrated service where everyone (consumer and care and services) is working together including carers
- Unified care plan across services
 - that commissioning agents accept that it is acceptable to have a unified care plan
- Recognition of non-pharmacological treatment and more inclusion of psycho-social interventions
- Balance of power across the team (including consumer and carer)
- Increased retention of staff and staff satisfaction

- Outcome measures for documentation is meaningful and helpful for the person
- Mental health facilities are inviting, comfortable, safe environments
 - improve design
- Consumer leading their care planning
 - capacity of consumer is developed to achieve this

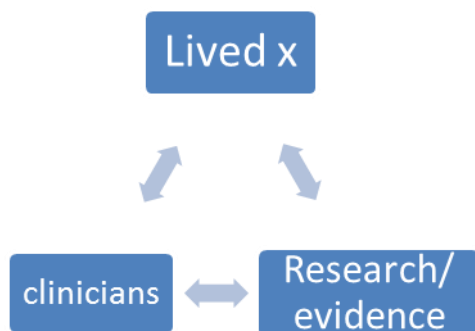
Results

- Working party to look at care planning approach
- Look at requirement of different services
- Involuntary treatment isn't traumatic for person
- Better prevention across all programs
- Reduced use of acute services
- Reduced time/readmission to acute services
- Crisis care is better managed so person spends less time in acute
- Crisis admissions are planned

Table 27

Workshop one – issues

Promotion



- Housing/ accommodation/ “houseless-ness”
- Abolish Graylands hospital
 - inpatients have single rooms and ensuite
- No more institutions
- Decrease stigma
- Mental health cut in ‘general hospital’
- Change organisational structure
- In balance of resources
 - specialising MH difficult
 - 8% of health budget
 - yet 11%? Of health burden is MH
- Everyone who wants a job should have one
- No places in the workforce
- Mental health programs supporting employment in the community
- Translating MH needs in transition to employment
- Raising community awareness

- Community ownership of MH
- Information to integration – education
- Episodic information to community to understand nature
- Promotion of lived experience
 - pitfalls/dangers of disclosure
 - ignorance of community to understand
- How?
 - use of community areas
 - lack of internet access
- Tackle community stigma
- Consequences of disclosure
- Coordination across sector/ Government/ Health/ Justice/ housing?
- No coordination business
- Across sector collaboration
 - all Government/NGO/Business
- Employment from employer perspective on work for people with MH
 - might be more problems at work
 - bring all problems to work
 - increase \$\$\$ for employers
- MH political “clout”
 - Sacked – could cause problems
- Balance promotional information for everyone
 - different needs
 - “normalisation” not de-stigmatisation
- MH networks present in wider community
- Innovation to encourage change
- Decrease physical health linked with MH and chronic health
 - needs to be part of chronic health network
- MH needs to link to chronic disease management network
- Strategies
 - 15-25yr diagnosis 1st contact
 - First contact – MH new attitudes and approaches
 - recovery, skills and strategies to manage
 - Page 41 Stokes review
 - trigger from
 - stress event
 - AOD event
 - medicine event
- Sell off of Medibank will have effect of private health and public health
- Common strands across public/private

Prevention

- Strategies for institutionalised people different for new consumers
- Abolish Acronyms
- Publicity and messages
- Embracing communication cultures
 - social media ways
 - talk their language

- whoever
 - Youth
 - Commerce
 - caLD
 - aboriginal
- Even across sector language
- Recovery not clinical vs. person
- AOD
- Definitions need to be clear
- Could we come up with broad definitions?
- We need to be integrated
 - mental illness same as any other illness
- Employment
 - barriers
 - disclosure/stability
- A person's right to have control over the condition.
- Person's right to live in community with a mental health condition
- Flexible service provision
- Preventative admissions
 - person take control of needs
- Hospital in the home
- If we can do it in palliative care why can't we do it in mental health?

Treatment

- Needs to be holistic
 - Pharmacology is only part of treatment
- Reduce barriers to entry for people to receive treatment
- Coordination access services/sectors
 - needs to be improved
 - get all stakeholders working together
 - allied health
 - GP
 - employment
- Get rid of silos
- Decrease in "double-up"
- One plan for one person
- Ownership of plan belongs to person
- Online Medicare/passport support one plan one person
- Rather than do to a person, do with a person
- Engaging with the patient's preferred treatment
- Life map planning
- Keeping in mind 'Family' needs
 - emotional/physical/psychological/spiritual health
- Funding allocation
- Compliance attached to funding

Rehabilitation

- Personal responsibility
 - just because you don't want to be responsible doesn't mean you cannot be accountable
- Handing over responsibility relief
- Lack of motivation
- Skills development
- Person local
- Sustainability of funds
- Contributor to dependence and we need to recognise this
- "needs based" for individualised services
- Recognising differences

Workshop two – priority issue

- De-stigmatisation – normalising the mental health experience in the wider community.
- Stability of funding and coordination between services

Workshop three – SOAR

Strengths

- Co-ordination
- Range of diverse groups with contacts and skills
- Strength from diversity
- People coming together 'on the same page'
- Exploring possibilities
- Allowing creativity and innovation
- Brain storming
- Being able to respond to innovation – will be difficult due to government layering
- Different capacities to be responsive
- NGO has greater ability to 'flex up decrease down' and department doesn't

Aspiration

- A just society
- Reduction in Red-Tape. The 'B' word
- Taking away barriers for access
- More employment opportunities – match abilities
- Seek earlier treatment
- More comfort on disclosure
- More holistic care = better outcomes - decreased hospitalisation and decreased Physical Health requirement
- Stability of funding and coordination between services
- Multiple stakeholder 'buy-in'
- Bilateral/Partisan agreement on funding streams
- Self-funded – employment – more stable productive staff
- Value and recognition of workforce – NGO, Government and commercial – repercussions for consumer and workforce
- Feedback/experience of service

- Consumer focused provision of service
- Respect and dignity for 'people'
- Acceptance

