



**TUNA BLUE**

**CONSUMER & CARER CO-REVIEW** of the  
**COMMUNITY SUPPORT PROGRAM AREA**  
for the **MENTAL HEALTH COMMISSION**

# **FINAL REPORT**

**AUGUST – SEPTEMBER 2019**



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Facilitation and reporting provided by  
Tuna Blue Facilitation



## Introduction

Twenty consumers, carers and peak body representatives from the Western Australian Mental Health and AOD system undertook a co-review process of the Community Support program area from the Mental Health Commission's (MHC) Procurement Schedule throughout August and September 2019 in partnership with the MHC.

The aim of the *Community Support Program Area: Consumer and Carer Co-Review Process* (the Co-Review) was to gain lived experience perspectives and input on the program area to inform the MHC in future procurement and contracting of the service streams.

The service streams included in the co-review process were:

- Group Support,
- Mutual Support and Self Help,
- Family and Carer Support,
- Personalised Support linked to Housing, and
- Individual Advocacy.

The 'Education, Employment and Training' community stream was reviewed in 2017 by Third Force Consulting and 'Personalised Support linked to Housing – Supportive Landlord Service' community stream were excluded from this review, as the Western Australian Association for Mental Health was commissioned by MHC to undertake a review of the service stream in 2019.

The two major outputs from the Co-Review are:

1. A range of lived experience **suggestions** for improvement of each service stream within the Community Support program area, and
2. A **co-designed process** for improved implementation of future co-reviews of the Procurement Schedule program areas.

These two outputs form the major sections of this Report.

# EXECUTIVE SUMMARY

## Co-Review Suggestions

The Co-Review proved a valuable exercise in gaining lived experience perspectives and suggestions to improve the commissioning, procurement and contracting of the service streams in the Community Support Program Area.

A summary table of the 41 Suggestions (33 from the lived experience group and 8 from the ATSI yarning session) is captured overpage.

Key themes from the Suggestions are:

- Greater **prevention and early intervention** efforts to meet the needs of 'mild to moderate' individuals, who without support, progress to experiencing severe mental health issues;
- **Contemporary, flexible and person centred approaches** that value social connection, warm referrals, individual led recovery and diversity of options (location, timing, environment etc.);
- Empowerment of **peer based activities and services** through improved recognition, simplified funding and contracting arrangements and genuine capacity building opportunities;
- Greater **family inclusivity, support and co-production** opportunities;
- More **flexible and empathetic understandings of experiences, family units and housing arrangements** rather than strict criteria and assessments;
- Increased **awareness, access and system navigation support** for individuals, families and carers to connect with appropriate services;
- Proactive efforts to change the culture and stigma towards mental health and AOD through **careful use of language** from the commissioning level through to service delivery; and
- Ongoing opportunities to build the capacity of the sector in **co-design and co-production** through genuine opportunities at all levels of procurement and contracting.

## Summary of Suggestions (Co-Review Group)

The below table summarises all Suggestions made by the Co-Review group across the different service streams. It is important to note that these Suggestions have been articulated in near verbatim language to honour the original intent and language of the group (minor grammatical and phrasing edits have been made by the Facilitator).

Scope / Program Area	Topic	Suggestion
Group Support and Mutual Support & Self Help	The Distinction Between 'Group Support' and 'Mutual Support & Self Help'	The Mental Health Commission considers removing the distinction between paid staff and unpaid peer workers that may cause confusion across the two service streams, as these two streams are not mutually separate (must be mindful of the impacts this may have on volunteer groups accessing funding in competition with NGOs).
	Wider Prevention Focus	The Mental Health Commission increases investment in the prevention program areas of the Procurement Schedule (include access and promotion strategies).
	Earlier Intervention and Support	The Mental Health Commission seek procurement and contracting arrangements and mutual support & self help that better link with earlier intervention services.
	Locations, Environments and Timing	The Mental Health Commission procures group support and mutual support & self help services that provide: <ul style="list-style-type: none"> <li>welcoming, non-clinical and inclusive environments and processes,</li> <li>a range of group sizes that cater to different needs for safety and anonymity,</li> <li>after hours services, particularly evenings and weekends, and</li> <li>provide mobile services or transport / pickup &amp; drop-off arrangements</li> </ul>
	Offerings and Models of Service	The Mental Health Commission procures group support and mutual support & self help that provides hopeful, flexible and strengths based contemporary practice and environments for a range of genders and cultures. Choice of offerings may also be provided in a range of local settings and by a range of service providers – diversity is the key.
	Social Connection	The Mental Health Commission procures group support and mutual support & self help that provide opportunities for social activities and settings to build interpersonal skills and friendships, improve community connectedness and complements therapeutic offerings.

	Promotion, Outreach and Access	<p>The Mental Health Commission procures group support and mutual support &amp; self help that may include providing:</p> <ul style="list-style-type: none"> <li>• creative, clear, wide reaching promotion strategies,</li> <li>• dedicated and co-designed promotion strategies and pathways,</li> <li>• active outreach models, including transport and pick-ups, and</li> <li>• peer champion, buddy or mentor type roles to attract and retain people.</li> <li>• targeted promotion and outreach to vulnerable populations (ATSI, CALD, Youth, Older Adult, LGBTIQ+ and Rural &amp; Remote)</li> </ul>
	Peer Support Opportunities	<p>The Mental Health Commission considers more equitable procurement and contracting structures for unincorporated volunteer peer support groups to access funding.</p> <p>The Mental Health Commission procures group support and mutual support &amp; self help that provides genuine opportunities for peer training, development and ongoing support as a critical recovery step.</p>
	Referrals and Ongoing Recovery Support	<p>The Mental Health Commission procures group support and mutual support &amp; self help that actively demonstrates a culture and practice of recovery by:</p> <ul style="list-style-type: none"> <li>• referring people to more suitable services, where appropriate,</li> <li>• provide opportunities for peer training, development and transition to paid roles, and</li> <li>• supports self-forming peer support groups to establish around ongoing recovery needs.</li> </ul>
Family and Carer Support	Overarching Support	The Mental Health Commission considers procurement of personalised and overarching support services for families dealing with multiple agencies (i.e. Strong Families and PIR models) through the family and carer support services stream or as a wraparound package in conjunction with other personalised mental health and AOD service streams.
	Different Family Units	The Mental Health Commission seeks providers to demonstrate sophisticated and nuanced of the diverse range of family groupings and kinships (not just nuclear) in models of service and governance for family and carer support
	Diverse & Collaborative Options	<p>The Mental Health Commission continues to procure a diverse range of family and carer support services that provide access through:</p> <ul style="list-style-type: none"> <li>• standalone family and carer support options not linked to other individualised services and supports,</li> <li>• connected family and carer support options that provide holistic and connected options with individualised services and supports in the same organisation (noting that privacy and governance are of critical importance), and</li> <li>• family and peer led options</li> </ul> <p>The Mental Health Commission incentives for procurement of services that demonstrate collaboration with other services to provide family units with the most appropriate care to their needs (i.e. all together or separate supports) as identified by the family</p>

	Family & Carer Designed Resources and Capacity Building	The Mental Health Commission considers greater levels of family & carer capacity building opportunities and family & carer produced resources in family and carer support services
	Contemporary & Practical Support	The Mental Health Commission considers family and carer support services that encourage family led solution finding and problem solving through contemporary language and understandings rather than solely medical information sessions; the provision of practical and small grants or rebates (e.g. \$500 respite funding or childcare vouchers) is important to increasing access and family empowerment.
	Social Opportunities	The Mental Health Commission continues to procure family and carer support services that provide social opportunities for family and carers to connect, share information, empathise and build knowledge with other peers in similar situations.
Personalised Support Linked to Housing	Family inclusivity	The Mental Health Commission procures personalised Support linked to housing services that include family, carer or neighbour involvement and education (where appropriate) to build stronger protective supports and options around the core service
	Awareness and Access	The Mental Health Commission considers the lack of access to personalised support linked to housing services due to low promotion, unclear offerings and models or inconsistent options dependent on location; sophisticated and locally knowledgeable peer navigators will improve access where services currently exist.
	Complex Needs including AOD	The Mental Health Commission acknowledges the complex, multi—system needs of a majority of the individuals accessing personalised support linked to housing including (mental health, AOD, justice and welfare systems etc.) and considers services that: <ul style="list-style-type: none"> <li>• identify and target this specific group of complex multi system individuals and their families,</li> <li>• demonstrate trauma informed understandings and approaches to dealing with complex needs (AOD usage in particular),</li> <li>• demonstrate joined up and sophisticated ways of working with other services to provide multiple system interventions, and</li> <li>• utilise peer workers with similar complex experiences and peer language to improve engagement and outcomes.</li> </ul>
	Homelessness and Step Down Housing	The Mental Health Commission considers personalised support linked to housing provides smooth access options for individuals in a range of housing situations (step down from accommodation settings, homeless seeking housing).
Individual Advocacy	The Distinction Between 'Navigation' and 'Advocacy'	The Mental Health Commission acknowledges that navigation of mental health services and supports is problematic and individual advocacy is inextricably linked to mental health navigation and therefore difficult to 'exclude' this component from service delivery in practice.
	GP Navigation	The Mental Health Commission works bilaterally with WAPHA to improve the understanding of GPs in mental health service navigation and the rights of individuals.

	Family, Carer and Supporter Advocacy	The Mental Health Commission considers targeted advocacy initiatives aimed at building the capacity of, and learning from, families and carers to navigate multiple systems (e.g. AOD, MH, Housing) and advocate for individuals, as an effective upstream measure prior to accessing individual advocacy services.
	Promotion and Understanding of Advocacy	The Mental Health Commission considers increased promotion and awareness of individual advocacy services and incentivises advocacy that occurs across multiple systems, institutions and advocacy bodies.
All MHC Procurement and Contracting	Using non-stigmatising language in service agreements	The Mental Health Commission reviews and considers the language it uses in procurement, policy and strategic processes to remove stigmatising and dehumanising terms like mental 'illness' and other restrictive language. Strengths based, recovery oriented should be encouraged. The term 'mental health issues or at risk of developing a mental health issues' is suggested.
	Co-design and Co-production	<p>The Mental Health Commission incorporates genuine co-design and coproduction into its procurement and contracting processes through:</p> <ul style="list-style-type: none"> <li>• co-designing service specifications pre tender phase with consumers, families and carers,</li> <li>• requiring tender applicants to show evidence of co-design with consumers, families and carers during the tender submission phase,</li> <li>• requiring successful applicants to show evidence of coproduction upon service planning and delivery of the funding,</li> <li>• providing dedicated funding for investing in co-design capacity building for the service's staff and lived experience members,</li> </ul> <p>The MHC develops an Engagement Framework Implementation Plan focused on building capacity with consumers, families, carers and providers in the sector.</p> <p>The MHC Engagement Framework and Toolkit should guide applicants throughout this process, including a requirement for service agreements to include evidence of the use of the Engagement Framework and Toolkit in service delivery.</p> <p>The Mental Health Commission extends the timeframe for tender applications to allow for more genuine co-design efforts from NGOs and to allow smaller groups adequate time to compete.</p> <p>The Mental Health Commission explores a 'conforming' and 'non-conforming' tender bids to drive innovation and equity between larger and smaller applicants.</p> <p>Acknowledgement that peer led groups and organisations may be disadvantaged in tender processes. Building the number and capacity of peer led approaches needs targeted procurement rounds like the ILC, NDIA and DPFO grants</p>
	Evaluation	The Mental Health Commission incorporates greater lived experience, family and carer input into evaluation processes through the existing National MH Accreditation Process, adoption of the Patient Opinion website or mystery shopper type initiatives and reviews.
	Rural and Regional	Acknowledgement that all of these comments apply to a factor of two in remote, rural and regional areas. Ensure that marginalised communities and populations (Aboriginal, youth, CALD, LGBTIQ+, Disability, Forensic) are also included in system planning and procurement



## Summary of Suggestions (ATSI Yarning Session)

The below table summarises all Suggestions made by at the ATSI Yarning Session. It is important to note that these Suggestions have been articulated in near verbatim language to honour the original intent and language of the group (minor grammatical and phrasing edits have been made by the Facilitator).