Table 28

Workshop one – issues

Promotion

- Awareness is increasing but has focused more on depression rather than illnesses such as schizophrenia
- In addition to mental health, person centred/ holistic
 - physical health
 - spiritual
 - emotional
- Funding not “recovery” focussed
- Who am I and what do I need to be healthy?
- Many programs do not have flexibility and don't allow from promotional activities
- The most disadvantaged don't feel included in current promotion
 - for example beyond blue
- How do you create inclusive messages?
- Mental health doesn't discriminate
- Consumers feel services are not always responsive to their individual needs
 - often “give people the run around”
- Eligibility a barrier to person centred – pathway negotiation
- Information not well targeted
- People may not identify with the messages
- Simple messages needed
- Medical vs social model and definitions
- Factoring in cultural perspectives
- Using methods appropriate to the target group
 - use technology where relevant but credibility is issue
- Promote wellness – mindfulness
- Boundaries and relationships – positive messages
- Promote at events and other places the target population are

Prevention

- Early intervention
- Keep people out of hospital
 - what needs to occur to support this?
- Mental illness is not a 9-5 issue
- Education
- Avoidance of harm then minimisation
- Trauma situation
 - recognise the triggers and address as part of the early intervention
- Recognise and educate on impact of critical life events

- Importance in workplace of having access to early supports
- “Pathologising” normal human responses to stress
- Drug and alcohol issues linked to culture and role models
- Work/life balance
- People put pressure on selves
- Parenting
 - poor outcomes can result from parents who can’t cope
- Holistic
- Prevention of sexual abuse
- Knowing the cause in early life of imbalances and illnesses in adulthood
- Suicide intervention/prevention/post-intervention
 - 24 hour support needed
 - lack of long-term assistance
- Issue of organisations who offer phone support not being “helpful”
 - they put it back on the consumer, “what do you want to do?”
 - not offering options/ alternatives

Treatment

- Across time – not just about pills!
- Social and environmental as well as medical/bio medical
- “Treatment” needs to incorporate the role of peers and supporters
- Partners in recovery and headspace work on the development person-centred plans which look at the psycho-social and clinical services
- Integrated approach allows for the escalation of “care” if required includes primary health and mental health in a shared care model
 - care coordination and resourcing
- Unsustainable!
- Activity based funding in mental health doesn’t necessarily have a person-centred recovery focus
 - more about widgets purchased!
- Treatment pathways are sometimes very complex
 - limited access and availability of services not always there for the long term
- Making sure the right info and programs are offered

Rehabilitation

- Connecting the social, for example groups
- Recovery begins the moment you walk in the door
- Understanding where to go to get help
- The low-key community based programs from “natural” community
 - for example friends, men’s sheds, neighbourhood centres
- Encourage inclusiveness and diversity links back to prevention
- Involving people with lived experience in ALL aspects of service/network
- Development and implementation
- Family and carer support
 - they are all first responders

Workshop two – priority issue

Service/care coordination –navigating the systems to access services covering the holistic spectrum of an individual's needs.

- People without mental health issue don't understand people living with MH conditions
- Difficulty in accessing inner city mental health services
- People are discriminated against when accessing mental health services
- Services not structured around what the consumer wants/needs
- Care coordination and services coordination and navigation through accessing MH services i.e. service broker i.e. partners in recovery for clients with severe/major MH issues
- Funding models don't allow for care coordinator for less severe/moderate MH issues
- Lack of MH. Coordinators across spectrum of MH issues – this would suit those with lived experience
- Promotion of wellness, boundaries, mindfulness issues. How to build resilience
- Early intervention and identification of risk factors and stressful events
- Accommodation options and access, affordability – group versus individual. Rental and supported accommodation

Workshop three – SOAR

Strengths

- Applicable to a range of population sub groups (CaLD, ATSI, Rural and Remote and equally to metropolitan
- Client focused with a range of modalities, internet based, face to face, videoconference etc.
- Care coordination is the clinical coordination service “ is about navigating
- Care coordination help the individual remain on the recommended treatment/program pathway. Caring groups and drop in centres are examples of caring organisations
- GPs spend little time meeting with patient. Counsellor and support worker can be available but access to service supports
- Minimise gaps and also avoid duplication and improving efficiency and benefits to patients
- Care coordination – better exchange of information support
- Health Care team card: who provides support for the individual and how it is delivered
- Continuity for the client

Opportunities

- To improve health literacy which then empowers the individual and family/carers to in the care pathway
- Opportunity to note use of lived experience, people with live experience or knowledge of this as well
- Improved access and support for people – improving the navigation of services etc.
- Connecting health and non-health (NGO and other) stakeholders to tailor care and support. A more holistic approach to care

Aspiration

- See systems change

- Cultural diversity and how to effect this
- Using resources efficiently, and effectively to achieve outcomes
- Person feels empowered to
- Accepting people with a mental health issue and not discriminating against people based on their experience/background
- Being fair and equal to everyone regardless of condition and state of illness

Table 30

Workshop one – issues

Promotion

- Overarching issue: poor representation of males at level of service provision of proportion of male consumers
 - For example of initiatives: Men’s shed; blokes in construction
 - Need for services that are designed to meet the different needs of males
- Comment re: identifying the presenting issues and then how to get them directed to the right services. This is especially true for those in co-morbidities
- Need for a more centralised approach
 - limited knowledge about what’s out there and how to access this
 - this exists for consumers and for health providers (for example GPs)
- Referral pathways (lack of visibility)
 - what are these, how do you find out about them?
 - website with services
 - how/who are these maintained
 - issues re access: this is not universal (especially with MH consumers)
 - other models of accessing info
- Role of pharmacy in being able to be a link between services, people, referrals, info etc.
- Workplace issues
- Google maps for MH services
- Need more awareness and collaboration between key organisations
 - especially across sectors, but also within sectors
- Need systems change
 - discussed that issues raised are analogous to the primary health network
 - need to change these things at the systems level
 - above and beyond MH
- Suggest strong link between primary care and MH
- Increased cohesion of services with better navigation and multiple entry points

Prevention

- Concern regarding waitlist times for common MH services
 - contributes to the need to use acute MH services
 - unable to get help in the early stages leads to deterioration
- Need supports and resources to help people while they’re on a waitlist
 - for example via GP, telephone services etc.
- Wrap around services are important