Access and Aboriginal Governance	<p>Ensure greater Aboriginal governance and input at all levels of tendering, procurement, service design and delivery through options including:</p> <ul style="list-style-type: none"> <li>• dedicated Aboriginal community based mental health organisations,</li> <li>• Aboriginal voices at the table in the Mental Health Commission’s decision making structures, and</li> <li>• greater support for Aboriginal mental health workers.</li> </ul>
Family and Carer Support specific to Aboriginal people	<p>Services should provide consistent, ongoing and practical support to Aboriginal families and carers, including transport and yarning opportunities to walk ‘side by side’ with families rather than criteria driven approaches.</p>
Incorporation of Cultural Security and Safety in supporting Aboriginal People.	<p>The MHC consider leading the mental health sector in cultural security for, and employment of, Aboriginal people and provide increased opportunities for sector development and capacity building in cultural competence and safety including sector wide Aboriginal Co-Design Forums to build mutual awareness and trust between Aboriginal people and services.</p>
Individual Advocacy specific to Aboriginal people	<p>The MHC consider procuring specific Aboriginal Navigator services and positions to provide individual advocacy for Aboriginal people across multiple systems and service providers; advocacy should link in with family support networks.</p>
Outreach to People’s homes	<p>The MHC could consider incentivise outreach activities by service providers that connect with Aboriginal people and bring them on board to provide services when needed.</p>
Including people who are at risk of becoming severe and persistent	<p>The MHC consider broadening access to the services within the Community Support Program Area beyond the ‘severe and persistent’ criteria, particularly as a diversionary and rehabilitation option for individuals in contact (or at-risk of contact) with the justice system.</p>
Service Provider Collaboration	<p>The MHC consider procuring services in a way that drives greater coordination and collaboration between service providers, for warmer person centred referrals and joined up support.</p>
Spirituality and Holistic / Non-Medical Support	<p>The MHC consider procuring Community Support services that provide holistic understandings of support and recovery including spirituality, cultural beliefs and practices, acknowledgement of trauma and SEWB frameworks for Aboriginal people.</p>

## Future Co-Review Process

The future Co-Review process summarised overpage is based on invaluable feedback from the participants plus refinements from the facilitator on the initial Co-Review process undertaken through August to September as a learning exercise.

Overall reflections on this inaugural Co-Review process are:

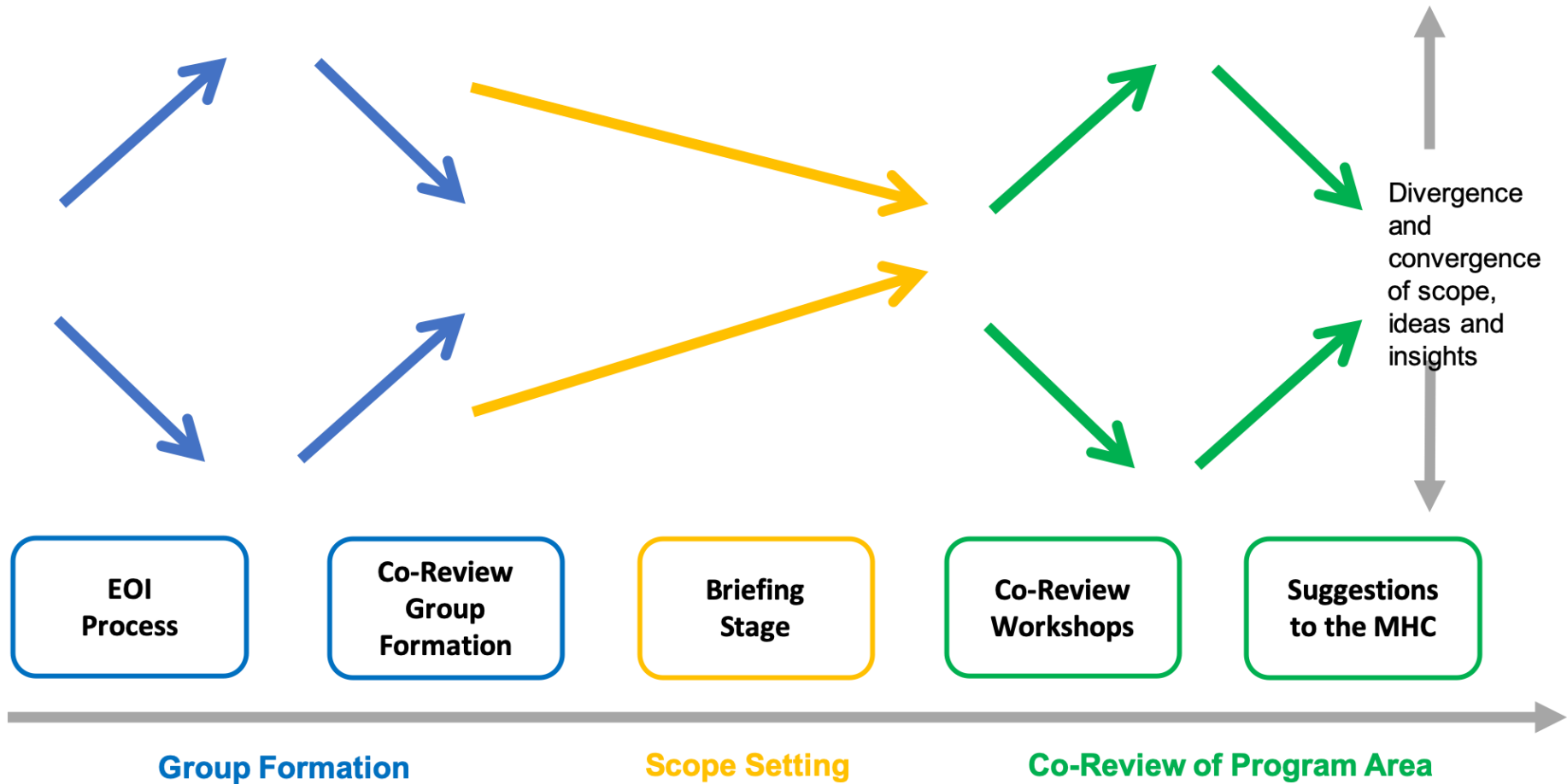
- The Co-Review provided the space for a wonderful **two way exchange** of ideas, empathy and learnings between the MHC and the lived experience members; the opportunity for each party to 'peel back the curtains' on the other's experiences, processes and challenges is invaluable to an empowered and transparent mental health system,
- **Peak bodies and the MHC** have an important role to play in clarifying the context, testing assumptions and encouraging deeper analysis throughout the Co-Review
- Ensuring a **diversity of membership** will require dedicated efforts to extend the EOI opportunity to 'hard to reach' communities or directly appoint members for diversity, where required,
- It is vital to provide **clear and concise briefing information** to the members on the system context, the commissioning, procurement and contracting processes, the scope of the Co-Review and the current delivery of the Program Area to ensure informed and genuine discussions during the Co-Review; creating this briefing information will require co-production with consumers to find the middle ground between procurement and lived experience explanations of key concepts.
- The nature of the content, the members and process meant that the best results were produced through **yarning, exploration and deep dive discussions** rather than task focused workshop exercises and activities,
- Individuals with lived experience are best placed to **draw on wider networks** of other lived experience individuals to ensure broader inputs and a diversity of experiences is considered in the Co-Review,

## Summarised Future Co-Review Process

The following Co-Review process is recommended for future implementation:

1. Conduct a broad and transparent **expression of interest** process
  - Broader distribution via peak bodies and sector networks to encourage diversity of applications
2. Ensure a balanced **Co-Review group forms** through EOI selection and direct appointments for diversity (if necessary)
  - Maintain a 20 participant maximum (12-15 lived experience)
  - Continued peak body and MHC participation
  - Mechanism to directly appoint members for additional diversity, if required (ATSI, CALD, LGBTIQ+, Rural & Remote, Youth)
3. Provide clear and simple **briefing information** on the content and process
  - Provide a co-produced Briefing Pack to group members upon acceptance of application (Briefing Pack to be developed)
  - Conduct a Welcome & Information Evening for the group members prior to the first workshop and provide any additional pre-reading
4. Facilitate Session One – Co-Designing and Scoping **Our Approach**
  - First participative session to co-produce an agreed set of preliminary Co-Review questions and a list of identified individuals and networks for semi-structured interviews by group members
5. Support a between sessions period - **Information Gathering Phase**
  - Two week out of session period for members to engage other lived experience individuals through semi-structured interviews and gather a wealth of raw data in response to the Co-Review questions
6. Facilitate Session Two – Sharing **Our Findings**
  - Second participative session to share interview raw data, discuss findings and draw insights for the Co-Review
7. Facilitate Session Three – **Deep Dive Analysis**
  - Third participative session to deep dive on findings and draw out a number of draft Suggestions as the key output of the Co-Review
8. Facilitate Session Four – **Suggestions** Ratification and Reflection
  - Fourth and final participative session to reflect on and refine the draft Suggestions to an agreed state for submission to the MHC.
9. Provide clear and transparent feedback on how Suggestions were used by the MHC to inform the overall review of the Program Area.

Future Co-Review process diagram showing the divergence and convergence of membership applications, scope / context and engagement, ideas and suggestions throughout the process.



## Moving Forward

Two initiatives are proposed for the transition period between the completed inaugural Co-review and the next Co-Review process to ensure a well prepared and consumer led exercise in the future.

1. **Co-Production of a Briefing Pack** that articulates the following in straightforward language and visuals
  - Role of the Co-Review group and what to expect as a member,
  - Where the mental health and AOD system is currently at (context) and where it intends to be in the future (the Plan)
  - How the MHC procures, contracts and reports on services (i.e. Procurement Schedule etc.) and understanding the complex language and governance
  - Which service streams are under review and what they include
  - How to get the most out of your participation on the Co-Review
2. Appointment of an **ephemeral Lived Experience Advisory Group** comprised of members of the inaugural Co-Review to further reflect on the recommended future process and advise the MHC as it prepares for the next Co-Review process. This group may likely meet 2 – 3 times over the next 6 months with the aim to develop a concise, simple language Process Manual to inform the next Co-Review. Such a product, with genuine lived experience input and a simple step-by-step outline, will ensure future Co-Reviews can be implemented by the MHC despite potential staff changes etc.

# COMMUNITY SUPPORT PROGRAM AREA CO-REVIEW

## Summary of Suggestions

The Co-Review group made a total of 33 Suggestions to the MHC to improve the commissioning, procurement and contracting of the Community Support Program Area in the future.

The range of the Suggestions is extensive and covers the below topics:

Co-Review Group	
Scope / Program Area	Topic
Group Support and Mutual Support & Self Help	The Distinction Between 'Group Support' and 'Mutual Support & Self Help'
	Wider Prevention Focus
	Earlier Intervention and Support
	Locations, Environments and Timing
	Offerings and Models of Service
	Social Connection
	Promotion, Outreach and Access
	Peer Support Opportunities
	Referrals and Ongoing Recovery Support

Family and Carer Support	Overarching Support
	Different Family Units
	Diverse & Collaborative Options
	Family & Carer Designed Resources and Capacity Building
	Contemporary & Practical Support
	Social Opportunities
Personalised Support Linked to Housing	Family inclusivity
	Awareness and Access
	Complex Needs including AOD
	Homelessness and Step Down Housing
Individual Advocacy	The Distinction Between 'Navigation' and 'Advocacy'
	GP Navigation
	Family, Carer and Supporter Advocacy
	Promotion and Understanding of Advocacy
All MHC Procurement and Contracting	Using non-stigmatising language in service agreements
	Co-design and Co-production
	Evaluation
	Rural and Regional

The separate ATSI Yarning group made 8 Suggestions to the MHC.

<b>ATSI Yarning Session</b>	
Access and Aboriginal Governance	Outreach to People's homes
Family and Carer Support specific to Aboriginal people	Including people who are at risk of becoming severe and persistent.
Incorporation of Cultural Security and Safety in supporting Aboriginal People.	Service Provider Collaboration - non Aboriginal organisations working and learning from Aboriginal organisations to better meet the needs of Aboriginal People
Individual Advocacy specific to Aboriginal people	The need for services to provide spirituality and holistic / non-medical support

## Group Support and Mutual Support / Self Help

### Summary Table

The key Suggestions for the service stream are in the table below:

Scope / Program Area	Topic	Suggestion
Group Support and Mutual Support & Self Help	The Distinction Between 'Group Support' and 'Mutual Support & Self Help'	The Mental Health Commission considers removing the distinction between paid staff and unpaid peer workers that may cause confusion across the two service streams, as these two streams are not mutually separate (must be mindful of the impacts this may have on volunteer groups accessing funding in competition with NGOs).
	Wider Prevention Focus	The Mental Health Commission increases investment in the prevention program areas of the Procurement Schedule (include access and promotion strategies).
	Earlier Intervention and Support	The Mental Health Commission seek procurement and contracting arrangements and mutual support & self help that better link with earlier intervention services.
	Locations, Environments and Timing	The Mental Health Commission procures group support and mutual support & self help services that provide: <ul style="list-style-type: none"> <li>• welcoming, non-clinical and inclusive environments and processes,</li> <li>• a range of group sizes that cater to different needs for safety and anonymity,</li> <li>• after hours services, particularly evenings and weekends, and</li> <li>• provide mobile services or transport / pickup &amp; drop off arrangements</li> </ul>
	Offerings and Models of Service	The Mental Health Commission procures group support and mutual support & self help that provides hopeful, flexible and strengths based contemporary practice and environments for a range of genders and cultures. Choice of offerings may also be provided in a range of local settings and by a range of service providers – diversity is the key.



	Social Connection	The Mental Health Commission procures group support and mutual support & self help that provide opportunities for social activities and settings to build interpersonal skills and friendships, improve community connectedness and complements therapeutic offerings.
	Promotion, Outreach and Access	<p>The Mental Health Commission procures group support and mutual support &amp; self help that may include providing:</p> <ul style="list-style-type: none"> <li>• creative, clear, wide reaching promotion strategies,</li> <li>• dedicated and co-designed promotion strategies and pathways,</li> <li>• active outreach models, including transport and pick-ups, and</li> <li>• peer champion, buddy or mentor type roles to attract and retain people.</li> <li>• targeted promotion and outreach to vulnerable populations (ATSI, CALD, Youth, Older Adult, LGBTIQ+ and Rural &amp; Remote)</li> </ul>
	Peer Support Opportunities	<p>The Mental Health Commission considers more equitable procurement and contracting structures for unincorporated volunteer peer support groups to access funding.</p> <p>The Mental Health Commission procures group support and mutual support &amp; self help that provides genuine opportunities for peer training, development and ongoing support as a critical recovery step.</p>
	Referrals and Ongoing Recovery Support	<p>The Mental Health Commission procures group support and mutual support &amp; self help that actively demonstrates a culture and practice of recovery by:</p> <ul style="list-style-type: none"> <li>• referring people to more suitable services, where appropriate,</li> <li>• provide opportunities for peer training, development and transition to paid roles, and</li> <li>• supports self-forming peer support groups to establish around ongoing recovery needs.</li> </ul>

The detailed commentary for each Suggestion of the Group Support and Mutual Support & Self Help streams is outlined in the following pages (in verbatim participant language).

## The Distinction Between 'Group Support' and 'Mutual Support & Self Help'

- Can the definition be 'people' not just 'mental health consumers'?
- The distinction between Group Support and Mutual Support and the NGO / volunteer distinction it makes creates real funding barriers for peers on the ground;
- At the lived experience level, we don't really care – we just want something that works;
- A lot of the smaller peer led volunteer support groups aren't always seen by funders because the bigger clinical NGOs get the support group money, so the distinction is important there
- There is so much grey area in the 'peer' category and what that constitutes; it's a balance between flexibility and a lack of clarity
- Need to bridge group support and mutual support more
- The ability to offer both group support and mutual support / self help on alternate weeks is important; they don't have to be 'mental health' organisations just because it's MHC funding (e.g. Men's Sheds don't have 'mental health' in the titles)

**Suggestion:** *The Mental Health Commission considers removing the distinction between paid staff and unpaid peer workers that may cause confusion across the two service streams, as these two streams are not mutually separate (must be mindful of the impacts this may have on volunteer groups accessing funding in competition with NGOs).*

Final workshop commentary

- Concern that if the two streams are merged, that group support and NGO providers will be favoured, thereby negatively impacting on volunteer groups
- Or just pay peer workers?

## Wider Prevention Focus

- The functioning of the Procurement Schedule modelling relies on other social systems (e.g. housing, Centrelink) functioning;
- The prevention investment is low, the focus is on symptoms
  - we need to be asking ourselves why people are having behavioural issues in the first place?
  - what is underlying and address those causes earlier in terms of trauma rather than the symptoms (the biomedical model)
- Lots of MHC funded group support activities seem to focus on the prevention and self-care end rather than the severe and persistent end anyway
- There needs to be more money for the grassroots, preventative group support and mutual support / self-help groups rather than the bigger NGOs; more equity

- If the group support and mutual support / self help investment was shifted to a wider target group to include 'mild to moderate', it would need to come with the large caveat that it requires huge access and promotion strategies

**Suggestion:** *The Mental Health Commission increases investment in the prevention program areas of the Procurement Schedule (must include access and promotion strategies).*

Final workshop commentary

- Prioritise primary school prevention, promotion and destigmatisation; teach children healthy emotional coping skills as a regular class
- Direct more money to prevention and early intervention
- Strengthen co-design in prevention streams
- Ensure these are programs that work for people, not just snazzy for communications campaigns
- Consider the barriers to accessing prevention and early intervention programs
- Prevention is also welfare, jobs, education, food, shelter and belonging

## Earlier Intervention and Support

- It's the relationships, not how they're funded that matters
  - these activities assume earlier intervention but people in crisis don't often access these group support settings because they're not getting the support early enough
- Services like St Patricks and St Barts that provide personalised care to enable readiness to access these group support services are critical

**Suggestion:** *The Mental Health Commission seek procurement and contracting arrangements and mutual support & self help that better link with earlier intervention services.*

Final workshop commentary

- Ensure early intervention is across the journey and at each 'experience' or 'episode' rather than early intervention in the chronological or lifespan sense
- Ensure people aren't stigmatised by the medicalisation of MH or AOD services

## Locations, Environments and Timing

- Don't like accessing these group support activities in clinical locations that preach best practice that means no tea and biscuits, no tables and people being followed to the toilet
  - treated like a criminal
  - I like when these support group settings feel like a home where you can make a cuppa
- People need to be ready for these support groups; our son balked at the idea, felt confronting and not safe

- You can join a group and not speak for six weeks because they're intimidating large group settings
  - Need space for some silence and safety, as well
- Closed groups, waitlists and restricted timeframes mean you're moved on from group support activities quickly
  - who makes the decisions for people to attend and be moved on
  - clinical locations, mega group sizes and judgemental / non-inclusive cultures aren't helpful
- Group work is really confronting and it takes real awareness and courage to take the first step
  - a welcoming environment and induction for new people is critical and NGOs should not lose sight of that
- Offering group support at a range of times, especially after hours is really critical (e.g. 6pm) and the procurement process needs to consider this in seeking tenders (i.e. extra unit price)
- Lack of centres that provide a mixture of group programs, not necessarily attached to one service provider; one negative experience with a service provider can create a real barrier to any other support at that service or location
- Occasionally rotating locations

**Suggestion:** *The Mental Health Commission procures group support and mutual support & self help services that provide:*

- *welcoming, non-clinical and inclusive environments and processes,*
- *a range of group sizes that cater to different needs for safety and anonymity,*
- *after hours services, particularly evenings and weekends, and*
- *provide mobile services or transport / pickup & drop-off arrangements*

Final workshop commentary

- Opportunity to join an ongoing group rather than waiting;
- Non clinical, safe, home like environments
- Offer mobile and pickup services

## Offerings and Models of Service

- Often group support is very illness focused if they offer psychoeducation rather than helping people to develop their own unique wisdom
- Need to provide for those interested in less therapeutic day centres (i.e. social activities)
- Opportunities to speak about achievements and positivity is really important
- There's a standard that needs to be achieved here; NGOs should be offering hopeful and flexible strengths based environments (i.e. contemporary practice)
- There's a real focus on traditionally female offerings in the group support space currently

**Suggestion:** *The Mental Health Commission procures group support and mutual support & self help that provides hopeful, flexible and strengths based contemporary practice and environments for a range of genders and cultures. Choice of offerings may also be provided in a range of local settings and by a range of service providers – diversity is the key.*

Final workshop commentary

- If in remote locations, be able to Skype into a group
- Diversity means having the option of self-experiences groups or joining the mainstream group experience

## Social Connection

- It's not just about therapeutic and recovery focused mutual support and self-help groups but the social connection purposes that are important too
- Some of the best activities we do as recovery community are the social activities (hitting golf balls, doing ropes adventure courses, casual BBQs) that provide hope;
  - we shouldn't lose sight of this; these settings create a totally different dialogue than structured therapeutic sessions
- The social activities and mentoring are important to acceptance; a focus outside of your MH and AOD concerns, not being treated as a one dimensional person

**Suggestion:** *The Mental Health Commission procures group support and mutual support & self-help that provide opportunities for social activities and settings to build interpersonal skills and friendships, improve community connectedness and complements therapeutic offerings.*

Final workshop commentary

- Group support should be community facing and not provider facing in terms of access and promotion
- Consumer respite opportunities and MH Cafes are important but should not be focused solely on mental health.