- Something that's working
 - providing stable housing, support networks and MH support
- Need to support carers (must co-occur)
 - must be included in all reforms, planning and service provision
- Need best practice patient pathway with lots of access points
 - which includes integration between professionals and carers)
- Need community awareness so that early signs an sx are recognised and encouraged to seek help/support
- Need to acknowledge the different needs of aboriginal communities

Treatment

- Need to be holistic
- GPs need to refer into support and community groups
- Over-reliance on medication
- Lack of acknowledgement of side-effects
- Over-reliance on medical model
 - with lack of contribution from beyond doctors
 - for example pharmacy, allied health, peers, support groups
- Pharmacy group: model of decreasing resilience
 - medications via holistic recommendations
 - also exists in a dementia? Sphere: ds-prescribing
- Need culture shift within psychiatry
 - shared decision making in clinical
 - collaboration with consumers in patient-centred treatment planning

Rehabilitation

- Words of hope, recovery and rehabilitation are not used during the treatment
- Missing compassion
 - a degree of shallow empathy exists
- Service standards and accountability need to encourage compassion
- There are benchmarks and ways to measure outcomes
 - both for organisations (how are we doing?) and consumers (how are they doing?)
 - mental health coordinating council (NSW)
- Safety and quality standards
 - need better policing and accountability
- Commissioning out services (purchasing of services) need to be looking at QUALITY and outcomes NOT cost

Recovery

- Working
 - raising awareness
 - supports are working (support groups)
- Not working
 - need to find self (not supported by services to find these)
 - family members treated badly by health services for challenging and speaking out
- Not helping
 - people telling families they shouldn't be sharing info about family member ("violating confidentiality")

- RBA: result based accountability
- Capacity to challenge the system
 - for example change GPs etc.
- Family that don't cope end up with homelessness
- "Act, Belong, Commit" campaign has made some impact
 - important to maintain this program
- Need a culture change where its encouraged to challenge medical and health professionals
- Benefits and risks of models of activity based finding
- Stop commodities MH

Workshop two – priority issue

Need to have a major change in culture, values and attitudes with a focus on companion, holistic recovery, shared decision-making and rehabilitation with a focus on 'healthy selves'.

- Holistic approach to integration of services and decrease reliance on medication and medical models. Model of Interdisciplinary care
- Education of community
- Absolute critical to incorporate carer's into service provision; health professional must work with carers.
- Shared decision making
- Health professionals and consumers, families/carers
- Need to have a change in Values and attitudes
- Should be a focus on compassion, recovery, rehabilitation (focus on 'healthy self')
- Outcome measures – are we measuring, what and how? And Quality and funding
- Services
 - for consumers
 - for carers/families

Workshop three – SOAR

Strengths

- Already existing:
 - homeless service: case manager model
 - engage with mental health and mobile GPs – creates MH stability, capacity and ability to then help maintain accommodation when it is obtained (as well as the system and society/community engagement broadly)
- Act Belong Commit - ? My way model: but MUST include carers and families
- Hospital in the home
- The recovery programs and workshops being run by Department of Health and MHC
- Recovery has to be flexible and involve community

Opportunities

- Tap into Primary Health Networks (federally funded) – commissioning body
- Fits with trauma (this model could be applied) informed care and practice
- Also work with NDIS again to ensure cohesion and not duplication
- Creating services which fill gaps rather than duplicating existing services

- utilise own strengths and broker in other existing services in areas of weakness or where you have a gap
- Need to get procurement right
 - has a gap analysis embedded
 - identifying existing services that are effective and cost efficient

Aspiration

- Empowering consumers and families/carer to direct treatment
- Dealing with human beings not treating patients
- That psychiatrists/health workers treat people as a person who exists within families and support networks – with a focus on recovery
- Like to intervene EARLY before issues become more serious or the consequences and impact is so great
- Genuine shared decision making

2.5 Aged

Table 1

Workshop one – issues

Promotion

- Health promotion (HP)
- Aboriginal aged care with dementia much younger prevalence
 - 3x more likely urban
 - 5x more likely rural
- Access to health promotion
- We are not giving HP a priority
- Need better partnerships
- Ageist
 - don't use technology to assist with providing information
- Duplication of services
 - we don't share resources well
- Need to network more
 - look at youth!
- Don't highlight issues
- We normalise ill healthy
- We underestimate the process of living with dementia
- Create pathways with youth
 - start early
 - make it more sexy
- Need a health promotion strategy
 - youthful
 - strategic
 - attractive
 - covers the needs of the sector

Prevention

- Use positive ageing
 - humour
 - link with youth
- Be inclusive
 - don't support segregation
 - for example don't plan for groups of people being "ill"
- Provide alternatives to GPs
 - wellness centres
 - AH Workers
- For
 - CaLD
 - Aboriginal groups
 - AOD
- Make it easier to access
- Link databases for monitoring GP input for transient
- Give more info about consequences
- Promote to the significant others to encourage early intervention
- Use technology
- Acknowledge literacy levels and offer alternative means
- Promote older adult input to society
- Offer positive retirement options including
 - financial
 - social
 - lifestyle
- Offer gender sensitive options

Treatment

- Allow risk!
 - need tools to identify what individual needs
- Lack of facilities to promote the stages of functionality
- Low skilled staff
 - not seen as requiring more
 - need
- Misdiagnosis due to medications
- Poly pharmacy
 - should be last resort
- One fix for all
- Medical model
 - cheaper but less effective
- Alternative therapies not subsidised enough
- Policy process practice
 - person centred
 - trauma informed
- Address the loneliness factor
- Treatment facilities
 - need to be cooperative for best outcome

- not for ABF
- Environments don't promote independence
- Must have hope
- "Moments of wellbeing"
- Need to be needed
- Partner with youth
- Link with local communities
- Integrate with others
- Focus on healthy
 - activity
 - social
 - emotional
- Be creative with incentives

Rehabilitation

- Fund it
- Individual
- Available
- Meaningful
- One fit for all doesn't work
- Goals
- Focus
- Education
 - where to access
- Allied health resources not available

Recovery

- Raise importance of wellness
- Understanding what it means for each individual
- Alternative therapies
- Specific services
 - not mainstream
- Treatment at home!
- Mobile resources
 - follow the individual
- Need more hospital in the home services
- Better data to understand patient movements
 - may respond to Pt need
- Don't address underlying issues
 - whole of person approach
 - cost shifting
 - duplications
 - need to provide carer support
 - financial physical
 - physical
 - environmental
 - emotionally

- Look at cancer services

Workshop two – priority issue

- Youthful, attractive, meaningful
- Mass media
- \$5 mill budget
- Health promotion strategy
- Better Partnerships
 - more networking
 - better info
 - groups, consumers and carers
 - more attractive
 - understand needs of sector and stakeholders
 - consumer informed
 - identify stakeholders
 - focus areas
 - dementia

Prevention

- Info sharing and knowledge transfer between sectors and services
 - i.e. database/online info of patient
- Good info management
- Positive ageing perspective

Treatment

- Individual, person centred, community focussed treatment strategies to achieve embed in system
- Need tools to identify what individuals needs are
- How do you apply psych-social approach?

Rehab

- Talk about person-centred, individualised, community focused care but systems don't support it
 - for example Insley bushes? We don't take risks
 - practice motivated by trying to minimise risk
- Allowing flexibility in MH and aged care systems

Workshop two – priority issue

Person-centred, individual, community focussed care, but the system/process doesn't allow it.

Workshop three – SOAR

Strengths

- Identifying and aware of individual needs
 - patient – centred care is recognised in policy
 - guidelines etc. and considered a good thing
- Statewide Specialist Aboriginal Mental Health Services (SSAMHS) – is to a large extent already doing this

- NMHS only?

Opportunities

- Develop tools to identify what individual needs are
- State-wide, standardised clinical documentation
- Recovery and wellness form
 - opportunity is that it could be mandated
- E-records for transient/homeless, to allow history and not have to repeat info
 - PCEHR
- Multidisciplinary team approach is best option
- Specialised support for individual personal care
 - for example DBMAS (Dementia Behaviour Management Advisory Service)
- Mapping partnerships
- Skills register
- E-directory for linked networks
- Developing and sharing clinical pathways
 - for example Commonwealth funded etc.
- Raising awareness of what is possible.

Aspiration

- Totally client-centred mental health service for elderly people
- Managed effectively and appropriately in the community rather than Tertiary/Acute services
- Integration and prevention
- Primary care and NGO to manage majority
- Map and community care
- Inform/influence policy
 - infrastructure
 - services
 - KPIs
 - outcomes linked to funding

Table 17

Workshop one – issues

Promotion

- Awareness raising
- Speaking up
- Advocacy – self and collective
- Challenging stigma
- Building connections – within community and between sectors
- Wellbeing education, for example Act, Belong, Commit!
- GP education – Recognising grief and loss not just mental health/symptoms
- Recognising signs
- Frameworks of understandings
- Intergeneration reciprocal valuing, for example: volunteer grannies

- Developing communities and villages rather than “facilities” – change policies to enable people to stay in their home. For example a builder felt forced to lie to local government because the approved stated he had to label plans “nursing home”, rather than wellbeing community
- Work and voluntary opportunities, for example mental health promotion and self-advocacy and leadership
- Recognise the need for purpose
- Shifting from burden language to “value” language

Prevention

- Access to affordable health nutritional food
- Innovative ideas for the gathering and distribution of healthy food
- Community gardens – local people powered veggie/herb fruit gardens for example even planter boxes in aged care facilities
- Exercise and lifestyle – exercise equipment in community parks and facilities – Armadale, Ellenbrook Social engagement opportunity
- Inclusive engagement – valuing our Elders creating leaderships opportunity to support them to rise and lead
- Promoting the value of our elders so young people want to volunteer, share and learn with them
- Rural and remote
 - tapping into community spirit of exchange
 - innovative technology knowledge
 - support access through education, IT, infrastructure, hardware and support

Treatment

- All options exhausted prior to medicating and acknowledge
- Poly Pharmacy
- Use a non-pharmacological approach first, for example Metformin and Stanton’s link to dementia and others that affect cognition
- Resolve the underlying problem
- Collaborate with pharmacist and clinicians support shared understandings of how “recovery” can contribute to wellbeing
- Building bridges between medical and recovery by empowering pharmacists to challenge Drs about contradictions
- Access to home based treatment
- Access to beds for people who can’t be placed in mainstream facilities
 - High dependency unit beds
- Young people spaces to free up older beds
- Least restrictive practice
- Looks beyond the behaviour to find what would sooth the persons reason for behaviour
- Identify the triggers of the behaviour and soothing strategies, for example baby – like the snooze land room

Recovery

- Right to meaningful and decent life
- Shared understanding

- Work to stop loss of life
- Access to talking, grieving, support and honest conversations that don't pathologise loss (normalising), recognising, celebrating, sharing successes
- Understanding the stages of grief as a part of recovery
- Recognising the above will facilitate the production of peers
- Recognising the basic needs people need to build a life
 - employment
 - housing
 - training
- Hostels
 - supporting elder peers with resources
 - hard/soft so they can share with other peer – capacity building
 - double beds
 - dignity for our elders
 - sexual health education, boundaries, context
- Small and big things that can make their environment
 - paint colour
 - comfy furniture
 - music
 - flooring
 - music
- Identify the individual unmet need
- Creating alternative recovery environment (CARE)

Workshop two – priority issue

Move away from a medical model towards a trauma-informed, social recovery model of care.