## Promotion, Outreach and Access

- They're hard opportunities to find as a carer
- They're helpful in the waiting list phase, to keep people engaged, but they require you to be ready and it would be helpful if the groups had an outreach function to proactively get people involved, instead of 10 page assessments
- There are ongoing and significant barriers to accessing these services, including a lack of outreach and transport, and deficit framing (i.e. you have to have a 'problem')
- Those enabling functions for these group support settings are often unfunded and restrict access

- Struggled in where to go as a carer and my son was definitely better at it than me; you can really feel like the ‘newbie’ in a group support setting and it’s important to not offer ‘one size fits all’ approaches
  - I rather like the sponsor or buddy notion (i.e. AA or NA) but provided earlier as outreach and supports the progression into a group setting
- Group support can often lack that ‘champion’ peer who’s further along the recovery journey and can really provide hope
- The Mandurah Youth Health Hub at the end of the train line is a different scope but is an accessible model with lots of options (skills and resilience programs, youth wellbeing education)
  - it’s an effective model because the person walks in and identifies their Agency wraparounds
- A quality to distinguish funding should be ‘have they demonstrated the marketing and promotion approaches to ensure the reach and audience is being met?’
- Really ratcheting up promotion of the group support opportunities is important

**Suggestion:** *The Mental Health Commission procures group support and mutual support & self-help that may include providing:*

- *creative, clear, wide reaching promotion strategies,*
- *dedicated and co-designed promotion strategies and pathways,*
- *active outreach models, including transport and pick-ups, and*
- *peer champion, buddy or mentor type roles to attract and retain people*
- *targeted promotion and outreach to vulnerable populations (ATSI, CALD, Youth, Older Adult, LGBTIQ+ and Rural & Remote)*

Final workshop commentary

- ‘KISS’ navigation in layman terms
- Ensure communities of support
- Ensure promotion and outreach to vulnerable areas geographically and vulnerable populations (youth, CALD and ATSI) and appropriate staff resourcing to do so (more than just extra staff)
- Consider ‘light touch’ procurement processes and contracting for smaller groups

## Peer Support Opportunities

- Support groups that are no clinician or social worker led but peer based are more effective but it’s really difficult for unincorporated groups to access the funding unless they receive support from Connect Groups
  - the access to flexible funding is not there to grow volunteer groups
- Contractual arrangements that ‘professionalise’ peer groups and models can be problematic; there needs to be recognition at funding levels that peer and clinical groups can coexist and are equally legitimate
- The ‘power of the peer’ is often undervalued and as soon as group settings have the words ‘mental health’ thrown in, there is a need for structure, power and control; operating in a more social sense for everyone’s mental wellbeing is important

- Grounding yourself within groups of people who are still using or struggling facilitates a sense of pride in their recovery
- Peer support and training opportunities in services means there are steps within, and a value placed on, my journey; that I hold a valued skillset and position

**Suggestion:** *The Mental Health Commission considers more equitable procurement and contracting structures for unincorporated volunteer peer support groups to access funding.*

**Suggestion:** *The Mental Health Commission procures group support and mutual support & self-help that provides genuine opportunities for peer training, development and ongoing support as a critical recovery step.*

Final workshop commentary

- Peer directory for carers, consumers, GPs and therapists is important

## Referrals and Ongoing Recovery Support

- Our needs sometimes cannot be defined in tick box questions and facilitators within these group support programs must show the skills to both provide the activity and to do the outreach but to also on-refer and support the ongoing transition to other peer led, volunteer based groups that fill a gap as the next step in recovery
- Should be focusing on the growth and journey for the individual, not the NGO ends
  - support to keep going with peers afterwards
  - once out of the severe period be supported to step out to put the foot in the water and hope for a ripple effect
- If there is no growth or next step in the situation after group support then you can feel really stagnant and stuck
  - need service models that incentivise the next step by making training available, paying peer workers and having a compassionate and realistic awareness that we may become unwell again at times
- Opportunities to maintain recovery through accessing more prevention opportunities and adaptability with peers; not to be considered 'functioning' now and then put on the backburner
  - support self-forming peers together for their different needs and life skills support and resilience building
- Organisations that acknowledge you're always growing and provide growth and development opportunities as knowledge comes along can mean a lot
- NGOs and competing services that aren't providing information or referrals to each other are challenging
  - should be that if an individual doesn't fit the need for the service, there shouldn't be fear to refer them to another service that meets their needs
- Organisations don't have the resources and processes to hold these collaborative discussions as partners in an individual's wraparound care

- Or is there reluctance as a culture to recommend and refer to other services?
  - where's the accountability in funding and reporting that services are referring as they should be?
- The outcome for the person may not be the best output for the service
- Referrals on and 'no wrong door' policies should be incorporated into core business as a part of procurement, contracting and QA

**Suggestion:** *The Mental Health Commission procures group support and mutual support & self-help that actively demonstrates a culture and practice of recovery by:*

- *referring people to more suitable services, where appropriate,*
- *provide opportunities for peer training, development and transition to paid roles, and*
- *supports self-forming peer support groups to establish around ongoing recovery needs.*

Final workshop commentary

- Having access to a peer navigator within medical centres or social emotional wellbeing centres that provide welcoming environments



## Family and Carer Support

### Summary Table

The key Suggestions for the service stream are in the table below:

Family and Carer Support	Overarching Support	The Mental Health Commission considers procurement of personalised and overarching support services for families dealing with multiple agencies (i.e. Strong Families and PIR models) through the family and carer support services stream or as a wraparound package in conjunction with other personalised mental health and AOD service streams.
	Different Family Units	The Mental Health Commission seeks providers to demonstrate sophisticated and nuanced of the diverse range of family groupings and kinships (not just nuclear) in models of service and governance for family and carer support
	Diverse & Collaborative Options	<p>The Mental Health Commission continues to procure a diverse range of family and carer support services that provide access through:</p> <ul style="list-style-type: none"> <li>standalone family and carer support options not linked to other individualised services and supports,</li> <li>connected family and carer support options that provide holistic and connected options with individualised services and supports in the same organisation (noting that privacy and governance are of critical importance), and</li> <li>family and peer led options</li> </ul> <p>The Mental Health Commission incentives for procurement of services that demonstrate collaboration with other services to provide family units with the most appropriate care to their needs (i.e. all together or separate supports) as identified by the family</p>
	Family & Carer Designed Resources and Capacity Building	The Mental Health Commission considers greater levels of family & carer capacity building opportunities and family & carer produced resources in family and carer support services
	Contemporary & Practical Support	The Mental Health Commission considers procuring family and carer support services that encourage family led solution finding and problem solving through contemporary language and understandings rather than solely medical information sessions; the provision of practical and small grants or rebates (e.g. \$500 respite funding or childcare vouchers) is important to increasing access and family empowerment.
	Social Opportunities	The Mental Health Commission continues to procure family and carer support services that provide social opportunities for family and carers to connect, share information, empathise and build knowledge with other peers in similar situations.

The detailed commentary for each Suggestion of the Family & Carer Support streams is outlined in the following pages (in verbatim participant language).

## Overarching Support

- Overarching support to help you meet with each of the agencies or services and design / coordinate creative solutions your behalf (Strong Families was a great program but is now defunded)
  - made the experiences feel connected between everyone rather than isolating supports for each family member
  - bring all the providers and players into one room to ask ‘what are you doing, how does that look and what are the timeframes?’
  - making everyone in the service space accountable to ensure everything thrown at the family is working
  - it was empowering to give myself and the family the space to learn about our rights and needs slowly rather than looking at the ‘one big bomb’ of a situation; helped to differentiate our needs and work through it piece by piece
- There seems to be a lot of light touch family and carer support, information and education but this more individualised, intensive recovery model for families is missing from this service stream
- Strong Families had a great model that was defunded
- Could family wraparound funding packages be added onto the ICLS and other existing programs to reclaim that space in what are quite individualised programs already?

**Suggestion:** *The Mental Health Commission considers procurement of personalised and overarching support services for families dealing with multiple agencies (i.e. Strong Families and PIR models) through the family and carer support services stream or as a wraparound package in conjunction with other personalised mental health and AOD service streams.*

Final workshop commentary

- Specific family with multiple agency involvements
- Keep things that work and share and teach what is working with all services;
- Some people do not want the family involved and it is important to adhere rigorously (can be counter-productive) but the consumer has the opportunity to involve the family later and disconnect at any time

## Different Family Units

- These support services must sit in a context of all services having family and carer access, involvement and evaluation in a contemporary way
- Important that the family and carer support programs are evaluated for their inclusiveness of the wider family and the individual in crisis, than just individualised support for specific family members
  - viewing the family as a unit
- But this must be based on the homework of who's caring for who, who's included and not included in separated families – independent vetting of whether other family members (e.g. ex mother in laws) are part of care decisions or not
  - the preference is often given to listening to people who appear 'sane' rather than those in crisis point
  - what governance is in place to distinguish the agendas in separated families
  - often non-documented family information is taken as gospel in family
  - understand that people are overworked but they need to look at the child's view rather than just all the dynamics and input surrounding the child
- Need for sophisticated and nuanced understandings of families and the diversities of family groupings and kinships, not just '2 and 2' nuclear families
- Decisions made on stereotyping and unfounded assumptions; he or she who arrives first and gets the first word in, is heard most

**Suggestion:** *The Mental Health Commission seeks providers to demonstrate sophisticated and nuanced of the diverse range of family groupings and kinships (not just nuclear) in models of service and governance for family and carer support*

Final workshop commentary

- Include funding to support services to develop this capacity

## Diverse & Collaborative Options

- Need for a diversity of options in terms of support for the consumer and support for the family and carers within the same organisation
  - sometimes it feels streamlined to have it all happening with the same organisation
  - sometimes separate support for consumers and family because it can feel a little water thin 'we do a bit of this and a bit of that'
  - consent and information sharing is also a concern
- Can be quite dependent on individual compassionate facilitators of programs for the consumer that are open to including families and carers
- For some instances like individuals with paranoia, it's best that supports are by separate services

- Even front desk reception staff play an important role in people feeling confident their privacy is secure
- What about the agencies that are not willing and comfortable to share their caseloads and family members around with other agencies? The business models for these organisations dictate that they'd likely want to hold onto an entire family unit for support rather than separate for everyone's best needs
- When you call the service providers, 'do you have NDIS?' has become the first question asked and the only space for focus at the front door because that's where the money stream is
- Collaboration vs competition, commissioning can encourage partnerships if they're explicitly stated at tender and service agreement level
  - voluntary partnerships tend to happen from interagency groups as a mechanism; not sure if there's a funded network in family and carer support?

**Suggestion:** *The Mental Health Commission continues to procure a diverse range of family and carer support services that provide access through:*

- *standalone family and carer support options not linked to other individualised services and supports,*
- *connected family and carer support options that provide holistic and connected options with individualised services and supports in the same organisation (noting that privacy and governance are of critical importance), and*
- *family and peer led options*

**Suggestion:** *The Mental Health Commission incentives for procurement of services that demonstrate collaboration with other services to provide family units with the most appropriate care to their needs (i.e. all together or separate supports) as identified by the family*

Final workshop commentary

- Need to recognise and fund the cost of collaboration (or mediation)
- Explore models that are not so Eurocentric and monocultural
- More focus on children, child carers and youth carers

## Family & Carer Designed Resources and Capacity Building

- Families and carers are not always the ones that require support ('doing to'); sometimes they're the ones informing and educating the services
  - an example is the consistent and anecdotal feedback plus formal inquiries that family and carers weren't getting access to clinical discharge and treatment meetings even after the MH Act changes; gained a small grant of flexible funding, brought together specific families that have the expertise and experience to codesign resources for families in this situation and developed a resource about family rights to provide to families and services also; these resources have been hugely embraced

- it's about families and carers leading the service providers rather than being 'educated', particularly in the cross sectoral and system space
- Family and carers are often a secondary or complementary thought but realistically they provide 90% of the care; if you want the individual recovery, then you must support this area
- Not currently providing capacity building of families and carers above and beyond providing information and self-care opportunities
- Would like to see stronger evidence from these family and carer support programs around the lived experience codesign with the individuals in distress (what works for individuals) and the capacity building activities for families, otherwise there's an overreliance on medical information and guidance

**Suggestion:** *The Mental Health Commission considers greater levels of family & carer capacity building opportunities and family & carer produced resources in family and carer support services*

Final workshop commentary

- Young carers training to know how to access supports
- Include ATSI, LGBTIQ+ and CALD and rural families

## Contemporary & Practical Support

- Not valuable to go to respite weekends that feel like indoctrination weekends where you have to sit in on an information / education session with a medical lens
- Focus on solution finding and problem solving through contemporary language and understandings rather than medical definitions diagnoses that your family member might refute anyway
- A positive example was an agency with a creative funding bucket that could be allocated in \$500 chunks with which the family decided how that money could be spent (e.g. hotel for 2 days with the person in crisis)
- Respite opportunities and residential education for new mothers;
- Practical vouchers for day care, to ensure your other family members are safe whilst you're supporting your individual with lived experience

- Would be nice to have consumer respite that is like a carer's retreat, not clinical and wheelchair bound or focused on 'living breathing and talking' mental illness
- GROW and Recovery Rocks are examples

**Suggestion:** *The Mental Health Commission considers family and carer support services that encourage family led solution finding and problem solving through contemporary language and understandings rather than solely medical information sessions; the provision of practical and small grants or rebates (e.g. \$500 respite funding or childcare vouchers) is important to increasing access and family empowerment.*

Final workshop commentary

- Lack of empowerment for leadership by families; there is a still a sense of 'supporting' families

## Social Opportunities

- There is a massive sense of isolation that you often bring upon yourself 'dig a hole, jump in and pull a lid on top';
  - sometimes the most important function is going to a group where you can be around other people who understand where you're at in a non-judgemental way, share information and learn
- We are part of the recovery as family and knowing what to say and what not to say is difficult; it's especially difficult to find out where to get the support
- There is a difficult balance in how to guide families to support the individuals but not step into a mode of parental or carer control

**Suggestion:** *The Mental Health Commission continues to procure family and carer support services that provide social opportunities for family and carers to connect, share information, empathise and build knowledge with other peers in similar situations.*

## Personalised Support linked to Housing

### Summary Table

The key Suggestions for the service stream are in the table below:

Personalised Support Linked to Housing	Family inclusivity	The Mental Health Commission procures personalised Support linked to housing services that include family, carer or neighbour involvement and education (where appropriate) to build stronger protective supports and options around the core service
	Awareness and Access	The Mental Health Commission considers the lack of access to personalised support linked to housing services due to low promotion, unclear offerings and models or inconsistent options dependent on location; sophisticated and locally knowledgeable peer navigators will improve access where services currently exist.
	Complex Needs including AOD	The Mental Health Commission acknowledges the complex, multi—system needs of a majority of the individuals accessing personalised support linked to housing including (mental health, AOD, justice and welfare systems etc.) and considers services that: <ul style="list-style-type: none"> <li>• identify and target this specific group of complex multi system individuals and their families,</li> <li>• demonstrate trauma informed understandings and approaches to dealing with complex needs (AOD usage in particular),</li> <li>• demonstrate joined up and sophisticated ways of working with other services to provide multiple system interventions, and</li> <li>• utilise peer workers with similar complex experiences and peer language to improve engagement and outcomes.</li> </ul>
	Homelessness and Step Down Housing	The Mental Health Commission considers personalised support linked to housing provides smooth access options for individuals in a range of housing situations (step down from accommodation settings, homeless seeking housing).

The detailed commentary for each Suggestion of the Family & Carer Support streams is outlined in the following pages (in verbatim participant language).

## Family inclusivity

- This is a good example of a service that needs family inclusive training
  - support given to the individual living in the home but the family, friends or neighbours aren't engaged enough, given that they're likely supporting outside the 3 hours a week that this personalised support is given
  - who's got spare keys or who looks after the house whilst the person is in hospital?

**Suggestion:** *The Mental Health Commission procures personalised support linked to housing services that include family, carer or neighbour involvement and education (where appropriate) to build stronger protective supports and options around the core service.*

Final workshop commentary

- Define housing services as more than a 'roof over someone's head' (coordinating transport routes, safety, utilities)

## Awareness and Access

- If you're a high functioning person or appear so, these services will overlook you
- Knowing about these services and accessing them is unclear
- Can be through a case manager, GP, psych or self-referral
- The challenge is that these services aren't available everywhere, there are access challenges and a complexity of information
- This is where we need resources for sophisticated, locally knowledgeable peer navigators to enable access to these services

**Suggestion:** *The Mental Health Commission considers the lack of access to personalised support linked to housing services due to low promotion, unclear offerings and models or inconsistent options dependent on location; sophisticated and locally knowledgeable cross-sector peer navigators will improve access where services currently exist.*

Final workshop commentary

- Geography and location matters
- Rhetoric is good but how will this be implemented?
- More funding is needed and needs to be for a peer led service



## Complex Needs including AOD

- Do these services have a tolerance around AOD use because they go hand in hand in many instances
- From the MHC perspective, there has been an observed increase in partnerships between MH and AOD services
- Impacts on other residents in cluster housing and staff are also a consideration (e.g. dealing drugs)
- What support is given to people with requirements for multiple interventions and supports across a range of services and sectors (MH, AOD, Justice, NDIS etc)
  - could contracting be more explicit in requiring services to show a joined up and sophisticated way of working to provide multiple system interventions
  - identify and target this specific group of complex multi system individuals and their families
  - if the support isn't provided across the systems because they're not funded to do so, the person ends up homeless
  - complex and multiple needs (e.g. forensic or violence funding)
- Peer workers with similar complex experiences and peer language can provide really great behavioural interventions for AOD concerns
- Language to have non-clinical discussions that call people on their behaviour (not 'I think...' or 'I would like you to consider...' but 'hey mate we know that...')
- Having compassion for those complex people (e.g. selling drugs to survive) who are likely marginalised is important
  - they need support as well and not heaving them out on the street is key;
  - if we're not supporting one person, we're not supporting everyone and then what do we stand for?
- Can't leave people high and dry for relapsing with AOD use; understand there are hard choices to make but a duty of care comes with this kind of personalised support to consider where that person would go next if kicked out
- Ensure agencies are evaluating their processes for safety of everyone, including the individual, when they submit a Direct Incidence Report
- How are services dealing with things in a trauma informed, collaborative way?
- Need to more explicitly state people with co-occurring MH and AOD as a target group in contracting for AOD and MH services moving forward
  - some is occurring already

**Suggestion:** *The Mental Health Commission acknowledges the complex, multi—system needs of a majority of the individuals accessing personalised support linked to housing including (mental health, AOD, justice and welfare systems etc.) and considers services that:*

- *identify and target this specific group of complex multi system individuals and their families,*
- *demonstrate trauma informed understandings and approaches to dealing with complex needs (AOD usage in particular),*
- *demonstrate joined up and sophisticated ways of working with other services to provide multiple system interventions, and*
- *utilise peer workers with similar complex experiences and peer language to improve engagement and outcomes*

Final workshop commentary

- Housing providers need to strengthen the sense of community (everyone knows where Homeswest areas are, so put in a café or other community offering, gestures to involve the community outside of Homeswest patrons)
- Service providers need to collaborate across the board
- Prisons are used as defacto mental health facilities
- Need to really develop peers here
- Youth specific housing support is needed
- Unfortunately, CALD and Aboriginal access to these services is low

## Homelessness and Step Down Housing

- How much of this funding is working as a step down to maintain tenancy after MH accommodation programs?
  - does this then make it more difficult to access for people who haven't been in MH accommodation?
- What are particular housing outcomes in this for the personalised support people who are homeless and looking to get into housing?
- Missing support for people who can no longer access support through HAC programs

**Suggestion:** *The Mental Health Commission considers personalised support linked to housing provides smooth access options for individuals in a range of housing situations (step down from accommodation settings, homeless seeking housing).*

Final workshop commentary

- Ensure equal access to SUSD model for people who are homeless

## Individual Advocacy

### Summary Table

The key Suggestions for the service stream are in the table below:

Individual Advocacy	The Distinction Between 'Navigation' and 'Advocacy'	The Mental Health Commission acknowledges that navigation of mental health services and supports is problematic and individual advocacy is inextricably linked to mental health navigation and therefore difficult to 'exclude' this component from service delivery in practice.
	GP Navigation	The Mental Health Commission works bilaterally with WAPHA to improve the understanding of GPs in mental health service navigation and the rights of individuals.
	Family, Carer and Supporter Advocacy	The Mental Health Commission considers targeted advocacy initiatives aimed at building the capacity of, and learning from, families and carers to navigate multiple systems (e.g. AOD, MH, Housing) and advocate for individuals, as an effective upstream measure prior to accessing individual advocacy services.
	Promotion and Understanding of Advocacy	The Mental Health Commission considers increased promotion and awareness of individual advocacy services and incentivises advocacy that occurs across multiple systems, institutions and advocacy bodies.

The detailed commentary for each Suggestion of the Family & Carer Support streams is outlined in the following pages (in verbatim participant language).

### The Distinction Between 'Navigation' and 'Advocacy'

- The improved ability to navigate and access mental health services is a clear outcome of individual advocacy, so excluding 'navigation' seems problematic
- If you're a high functioning person (or appear so), or you don't fit into a particular box (not deemed unwell or complex enough by a service provider) these services won't give you a look in
- Navigation and access are 'rights', as per UN conventions; you don't have the right to unlimited access but navigation and the opportunity to access is a right
- I've had good experiences where they will see anyone; they won't do everything for you but they'll see you and explain things
- Due to a lack of service resources, some providers are prioritising access to services and sometimes this may not be clear or be done problematically

- Caseloads in this space are growing hugely due to a lack of services in other areas and service access prioritisation via confusing criteria and assessments processes
- Navigation is one of the elephants in the room and how that is most effectively addressed is the major challenge
  - what about the Green Book?
  - what's our common point of contact - a GP?
  - it's great to have CoMHWA but you need to know about them which is difficult if you're in distress
  - so, what is the fairy-tale central point of navigation?
- The MHC Online Service Directory is an online one stop shop navigation option
- This directory is also merging with AHCWA's MAAPA tool
- GPs often don't know the services available and need a one stop shop themselves

**Suggestion:** *The Mental Health Commission acknowledges that navigation of mental health services and supports is problematic and individual advocacy is inextricably linked to mental health navigation and therefore difficult to 'exclude' this component from service delivery in practice.*

Final workshop commentary

- High unmet demand for individual advocacy support related to disputes, rights and access

## GP Navigation

- GPs need the education on rights and the current ones really need a major culture change
- Their proposed scope of mental health support at the primary level is huge
- What about funding mental health advocate nurses for the doctors?
- Concern about GPs as the gateway, as it places advocacy and support in the medical space
- Experience is of GP inadequacy to dealing with comorbidity and AOD use 'come back when not pissed or stoned' or medication reliance
- Very difficult to find a good GP, they're often making diagnoses they're not trained to do and drawn to labels
- Can take a really long time to build your own advocacy knowledge and understand where the right supports and GPs are but when you get the right advocacy support it can be really valuable
- GPs and service providers really need the navigation training and resources; they need the goodwill to refer on and share that information
- Willing and receptive GPs, psychologists and service providers that are eager to learn and understand how I accessed the next step if they were unable to assist, are helpful
- Should I be supplying information to professionals though?