- Promotion
 - wellbeing education
- Prevention
 - technology to facilitate
 - access to peer support and services (rural/remote and metro)
- Treatment
 - non-pharmacological approach (masks underlying issues)
- Rehab and Recovery
 - building peer support capacity within the system

Workshop three – SOAR

Strengths

- People heal and move out of the system. People still in system will have a life choice, meaning and dignity reduces the impact of iatrogenic of the medical model
- Cost effective – people out of hospital living independently and connected to community
- We can draw on the local and international evidence base

Opportunities

- While national standards and policies are being reviewed, we should embed this in to the curriculum of all health care professionals
- As sector moves to consumer directed model – we have opted to embed trauma informed, social and recovery approaches
- Opportunity to tap into education and training, existing resources for both health professional/doctors/consumers/elders – for example adults surviving child abuse, mental health website resources
- Consumers of Mental Health WA (Inc) (COMHWA) can support coordination and bring people together to support (Peer development, genuine consumer participation/co production)
- Creating an organisation/community culture that values the role of our Elders
- There will be an opportunity to share this good practice with other sectors once it is rolled out
- Opportunity to be leaders in this space

Aspiration

- We will see older people engaged in life not pathologised and healed from trauma
- Older people will be valued in our society
- People are self-determined and support to keep making decisions
- People are enabled to be in their own homes longer to be independent and retain their dignity
- Society and communities will be more open and understating of difference

Results

- We will see our aspirations realised
 - quality of life measures
 - recovery outcomes measures
 - count how many people are engaged and disengaged in life

Table 18

Workshop one – issues

Promotion

- Suicide (prevention) promotion neglected
- Every area
 - it's not happened in the past
- Social engagement
 - build on research
- Physical health
 - promotion
 - exercise
 - injury prevention
 - access to physio
- Dental health
 - residential care

- Mental health literacy
 - CALD
 - Plus issues regarding reverting to original language
- Aboriginal MH promotion
 - policy DHWA – ATSI
 - ‘old’ = 45+
- Disability sector + aged + mental illness
 - how do we link
 - not take over but cooperate
 - Overcome “history” of two sectors and stigma
- AOD (see above)
- LGBTI – aged care
 - stigma but future needs will be more ‘vocal’
- Address stigma of aging plus mental illness

Prevention

- Healthy aging
 - change community mindset regarding burden
- Health literacy
 - diet
 - exercise
 - medications (multiple)
- Staff education
 - to identify early issues
 - ER – GPs – all staff in health related industries
 - relate to Primary care
- Suicides
 - early intervention
 - remote farmers
- Aged care bonus
 - similar to child care bonus
- Local government
 - zoning laws to support granny flats
- Carers pension rates
- Infrastructure
 - transport support
 - seniors card – ‘hold it’
 - more local and community based
 - socialisation
- Groups
 - carer and family individual
- Drugs and alcohol
 - undiagnosed
 - unadmitted
- Prescribed medications
 - problems
 - overdose accidents
 - storage

- over the counter
- discount chemist
- natural
- Antipsychotic medications + patients with dementia
- Benzodiazepines
- Vitamin B12 and urinary tract infections
 - as part of health literacy families

Treatment

- Carers and families involved or advocate
- Commonwealth funded services
 - hostels
 - new homes?
 - need to be part of network
- MH + Hostels
 - high MH issues
 - low support provided
 - low staff training
 - high CALD
- Co-ordinated care plan
 - regardless of where the person is living
- Stigma regarding diagnosis
 - for example schizophrenia discrimination, cannot access services
- Research needed
 - specific to this group
- Lack of services in R/R areas
 - impact on person – family – community
- Intergenerational issues
 - CaLD
 - ATSI

Rehabilitation

- Change of mindset
 - older people can and do recover, or can improve
 - quality of life
- Looking at lifespan and a good death
 - respect for wishes
 - advance directives
- Dignity of risk
- Acceptance of cultural 'norms'
- Sophistication around people choices re death
- Maintain skills they have
 - co-produced skills
 - for example they can dust, some can vacuum
- Facilities should be modern and respectful
 - most rehab should be in facility that person is going to reside
 - model of community rehab services
 - clinical and non-clinical facilities and services

- Transitional care model be correctly applied to mentally ill and aged persons
- Creative
 - veggie gardens
 - mix with schools
 - pets
 - adopt a grandparent

Recovery

- Definition of this group needs to be clarified
 - living a meaningful life
 - quality of life
 - being valued
 - for person
 - for carers/family
 - for community
- Stigma
 - Regarding language we use
 - seniors
 - aged
 - elder
 - older
 - crinklies
 - grey
 - wrinklies
 - geriatric
 - gerries
- Support needs
 - socialisation
 - ability to meet
- Geographical needs
 - PH and mentors
 - befrienders
 - valued and paid
- Never give up on recovery for each individual
- Appropriate 'in-reach' to people
 - For example hospital in the home
 - NH/hostel
 - rehab in the home
 - OT
- Discrimination from younger people in NH sector who don't want to be with "these old people"
- Decent food helps recovery
- Culturally appropriate

Workshop two – priority issue

The Mental Health Network creates synergies with other networks to promote the mental health of older adults for an appropriate range of services and reduces stigma.

Workshop three – SOAR

Strengths

- Synergies
 - holistic way
- Leverage work already done by other networks
 - more in common than different
- Normalise = de-stigmatise
- Bigger voice – collective
- MH then in the other networks consciousness and their “issues” are in mental health
- Best service design standards in other networks should “wash” across
- Hear what didn’t work for other networks
- Learn from them what did work
- MH awareness as part of other networks develops information and actions that include mental health within
 - other models of care, for example stoke, includes references to MH issues
- As part of Health networks
 - the MH networks are aware of other network plans and can advocate to fill the “missing parts”

Aspirations

- Equality for older people in MH
- All services are inclusive of age
 - CaLD, gender etc
 - residential address
 - zero barrier
- No stigma
 - work with aged care sector by 2016-17
 - anti-stigma campaign by 2017/18
- Services available
 - any time
 - anywhere
 - anyone
- 50% reduction in current wait lists by 2017
- Older people with MH issues remain integrated within community/families/society and connected
- CW and State negotiations COAG agenda 18 months – 2 years
- Systems to support a sustainable, mentally healthy and happy workforce.
- Implementation of compulsory framework by 2016
- 10 year reduction in average age of MH workforce by 2020/2021
- Older people have sufficient psychological literacy to navigate the system and participate in all levels of planning and all aspects of their lives
 - communication plan developed to ensure by 2015
 - plan implemented 2015 – onwards
 - plan evaluated – refined if need be
 - repeat activities
- Resources available as needed/required
- Suicide prevention plan which articulates issues within older people age group

- plan implemented, evaluated, refined if need be
 - plan continues with prevention activities 2015/16
- Suicide rates in the older population is reduced by each year from 2015 and reported on in MHC – Annual Report

3. Rural and remote

In order to provide as much opportunity to capture the specific issues for rural and remote populations, a separate dedicated video conference session was held. A total of seven sites across WA registered for the video conference. Four sites contributed on the day:

- Wheatbelt (Northam)
- Goldfields (Kalgoorlie)
- Kimberley (Broome)
- Pilbara (Karratha)

The workshops were coordinated from the Graylands Hospital site and co-facilitated by WA Country Health Service (WACHS), Head Office personnel and a Health Strategy and Networks staff member.

Due to unforeseen circumstances the start of the video conference session was delayed. This culminated in having to modify the program to two workshops:

Workshop one:

- brainstorming of the general regional issues
- brainstorming of the drug and alcohol issues (full transcript in the supplementary report).
- Workshop two – brainstorming priority issues for their region.

In Workshop one, sites were asked to provide feedback on what they identified as their regions specific issues. Each site then shared their issues with the other regions. During the course of the workshops the lead facilitator listened and organised the issues into themes (section 3.4). These were fed back to the participants at the end of the workshops for verification and agreement.

3.1 Site specific issues (general)

3.1.2 Goldfields (Kalgoorlie)

- Attraction and retention of staff to enable provision of services
- Disparity across the region about what other support services exist. For example, [Bay of Isles Community Outreach Inc \(BOICO\)](#) in Esperance but not Kalgoorlie
- Staffing and staff qualifications also an issue for non-government organisations.
- A specific program may succeed in the Eastern states but in Kalgoorlie. For example, [Headspace](#) is a good step forward but very dependent on capacity of the consortium members.

3.1.3 Pilbara (Karratha)

- There is a lack of non-government organisations and it is hard for those who are available due to lack of accommodation, poor staff retention.
- There is a lack of recovery enabling activities for clients. Adoption of hobbies is a significant feature of recovery.
- There is a lack of consumer and carer positions and support for these.
- Lack of administrative staff so clinicians end up doing this type of work
- Lack of ability to gain learning experience.
- Looking forward to joining networking activities

- Join in research activities and included in outcomes as well as research trials.
- permission to travel not given because of lack of funding
- Walgett Aboriginal Medical Service (WAMS) – looking to extended training into rural area. Mental Health and Drug and Alcohol sectors to connect.

3.2.4 Wheatbelt (Northam)

- Recruit and retention
- Access to clinical psychologist/psychiatrist poor particularly for adolescence specialities
- Good NGO access and potential to strengthen with good access to clinical psychiatry
- State-wide forums good but not implemented well
- There is a local AMS so access to Aboriginal specialists is good
- Not able to fill to establishment
- A change in policy and procedures mean time is invested in change and implementation. A big task for small services to implement everything. For example, the Mental Health Act requires giving people accurate information.
- To engage in policy and procedure implementation of any type. We need WACHS Head Office to lead a process to roll out to all services. Small services, could engage in a working group but a better process is for WACHS to write a draft for consultation.

3.1.4 Kimberley (Broome)

- Agreed with Central Office overview
- WACHS very lean and resourceful at getting services on the ground, sometimes to their detriment.
- What can we consistently offer in terms of training and development? We need a standardise approach.
- What standard do we want and what do we need to deliver that standard? For example, these are the type of CAMS, Drug and Alcohol Adolescent services we want, to this standard so we require these resources to achieve that.
- Need established clinical governance and resources to support this governance.
- State based services need to pool dollars together to deliver state-wide services into the regions.
- We are reliant on locum services that are poor investments as locums are transient so do not establish a service, but if delivered to regions by a state body a better service could be provided.
- ABF – model for acute services in remote area causes great head-aches for hospital based services.
- Interphase with Commonwealth funded programs: how do state and federal services work better together to deliver state based services into the regions.
- Too much time spent recruiting and retraining – can't get off the treadmill
- There is no doctor in the region. The state needs to decide on a best practice model.
- Suicide, suicide prevention an issue in this region.
- NGOs working in mental health need to proliferate but need assistance to develop. So we need to house NGO and state services together.
- Area Head Office needs to assist regions as an umbrella governance organisation.

3.1.5 WA Country Health Service (Perth)

- Lack of standardisation of process and communication across region, for example establishment of effective standard mental health data collection and communication tools is required.
- Agree with staffing issues raised by the regions
- Need to look at different ways to provide services, for example tele-mental health.
- Need to establish a process to identify gap and develop solutions
- We need to partner with NGOs and other agencies.
- For mental health budget deficits and surpluses: We need to develop an agreed process for use of surpluses in one area on deficits in others.
- Roll out of Mental Health Act also an issue for us
- SSAMHS Program - how to guide it into base budget
- Stokes review initiatives roll out an issues for us
- Performance monitoring
- Clinical indicators are required for measurement of service
- Engage CAMS
- Engagement of consumers and carers
- Rely heavily on NGOs and Population Health to do MH prevention and promotion. Central Office needs a stronger role in these areas
- Link in better with metro services. Particularity those labelled state-wide – we need better links.
- Rural/metro transfer between mental health beds
- Investing in workforce recruitment and retention, education and professional development.
- Future funding – SSAMS – Aboriginal MOC implementation across regions metro / country pathways
- Tele-mental health – Need more support from Telehealth services based in Subiaco for technical support.
- Infant mental health: lack of resources for child and youth clinical services should be considered prior to focusing on promotion/prevention
- Consumer/carer engagement lacking – hard for WACHS sites to pick up initiatives. Too many things come for sites to respond to. Hard to involve self, let alone try to engage others. Perhaps something the Health Network could work on.