- There is a huge and complex scope for GPs with their generalist roles (epilepsy, autism, heart disease etc.) and they don't just focus on mental health, so they need simpler information
- Could the Mental Health Commission have accredited GPs that are mental health trained?
- The AMA will fight tooth and nail against this in fear it will favour some doctors over others

**Suggestion:** *The Mental Health Commission works bilaterally with WAPHA to improve the understanding of GPs in mental health and AOD service navigation and the rights of individuals, in partnership with peers.*

Final workshop commentary

- Why rely on WAPHA and the Federal agenda?
- GPs are often not even part of the equation

## Family, Carer and Supporter Advocacy

- Families, friends and supporters need the investment in their education to provide informal advocacy which can ready people to then work with professional individual advocates to navigate 'the' mental health system (it's not one system in reality) plus other AOD, criminal justice and food and emergency relief systems
- Really experienced peer navigators that can advocate across systems are needed
- Need for advocacy across a number of systems (AOD, MH, Housing etc.) and needs to be integrated because my experience of distress is that it doesn't fit in neat boxes
- So much of the advocacy is done by families and carers and this group needs to be informed and supported to help advocate for rights
  - targeted training for family members and carers is what's needed

**Suggestion:** *The Mental Health Commission considers targeted advocacy initiatives aimed at building the capacity of, and learning from, families and carers to navigate multiple systems (e.g. AOD, MH, Housing) and advocate for individuals, as an effective upstream measure prior to accessing individual advocacy services.*

Final workshop commentary

- Capacity building is not just training – mentoring and peer groups can also assist
- Aim to build individual and family level self-advocacy

## Promotion and Understanding of Advocacy

- The understanding that you have a right to access advocacy is not very strong; it's public information not widely promoted as an option
  - feeling that you don't have the right to advocacy as it's 'all your fault anyway' and we should just take the services we can get
- Psychologists have no idea about some of the services

- Individual advocacy can be really siloed dependent on the advocacy issue you have across systems (e.g. HCC, Statutory Advocacy, Community legal centre, Disability advocacy)
- Seeking advocacy for financial debts and when in a really poor space, Lifeline has provided some great options and navigation support in crisis
- A lot of discussion about going online and people searching out the information they need when in crisis mode but lack of internet, phone and housing are major barriers to access for a lot of people in crisis

**Suggestion:** *The Mental Health Commission considers increased promotion and awareness of individual advocacy services and incentivises advocacy that occurs across multiple systems, institutions and advocacy bodies.*

Final workshop commentary

- Consider holistic rather than siloed advocacy contracts
- Consider pathways and models that enable people to access the right advocacy
- More funding is needed in individual advocacy (holistic, non—statutory MH and AOD) – advocacy is currently delivered in siloed contracts

## All MHC Procurement and Contracting

### Summary Table

The key Suggestions for the service stream are in the table below:

All MHC Procurement and Contracting	Using non-stigmatising language in service agreements	<p>The Mental Health Commission reviews and considers the language it uses in procurement, policy and strategic processes to remove stigmatising and dehumanising terms like mental ‘illness’ and other restrictive language. Strengths based, recovery oriented should be encouraged. The term ‘mental health issues or at risk of developing a mental health issues’ is suggested.</p>
	Co-design and Co-production	<p>The Mental Health Commission incorporates genuine co-design and coproduction into its procurement and contracting processes through:</p> <ul style="list-style-type: none"> <li>• co-designing service specifications pre tender phase with consumers, families and carers,</li> <li>• requiring tender applicants to show evidence of co-design with consumers, families and carers during the tender submission phase,</li> <li>• requiring successful applicants to show evidence of coproduction upon service planning and delivery of the funding,</li> <li>• providing dedicated funding for investing in co-design capacity building for the service’s staff and lived experience members,</li> </ul> <p>The MHC develops an Engagement Framework Implementation Plan focused on building capacity with consumers, families, carers and providers in the sector.</p> <p>The MHC Engagement Framework and Toolkit should guide applicants throughout this process, including a requirement for service agreements to include evidence of the use of the Engagement Framework and Toolkit in service delivery.</p> <p>The Mental Health Commission extends the timeframe for tender applications to allow for more genuine co-design efforts from NGOs and to allow smaller groups adequate time to compete.</p> <p>The Mental Health Commission explores a ‘conforming’ and ‘non-conforming’ tender bids to drive innovation and equity between larger and smaller applicants.</p>

		Acknowledgement that peer led groups and organisations may be disadvantaged in tender processes. Building the number and capacity of peer led approaches needs targeted procurement rounds like the ILC, NDIA and DPFO grants
	Evaluation	The Mental Health Commission incorporates greater lived experience, family and carer input into evaluation processes through the existing National MH Accreditation Process, adoption of the Patient Opinion website or mystery shopper type initiatives and reviews.
	Rural and Regional	Acknowledgement that all of these comments apply to a factor of two in remote, rural and regional areas. Ensure that marginalised communities and populations (Aboriginal, youth, CALD, LGBTIQ+, Disability, Forensic) are also included in system planning and procurement

The detailed commentary for each Suggestion of the Family & Carer Support streams is outlined in the following pages (in verbatim participant language).

## Language

- The language used in these procurement definitions in terms of mild to moderate mental ‘illness’
  - can less stigmatic language be used like mild to moderate mental health ‘concern’
  - for many individuals, these are not illnesses, they are normal responses to trauma
  - the language needs to appreciate a spectrum of support and personal experience, rather than service boxes (someone accessing ‘mild to moderate’ services may actually have ‘severe’ traumas and concerns)
- People are not accessing these services until they’re in crisis but they should be at earlier stages when they’re deemed ‘mild to moderate’
  - a lot of people don’t have the financial or social capital to access these services at the primary stage and end up first accessing support at the top of the service level pyramid
- It speaks to having to be proficient in two languages – the consumer language and the procurement language;
  - the MHC needs to acknowledge this duplicity and use this procurement language to convince politicians;
- But it’s also important for the MHC to model leadership around language and keep pushing up, as the politicians will never change their understanding if they keep hearing words like ‘illness’ or ‘consumer’ rather than ‘lived experience’
  - Even ‘lived experience’ is a service term, most people will just say they have ‘experience’ or a ‘past’
- It’s not just politicians but even well trained nurses in the system that don’t understand what ‘lived experience’ is



- Rather than two languages (inwards and outwards), language to politicians around key terms is really important because they hold the money
- You're often dehumanised to an 'illness' which is why the language is confronting;
- Need to acknowledge that the MHC does use the term 'distress' much more now, so has come a long way and needs to continue that.
- I think we're also misrepresenting the current state when we call the mental health system a 'system', it's more a series of disjointed entities
- Education needs to occur for police and family court judges around help seeking for mental health
  - there's a stigma that if they see you've accessed group support, they'll judge you

**Suggestion:** *The Mental Health Commission reviews and considers the language it uses in procurement, policy and strategic processes to remove stigmatising and dehumanising terms like mental 'illness' and other restrictive language. Strengths based, recovery oriented should be encouraged. The term 'mental health issues or at risk of developing a mental health issues' is suggested.*

Final workshop commentary

- Important to stop compartmentalising people's needs; it's all about individuals!
- 'Recovery' and 'recovered' are not synonymous
- Almost more than a language challenge, it's about a dominant biomedical approach
- Include 'relational' recovery

## Codesign and Coproduction

- There seems to be a difference in what's on offer and what people are keen to see and experience; where in procurement and contracting are services required to evidence that they are codesigning offers being put up for tender?
- Where is the investment in codesign skills and the time to do it for people with lived experience and NGOs; it should be embedded in service design, delivery and evaluation
- The tender process can be quite short and the MHC should provide more robust and genuine time periods for codesign, otherwise NGOs will just quickly check their preconceived notions
- Build it as explicit criteria in the tender process; the NGOs need a signal
- The signal is already there in service agreements though and should be observed
- Codesign must be with those in the target group (i.e. severe and persistent) which requires a real build up in equity for these individuals to participate
- There are a number of longstanding contracts that assume a level of feedback of feedback and codesign;
- But it's not happening and it needs a proper investment in the space
- The short 4-6 week tender timeframes shrink the market to those with professional tender writers and 'programs' they can roll off the shelf

- NGOs and groups are provided 9 months it will go out to tender but have no idea what will go into the criteria
- One example from outside the mental health space I've seen is 'conforming' tenders and 'non-conforming' tenders (must submit a conforming but can also submit a non-conforming in addition) and it yielded innovative models
- Codesign in the tender to secure the funding or codesign in the service after winning the funding?
  - maybe NGOs should show evidence of how the MHC Engagement Framework will be utilised in the tender process, as an explicit lever

**Suggestion:** *The Mental Health Commission incorporates genuine co-design and coproduction into its procurement and contracting processes through:*

- *co-designing service specifications pre tender phase with consumers, families and carers,*
- *requiring tender applicants to show evidence of co-design with consumers, families and carers during the tender submission phase,*
- *requiring successful applicants to show evidence of coproduction upon service planning and delivery of the funding,*
- *providing dedicated funding for investing in co-design capacity building for the service's staff and lived experience members,*

**Suggestion:** *The MHC develops an Engagement Framework Implementation Plan focused on building capacity with consumers, families, carers and providers in the sector.*

**Suggestion:** *The MHC Engagement Framework and Toolkit should guide applicants throughout this process, including a requirement for service agreements to include evidence of the use of the Engagement Framework and Toolkit in service delivery.*

**Suggestion:** *The Mental Health Commission extends the timeframe for tender applications to allow for more genuine co-design efforts from NGOs and to allow smaller groups adequate time to compete.*

**Suggestion:** *The Mental Health Commission explores a 'conforming' and 'non-conforming' tender bids to drive innovation and equity between larger and smaller applicants.*

**Suggestion:** *Acknowledgement that peer led groups and organisations may be disadvantaged in tender processes. Building the number and capacity of peer led approaches needs targeted procurement rounds like the ILC, NDIA and DPFO grants*

## Final workshop commentary

- This is all at the tender process, after the specs have been designed;
- MHC should engage before the tender process to enable diversity and options for lived experience input to what is needed
- This needs to be an opportunity for people to have an open and transparent say on their experience or access attempts for these programs (to inform the pre-tender process)
- Need for the MHC to invest in capacity for co-design and co-production before the tender processes
- Community decision making and ensuring all those who have a stake are in the room
- Consider how to support organisations to uptake codesign to inform tender response through a 2 phase approach:
  - funding co-design process
  - tender process to evaluate results of the co-design process
- State Government policy requires that service providers are also engaged in co-design processes, bringing everyone together means learning together and giving direct lived experience
- ‘Ringfenced’ means attached to service contracts; do you mean dedicated funding for co-design capacity building (we recommend this approach)
- Skills building is just one side of capacity building – change to ‘capacity building’
- Also, investment in lived experience leadership and capacity building (e.g. citizen led approaches to co-design)
- Co-design framework implementation plan with the consumer, family and carer sector
- Consider how to ensure that the timeframe for tenders are at least as long (if not longer) as the ‘internal’ parts of the process
- Acknowledgement that peer led groups and organisations may be disadvantaged in tender processes. Building the number and capacity of peer led approaches needs targeted procurement rounds like the ILC, NDIA and DPFO grants

## Evaluation

- Proper evaluation needs to happen independently too
- The MHC could have a group of mystery shoppers that could cold call services and attend group support and mutual support activities to evaluate them
- Patient Opinion website is a valuable tool for collecting feedback for the MHC on experiences; it needs greater promotion though
- The shift in QA processes to the National MH Accreditation process should have had family and carer input
- The National MH Accreditation process does spend time on the consumer and family experience

**Suggestion:** *The Mental Health Commission incorporates greater lived experience, family and carer input into evaluation processes through the existing National MH Accreditation Process, adoption of the Patient Opinion website or mystery shopper type initiatives and reviews.*

Final workshop commentary

- Important to authentically value the consumer voices in this space

## Remote, Rural and Regional Access

- Acknowledgement that all of these comments about access apply to a factor of two in remote, rural and regional areas
- Rural and regional options are really limited; the services are generally large group settings, one way conversation / talked down to from the text book by the group leader; so you don't go back a second time
  - in the regions the question becomes 'where would I go?'
  - the lack of mental health support often then deteriorates to AOD coping
- Or if there are other options, they're little closed groups with the same four people, the same message and the same stories delivered year after year after year which becomes tired quickly
- Indigenous access, particularly in regional and remote areas is also a major issue

**Suggestion:** *Acknowledgement that all of these comments apply to a factor of two in remote, rural and regional areas. Ensure that marginalised communities and populations (Aboriginal, youth, CALD, LGBTIQ+, Disability, Forensic) are also included in system planning and procurement.*

Final workshop commentary

- Need to include marginalised communities and populations (Aboriginal, youth, CALD, LGBTIQ+, Disability, Forensic)

## ATSI Yarning Session Suggestions

A dedicated yarning session was held with 5 members of the Noongar and Yamatji communities, a WAAMH representative and MHC staff on Tuesday, 17 September 2019.

The three hour discussion covered the Community Support Program Area and the participants made a number of suggestions.

### Summary Table

The key Suggestions from the ATSI Yarning Session are in the table below:

Access and Aboriginal Governance	<p>Ensure greater Aboriginal governance and input at all levels of tendering, procurement, service design and delivery through options including:</p> <ul style="list-style-type: none"> <li>• dedicated Aboriginal community based mental health organisations,</li> <li>• Aboriginal voices at the table in the Mental Health Commission's decision making structures, and</li> <li>• greater support for Aboriginal mental health workers.</li> </ul>
Family and Carer Support specific to Aboriginal people	<p>Services should provide consistent, ongoing and practical support to Aboriginal families and carers, including transport and yarning opportunities to walk 'side by side' with families rather than criteria driven approaches.</p>
Incorporation of Cultural Security and Safety in supporting Aboriginal People.	<p>The MHC could consider leading the mental health sector in cultural security for, and employment of, Aboriginal people and provide increased opportunities for sector development and capacity building in cultural competence and safety including sector wide Aboriginal Co-Design Forums to build mutual awareness and trust between Aboriginal people and services.</p>
Individual Advocacy specific to Aboriginal people	<p>The MHC could consider procuring specific Aboriginal Navigator services and positions to provide individual advocacy for Aboriginal people across multiple systems and service providers; advocacy should link in with family support networks.</p>
Outreach to People's homes	<p>The MHC could incentivise outreach activities by service providers that connect with Aboriginal people and bring them onboard with services when needed.</p>
Including people who are at risk of	<p>The MHC consider broadening access to the services within the Community Support Program Area beyond the 'severe and persistent'</p>

becoming severe and persistent.	criteria, particularly as a diversionary and rehabilitation option for individuals in contact (or at-risk of contact) with the justice system.
Service Provider Collaboration	The MHC could consider procuring services in a way that drives greater coordination and collaboration between service providers, for warmer person centred referrals and joined up support.
Spirituality and Holistic / Non-Medical Support	The MHC could consider Community Support services that provide holistic understandings of support and recovery including spirituality, cultural beliefs and practices, acknowledgement of trauma and SEWB frameworks for Aboriginal people.

The detailed commentary for each Suggestion of the ATSI Yarning Session is outlined in the following pages (in verbatim participant language).

### Access and Aboriginal Governance

- Difficult to know if many Aboriginal people are attending these services
- Why can't there be community based Aboriginal organisations that specifically focus on delivering these services; it would be more comfortable for people on a very sensitive issue
  - would have to be a Noongar initiative on Noongar country with the right governance
- Need for some more talking and sharing of issues with the Wadjela mob – not just start these services from the white box, talk from the grey box and change the system to fit with us
- We're all in the same predicament as Aboriginal people, don't like to see myself as separate or with all the answers, need to share the information to develop the answers together
- Needs to start with community – what support is there in a group sense for workers to be culturally knowledgeable and competent?
- An Aboriginal voice at the table for the Mental Health Commission
- An Aboriginal community based mental health organisation would be great
- Holistic family based opportunities to come together
- Would look like a major Aboriginal Medical Service but in a standalone place to cater for Aboriginal people with mental health concerns
- Would need to be disability friendly and linked to NDIS programs and packages
- Really focused on improving quality of life
- Build comfort and confidence attending this place and developing our voice to present to the wider world of mental health
- Tied into focusing on wider issues outside of mental health like homelessness and poverty
- Not a place where you have to 'fit' a criteria through strict assessment – a no wrong door approach that addresses 'disadvantage' not the mental health boxes

**Suggestion:** *Ensure greater Aboriginal governance and input at all levels of tendering, procurement, service design and delivery through options including:*

- *dedicated Aboriginal community based mental health organisations,*
- *Aboriginal voices at the table in the Mental Health Commission's decision making structures, and*
- *greater support for Aboriginal mental health workers.*

## Family and Carer Support

- 24/7 support for family and carers – the reassurance they're not on their own; a consistent flow of services and know that someone's going to walk side by side with them and not look to put them in boxes and criteria
- Transport support
- Yarning opportunities
- Important for services to work with the whole family and respect their knowledge of what works and doesn't work
- And also understand the different families within communities and the support that they can provide
- No referrals to family support when at crisis / hospitalisation level

**Suggestion:** *Services should provide consistent, ongoing and practical support to Aboriginal families and carers, including transport and yarning opportunities to walk 'side by side' with families rather than criteria driven approaches.*

## Cultural Security and Safety

- Group support services delivered by mainstream organisations must win the confidence and trust of Aboriginal people; it takes listening with different ears, not just their mainstream thinking
- A practical thing would be yarning opportunities - train up Aboriginal people to run these discussions under the mainstream structures
- A series of Aboriginal identified positions within the MHC (50(d) positions) with some authority and support to make change within the organisation and not be placed with the bulk of all Aboriginal engagement (must be owned across the MHC – they have to be part of the change); not just an Aboriginal Programs team
- Cultural security must be across the MHC and services – extra level of specific support
- Cultural competence training

- These organisations must be culturally secure from the top down, otherwise it relies on the one Aboriginal person employed; needs Aboriginal teams to provide support to each other and address the naivety amongst the bigger service providers that assume they understand the context of Aboriginal people and their lives
- Elders in residence programs and RAP's are positive
- Aboriginal people need to feel comfortable that their story has been heard, listened to and is reflected in RAP's, MoU's, engagement structures; then the trust will come to access the services;
- Ongoing co-design forums for Aboriginal people to connect with potential services and the sector to tell their stories, spill their guts and build the trust that they're providing appropriate advice; connect Aboriginal people and services – what's on the map;
  - each forum with an agenda modelled on progress and iteration
  - need to get all these organisations together to begin talking and build mutual awareness
- Must be joined up to the mental health system, not segregated from the Wadjela groups
- Quarterly regular forums to paint the picture of the support out there and learn from Aboriginal people – get to know what the Aboriginal issues are
- Accessible to a range of Aboriginal people (disabled, severe and persistent)

**Suggestion:** *The MHC should lead the mental health sector in cultural security for, and employment of, Aboriginal people and provide increased opportunities for sector development and capacity building in cultural competence and safety including sector wide Aboriginal Co-Design Forums to build mutual awareness and trust between Aboriginal people and services.*

## Individual Advocacy

- Needs a whole team of Aboriginal people to support Aboriginal people to navigate and access services (where the resources are, where to go for help)
- Navigators that understand the disadvantage and social context from colonisation and intergenerational trauma – someone to help cut across the different systems and join up the different advocates
- Individual advocacy services need to link into the families
- Experience is that they work really well with the family, take what the person says on face value and present that to the Mental Health Tribunal; feel empowered

**Suggestion:** *The MHC should consider procuring specific Aboriginal Navigator services and positions to provide individual advocacy for Aboriginal people across multiple systems and service providers; advocacy should link in with family support networks.*



## Outreach

- Rural and remote areas just don't have the services, often have to move to the city
- Need to advertise and promote services more to Aboriginal people; need for the resources to go out into the community and do the outreach
- No outreach and promotion funding for services means reaching diversity in clientele is really difficult
- Need someone interested enough to go to people, do the assessment and bring people on board and connect them to their needs
- Greater number of outreach workers is needed

**Suggestion:** *The MHC should incentivise outreach activities by service providers that connect with Aboriginal people and bring them onboard with services when needed.*

## 'Service Eligibility

- Access should be wider than those with 'severe and persistent'
- What about the people that are not experiencing severe and persistent symptoms?
- How do they access services without the knowledge of what support is available?
- Need to allow the flexibility to meet the needs of the people at risk of becoming severe and persistent not just the 'severe and persistent' because we all have the same histories and traumas, and these people need to be picked up
- Frustrating for families to have to push for services to take on people who don't fit the definitions; it's a struggle and people become more comfortable in jail because they have respect, brotherhood and things are clear
- Need to break the cycle of young Aboriginal people going to prison
- Opportunities for the services to provide support in prison settings, so that the relationship starts before people get out

**Suggestion:** *The MHC consider broadening access to the services within the Community Support Program Area beyond the 'severe and persistent' criteria, particularly as a diversionary and rehabilitation option for individuals in contact (or at-risk of contact) with the justice system.*

## Service Provider Collaboration

- So many service providers and groups out there, there needs to be greater coordination of these groups from the Minister
  - a lot of duplicity, some of them have the same clients
- Hard to know where for \$ for small groups to access these opportunities
- Multiple services all with the same client but none of them talk to each other and coordinate and link up for the clients
- Loose communication, either don't refer to other services or they give you a name on a piece of paper with no introduction
- They're competing for funding, so they don't collaborate
- They need to come together in communities of practice to work for the person holistically

**Suggestion:** *The MHC should procure and contract services in a way that drives greater coordination and collaboration between service providers, for warmer person centred referrals and joined up support.*

## Spirituality and Holistic / Non-Medical Support

- The medical system does not always fit for us and once you're in that box there's no getting out of it, locked into medication; would prefer to use alternative ways of healing
- Recognising and supporting the spirituality of Aboriginal people and how this connected to families and support is a starting point
- Important for support group and mutual support / self help to happen on country and focus spiritually, not just mental health approaches by mental health organisations; focused on SEWB, trauma and healing, not just mental health
- Assessment and evaluation needs to be more holistic too – get the client feedback and stories from broader systems and outcomes than just the direct service;
- Compassion and care level of people in power; need for acknowledgement of trauma and history at the highest levels;

**Suggestion:** *The MHC should procure Community Support services that provide holistic understandings of support and recovery including spirituality, cultural beliefs and practices, acknowledgement of trauma and SEWB frameworks for Aboriginal people.*

# CO-DESIGNED PROCESS FOR FUTURE LIVED EXPERIENCE REVIEWS

## Summary of Future Co-Review Process

The following process is recommended by the facilitator for future co-reviews of program areas and is sourced from a combination of participant feedback and facilitator reflections.

The key stages are:

1. Expression of Interest Process
2. Group Formation and Direct Appointments for Diversity (if necessary)
3. Briefing Pack and Session
4. Session One – Co-Designing and Scoping Our Approach
5. Between Sessions - Information Gathering Phase
6. Session Two – Sharing Our Findings
7. Session Three – Deep Dive Analysis
8. Session Four – Suggestions Ratification and Reflection

The process uses particular terms, defined as:

- Findings – the information gathered by group members from yarns and interviews with lived experience individuals in their networks
- Insights – The key learnings and takeaways made by group members in considering and analyzing the Findings
- Suggestions – The final suggestions made by the group members to the MHC as a synthesis of the Findings and Insights and best practice they've discussed.