3.2 Site specific issues (drug and alcohol specific issues)

- Graylands (Suite 3):
 - Agree with Broome regarding AOD.
 - Need to identify what we need, how much it will cost then adequately fund.
 - MHC review = need double current FTE is required
 - Need to staff to meet triaged services needs in a timely manner.
 - Need to also consider Mental Health of workforce. More support demanded from central office but central office needs support to.
- Pilbara (Karratha):
 - Did have a good Drug and Alcohol Service now ceased as part of amalgamation with Mental Health Services. Mission Australia has the contract for services but are not able to get up and running properly. The gap is picked up by mental health

staff who are now overwhelmed. Now a high risk from a governance perspective – all services need to be around the table to discuss and develop solutions

- Kimberley (Broome):
 - Recommend considering the Geraldton Population Health Model which is interesting
- Wheatbelt (Kalgoorlie):
 - Has good relationship with NGO
 - There is currently an uncoordinated approach to new initiatives such as sharing buildings.

3.3 Rural and remote priority issues

In Workshop two, participants were asked to state the priority issues for their region. The priority issues for each region are as follows:

3.1.1 Goldfields (Kalgoorlie)

- Recruitment and retention of staff.
- Changing expectation and demand on services.
- Need for agreement on the type of service the region should offer and be realistic about what can be provided by the particular region.
- Explore opportunities to link with other regions or NGOs to meet expectations.
- WACHS sites need to be resourced to support NGOs more to create linkages and partnerships.
- Professional development and training – difficult to access in practice, for example permission to travel is restricted, the electronic classroom is not as effective as it might be.
- Invest more centrally in the dissemination of information around new policy and procedures.

3.1.2 Pilbara (Karratha)

- Growing number of problems to address but fewer staff to address them.
- Lack of NGOs so the general public expect the state health system to provide everything, for example Mission Australia: Drug and Alcohol can afford staff but not housing. Also, Mental Health Week puts pressure on state staff.
- Many clients are homeless so treatment and recovery is hampered.
- Some professional development sessions/requirements are difficult to design as staff need to be all things to all people – but there is no staff. For example the 'staff recruitment freeze' left us with no services in Roebourne.
- It is hard to look beyond core business.

3.1.3 Wheatbelt (Northam)

- More support for SSAMHS programs into core business. What does that look like? How do SSAMHS staff work with clinical staff?
- Staffing and recruitment – lack of NGO services means we are constantly asked to do everything for everyone. How much could be standardised and rolled out by region not site?

- Videoconference is not a solution as most outer Wheatbelt sites cannot access the bandwidth required. If offered generally by WACHS with Northam as a central hub, this would increase access for other towns like Bencubbin.

3.1.4 Kimberley (Broome)

- Remodel remote Mental Health Services to overcome current flaws, for example mental health and primary care interface for service delivery.
- What staff do we have/what staff do we need in the regions, for example multi-skilled and flexible.
- Having staff with dual qualifications in place is essential for all regions. Regional staff should have primary care, mental health and drug and alcohol qualifications with services all on the same page, inclusive of aged care and AMS.
- Locums funded by Medical Specialist Outreach Assistance Programs (MSOAP) (Federally funded) – are not consistent, so clients have many new service providers and constantly need to re-tell their story, build rapport etc.

3.1.5 WA Country Health Service (Perth)

- Staffing and housing – 26th parallel subsidies should also apply for Kalgoorlie, Collie and Katanning.
- Need collaboration between the Department of Health and Homeswest.
- Esperance did have four mental health houses but now has none.

3.4 Rural and remote themes

- The lead facilitator shared the list of themes that had emerged having listened to the workshops. The following themes were recounted to participants for verification and agreement:
- Recruitment and retention of staff via:
 - Addressing mental health across the life-course and, drug and alcohol skill set deficits by re-modelling to create a multi-skilled and flexible workforce.
 - Housing that meets the needs of a transient workforce.
 - Assist staff to cope with the changing expectations of their role particularly in regard to supporting NGOs and the need to be ‘all things to all people’ by centralising and standardising some processes.
- Education and training: outreach is a better model for roll out of reform initiatives such as the *Mental Health Bill 2013*, the new Western Australia Mental Health, and Alcohol and Other Drug Services Plan 2015–2025 and Stokes Review 2012 initiatives.
- Clarification and articulation of what statewide services are. For example what does service ‘X’ look like, who is responsible for it, within it and where is it best located? What are state services as opposed to non-government services?
- Consumer and carer engagement.
- Benchmarking of services.
- Centralised methods to assist establishment of NGOs in the rural and remote areas.
- Consideration of the implications of ABF on acute hospital services.
- Better integration, navigation, monitoring of workforce, culture and service delivery across the state.

3.5 Video conference feedback

Wheatbelt (Northam)

Found this useful. Good to see others have similar issues.

Pilbara (Karratha)

Agree with Wheatbelt. It's great to be listened to.

Goldfields (Kalgoorlie)

Valuable to identify the issues but this is not the first time these have been raised. Grappling with how

The network might make a difference so interested to participate in future discussions about what the network can do?

Kimberley (Broome)

Happy to be involved. We have solutions but no means to employ them.

WA Country Health Service (Perth)

Found this session useful. Unclear about how the mental health network will work.

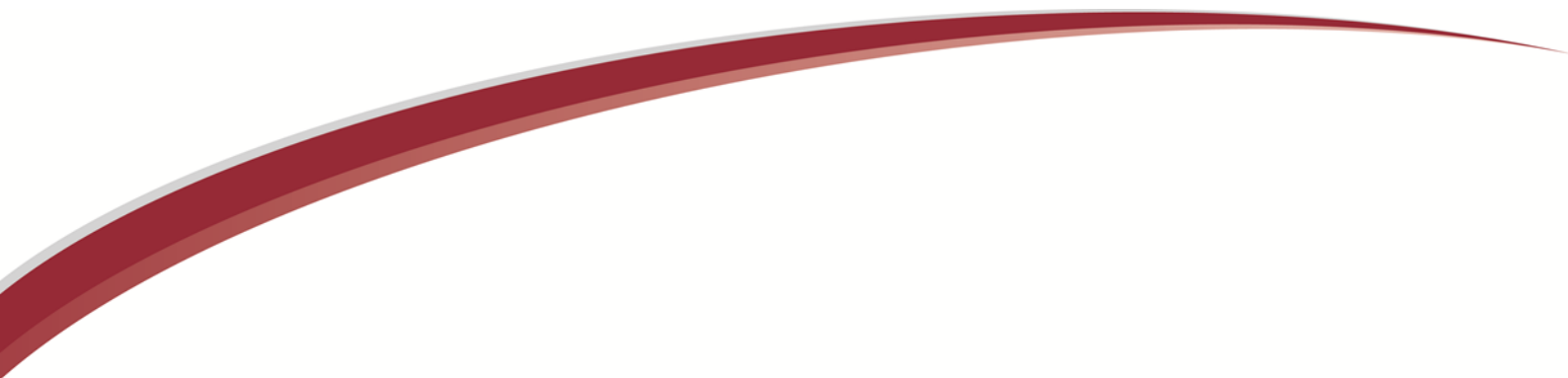
4. Burning issues responses

A broad range of 'Burning issues' have been collected and are recorded verbatim. These will be considered by the Co-Leads as part of the process which will help identify priority areas the Network can support.

- Diagnosis of mental health issues for Aboriginal people especially in remote non-English speaking places like north and the top end of WA.
- Teen/Youth – preventative care – suicide and self-harm prevention – drug and alcohol abuse.
- Consistency of funding.
- The mental health older adults in transitional care beds (awaiting placement) have the same access to rehabilitation as mainstream geriatric patients.
- Lack of housing options – no long term plans/vision to solve this issue.
- Early diagnosis is the key to prevention.
- Teen/Youth – Treatment of alcohol and other drug issues with co-morbidities. The need for a unified approach between Mental Health Services and Drug and Alcohol Services.
- Teen/Youth – Prevention – Helping Aboriginal youth/communities to identify emerging mental health difficulties and then connect to appropriate services.
- Dementia – should be prioritised further.
- Prevention and its importance in addition to recovery (particularly important for perinatal and infant mental health).
- The system is not a caring system. People without a mental health issue don't understand people living with mental health conditions.
- *Do something* – stop talking about it and do something at the coal face.
- Freedom to take risks in a risk-averse environment (creative treatment options).
- IT – huge issues across all areas.
- Who is responsible for doing promotion and prevention and how do we evaluate it in an outcomes funded world?
- The likelihood/vulnerability/consequences for children of adults with mental health issues. Such children are at risk of being overlooked, for example triage/assessment/intake of adults with mental health issues rarely includes questions to discover if the adult has children or establish if the children are safe in the short, medium and long-term.
- Coordination of welfare and mental health services – Often operate separately. This can occur with mental illness, children in care with mental health issues, and in young people who are leaving care. The issues are so interwoven it is unfortunate the systems are so separate.
- Perhaps invite young people along to the Network (for example as part of their school credits) to contribute to this discussion.
- Prevention of mental health long term requires a focus on wellness, building resilience, boundary protection and Mindfulness.
- Youth – Aboriginal mental health workers when well supported in a team and given an equal voice can markedly increase the services capacity to attract, and retain Aboriginal clients and these workers are valuable across the episode of care:
 - identifying young people
 - strengthening links with community and relevant services
 - providing ongoing cultural consultation.
- One Aboriginal and Torres Strait Islander Mental Health Worker is not enough.

- Use of Home Medication Review for all people over the aged of 65 discharged from hospital. (Evidenced based research with Department of Veterans Affairs).
- Alcohol and Drug not one of true domains but is front and centre in mental health.
- We need to acknowledge work that has been done and increase the funding.
- Stigma with health professionals.
- Over prescription of anti-depressants/chemical imbalance.
- Social issues which affect mental health/can cause mental illness.
- Acknowledgement and respect of the traditions of the cultures when following policy/regulations. This can be damaging to the family relationship and contributing to mental health issues. For example children sleeping in bed with parents resulting in claims of child abuse or children touching adults for comfort as traditionally taught.
- For six years I've been treated like a mushroom. "Typical silo effect". I'm looking for mentorship and to be educated so I can learn and grow to help my community.
- Needs of lesbian, gay, transgender, transsexual or questioning youth and making services 'queer' friendly.
- Pressures on Psychiatrists – patients reports etc... have a repository of what is available in community, for example service mapping what each suburb has available for referrals.
- We have had plans and maps. We have talked, and talked, and talked etc.; we now need to progress the recovery of the mental health system. Let's act – no more maps, plans or mapping.
- Recorded by a facilitator on behalf of a participant – Somehow the Mental Health Network needs to develop a reputation as a source for testing 'appropriateness' of messages out in the community, for example the Bethlem Insanity Hospital display at the Royal Show. Even though the sector protested and the community managed to get the name of the ride changed, the original name stayed in the program and Royal Show advertising. If the Royal Agriculture Society had contacted the mental health sector prior to setting up the display then they would have saved on millions of dollars and the printed message would not still be out in the street.
- Recognition of multiple adverse experiences especially during childhood as causal to adult mental health issues for example:
 - viewing of mental health 'symptoms' from the childhood developmental psychology point of view.
 - attachment and bonding as core to future healthy psychology.
- Recognition that secure, insecure and/or disorganised attachment styles be recognised in primary alcohol and other drug/mental health assessments as indicative of trauma. Trauma recovery approach additional and underlying emergency intervention capacity built for long, medium term support and ongoing and same provider via counselling – solution – self-directed funding.
 - focus on trauma
 - recognise alcohol and other drugs as 'self-medicating'
 - provide money and mentoring for self-directed funding.
- Mental health and intellectual disability – people who have a diagnoses of both. The problem that this causes for individuals (the game of 'ping pong'), needs to stop disabilities versus mental health. The need for mental health clinicians to understand the complexities of the co-existing disorders and the need for more clinicians to understand intellectual disability.
- Current focus on mental health reform and Mentally Impaired Accused (MIA) Act equals a contradiction unless MIA legislation changes.

- Housing tenure (co-ordination) – homelessness needs to be addressed and improved.
- We want to provide more early intervention services but so many of our programs have eligibility criteria which require individuals to have a severe and persistent mental illness. This means that individuals must evidence a long history of mental illness which prevents early intervention services.
- Teenage/Youth – Options for assessment and treatment of young people with Autistic Spectrum Disorders (ASD) are currently very limited. ASD is under-diagnosed and not clearly managed in mental health services or disability – particularly the higher functioning ASD (for example formerly diagnosed as Asperger's).



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