## Detailed Future Co-Review Process

The detailed process for the next Co-Review recommended by the facilitator is outlined in the following eight steps.

### 1. Expression of Interest Process

- 1.1 Conduct an Expression of Interest to seek Co-Review participation by lived experience individuals
  - EOI opportunity should be widely circulated via MHC channels and through MH and AOD sector networks (WAAMH, COMHWA, AODCCC, Connect Groups, AHCWA etc.)
  - Allow generous time for application (4 weeks).
- 1.2 Simplify the EOI requirements to
  - Be a consumer, family member, carer or community member willing to contribute their perspective and experiences of mental distress and/or AOD use
  - Understanding, knowledge, skills or experience of non-Government mental health and AOD community services specifically those within the Program Area for review
  - Willing to consult with their relevant networks (formal or informal) and express or represent others views
  - Previous experience or willingness to engage with a participative co-design or co-production format
- 1.3 Provide dedicated and direct opportunities for individuals from the following populations to submit EOIs:
  - Aboriginal and Torres Strait Islander
  - Culturally and Linguistically Diverse
  - LGBTIQ+
  - Rural & Remote
  - Youth

### 2. Group Formation and Direct Appointments for Diversity (if necessary)

- 2.1 Cap the maximum group size at 20 participants total with a balance of 12 - 15 lived experience members and 5 - 8 peak body representatives

- 2.2 Weight the selection of EOI applicants towards:
- Diversity (age, gender, minority groups in 1.3)
  - Recent and direct interaction with services within the Program Area for review (or desire to access services but inability to)
- 2.3 Upon first round shortlisting of applicants, consider whether dedicated positions need to be established with direct appointment of individuals from the groups in 1.3
- 2.4 Maintain peak body representation on the group and with clearly defined role to:
- Clarify the systemic and service provider context,
  - Articulate the service provider perspective
  - Test the thinking of the group
- Make peak body representatives' role visible through including organisation information on different coloured name badges and introductory exercises
- 2.5 Maintain MHC Procurement Team staff participation in the group in the capacity of empathetic and non-judgemental observers with the role to:
- Present key information, as appropriate
  - Clarify any questions or information
  - Seek MHC internal or systemic information on behalf of the group
  - Provide their reflective key takeaways and learnings in the final session

### 3. Briefing Pack and Session

- 3.1 Prior to kick-off with the Co-Review group, engage a small lived experience project team (3-5 people) to co-produce a simplified (layman's terms) and visual Briefing Pack of information to inform and brief new members of the Co-Review group in association with the MHC Procurement Team, including (but not limited to):
- Role of the Co-Review group and what to expect as a member,
  - Where the mental health and AOD system is currently at (context) and where it intends to be in the future (the Plan)
  - How the MHC procures, contracts and reports on services (i.e. Procurement Schedule etc.) and understanding the complex language and governance
  - Which service streams are under review and what they include

- How to get the most out of your participation on the Co-Review
- Ideal candidates to co-produce this Briefing Pack are recent members of the 2019 Community Support Program Area Co-Review process
- 3.2 Provide the newly selected Co-Review group members with the Briefing Pack upon acceptance of applications
  - 3.3 One week prior to the beginning of the Co-Review process, hold an evening 1.5hr information and welcome session for group members to focus on:
    - Welcome and getting to know each other
    - What to expect, what's in scope, what's not
    - Any questions or reservations on the process
  - 3.4 Provide group members with any further take home pre-reading on the service streams and current delivery / context.

#### 4. Session One – Co-Designing and Scoping Our Approach

- 4.1 First participative session to cover:
  - Welcome, introductions, context and working together
  - Our experiences of the service streams under review
  - The key questions we want to gather further information on throughout this process
    - *e.g. What is the most valuable offering of these services?*
    - *e.g. What would make this service stream more accessible to youth?*
    - *e.g. Why aren't services providing outreach for this service stream?*
  - Who will we speak to?
    - Setting personal targets for yarning with /interviewing other lived experience individuals within our networks or facilitated by service providers and peak bodies
  - Capacity Building – how to conduct and record a semi structured interview
  - Wrap up and reflection
- 4.2 Session Outcome – Engaged and comfortable group members with a clear understanding of the questions, format and targeted individuals for gathering further information with other lived experience and service provider individuals

- 4.3 Session Output – Agreed set of preliminary Co-Review questions and list of identified individuals / networks for semi-structured interview
- 4.4 Duration – 4 hour workshop

## 5. Between Sessions - Information Gathering Phase

- 5.1 Group members spend a two week period engaging with their personal networks or with individuals facilitated by service providers and peak bodies
- 5.2 Group members expected to conduct a 30 min yarn / semi structured interview and record key information and findings for presentation to the Co-Review group at Session 2
  - Interview guide and reporting template provided
  - MHC and Facilitator to aid with final collation, if required
- 5.3 Group members likely to conduct 2-3 engagements and are paid MHC Consumer Payments for this effort
- 5.4 Outcome – Broader consultation with the sector and capacity building of Co-Review group members in consultative processes.
- 5.5 Output – Raw Findings to Co-Review questions
- 5.6 Duration – 2 week period between Session One and Session Two

## 6. Session Two – Sharing Our Findings

- 6.1 Second participative session to cover:
  - World Café style report back on findings and information gathered for each question
  - Workshop session in small groups to analyse the information and highlight initial Insights and/or Suggestions forming
  - Homework – research best practice from WA, interstate or internationally for service delivery
  - Reflection and Wrap Up
- 6.2 Session Outcome – Greater level of understanding of the broader lived experience of the service streams under review outside of the direct Co-Review group.
- 6.3 Session Output – Initial Findings to Co-Review questions and preliminary Insights
- 6.4 Duration – 4 hour workshop within two weeks of Session Two

## 7. Session Three – Deep Dive Analysis

### 7.1 Third participative session to cover:

- Whole of group deep dive discussions on the questions and preliminary Insights and any learnings from homework on best practice
- Small group workshop to form Suggestions to the MHC for improvement of the service stream
- Seek consensus on Suggestions from the whole group
- Participants are provided opportunity to reflect on the Suggestions prior to the Session Four
- Reflection and Wrap Up

### 7.2 Session Outcome – Synthesis of lived experience information.

### 7.3 Session Output – Agreed set of Suggestions to the MHC for consideration

### 7.4 Duration – 4 hour workshop within one week of Session Two

## 8. Session Four – Suggestions Ratification and Reflection

### 8.1 Fourth participative session to cover:

- Final reflection and ratification of the Suggestions as a group
- Reflection on the Co-Review process (what worked, what didn't)
- Wrap Up and Thanks



## Participant Feedback on the Process

In the last session of the Co-Review process, the participants reflected on the overall process and provided feedback to improve any future processes. This feedback has formed the basis of the recommended Future Co-Review Process outlined in the previous section.

A summary of the feedback is provided in the table below.

Clarity of process and ongoing co-design	More clearly articulate the purpose and expectations of the Co-Review at the EOI stage and outset of the participative process
	Conduct the Co-Review earlier in the overall MHC procurement review process to enable sufficient time and flexibility for the MHC and participants to consider outcomes.
	Expand the Co-Review process to a wider audience of consumers, particularly direct and recent users of the services being reviewed (or those who were unable to access the services)
Group size and composition	Maintain the group size of 20 individuals maximum with similar balance of lived experience and peak bodies; establish clearer and more visible roles for peak bodies or specific sessions dedicated to peak body / service provider input and networking.
	Maintain the diversity of experience (MH, AOD, Consumer, Carer, Family) in the group but make a significant effort to increase the participation of diverse minority groups such as Aboriginal, CALD, LGBTIQ+, Rural & Remote and Youth service users.
Group dynamics and learnings	Acknowledge the positive and significant learning component of participating in a Co-Review process and formally recognise the individuals' completion for future reference.
Facilitation, Discussions and Exercises	Maintain a designated facilitator role (whether MHC, contracted or consumer) to design and oversee participative process and specific discussions.
	Continue to refine facilitation approach and exercises to balance the diversity of views and comfort within the group.
MHC staff involvement	Continue participation of MHC procurement staff in empathetic and non-defensive observer / clarification roles; also continue to the practice of MHC staff providing their key takeaways and learnings on the content in the last workshop.

Timing and spacing of workshops	Sequential half day (4 hour) workshops at one week intervals were well accepted and longer breaks may contribute to a loss of momentum.
Information and pre-reading	Provide much clearer and simpler information on the group's purpose, the proposed Co-Review journey and the MHC Procurement Schedule / Program Area's context and language prior to the first workshop through pre-reading and/or information sessions etc.
Capture of outputs	Continue to synthesise and provide the group's outputs iteratively between sessions in the current format (suggestions supported by commentary)
Catering and venue	Catering and hospitality was well received; provide more healthy and low sugar options in the future.
	Ensure workshops are held in a consistent room with adequate space for varied formats of participation (individual reflection, small group exercises and whole of group discussions).

The detailed feedback from the participants is captured in near verbatim language below.

### Clarity of process and ongoing co-design

- Make sure we know what you want from us
- Pre-reading and information outlining the process and what was expected would have been useful
- Would have been good to get an understanding of the MHC scope, process and constraints as this was not clear at the outset

**Takeaway:** *More clearly articulate the purpose and expectations of the Co-Review at the EOI stage and outset of the participative process*

- Need for a longer timeframe for the EOI and a broader scope
- Earlier involvement to help the MHC do their job at an easier pace would be better (not late like the Government norm)
- Process should have been earlier to best inform decision making

**Takeaway:** *Conduct the Co-Review earlier in the overall MHC procurement review process to enable sufficient time and flexibility for the MHC and participants to consider outcomes.*

- Value options to engage outside of this group, as well as this group which has been really great but is exclusive by design, so people who don't know about it have access barriers or don't get selected and need to be given another way to engage (e.g. MHC engage consumer leaders to engage other consumers); this is a very significant limitation

- Needs to be a bridge built between the requirements of the DCSP Policy and the MHC's wonderful Engagement Framework (how to make the two work together?). For this to truly be a review of service streams, a more robust process should be developed, in particular with a broader cross section and higher numbers of consumers who have used the services (e.g. no one seemed to understand Personalised Support linked to Housing yet the MHC may say it has now been reviewed which is not very transparent). A group process allows for a lovely 'deep dive' on content but the breadth and diversity missing is a critical issue. It's a lot of work to do, a better process might be a committee for each service stream rather than 5 streams rolled into 1 - this would also allow more people that used the service or would have liked to, to participate; it would also have enabled people participating to understand the service streams in more depth, then to workshop them in more depth how they might change. These elements would make for a more robust review
- Confident that the MHC will include consumer / carer representation on their Commissioning Committee and at as many decision making levels as possible
- MHC must embed co-design and consumer voice in all of its decision making processes with full transparency at all stages of funding discussions.
- Opportunities should be provided for consumers and carers to be involved in more varieties of processes

**Takeaway:** *Expand the Co-Review process to a wider audience of consumers, particularly direct and recent users of the services being reviewed (or those who were unable to access the services)*

## Group size and composition

- Liked the group size
- Group size, diversity of experience and consumer / peak body balance was effective and worked efficiently
- Group size was fine
- Max 20 people group size was good
- Group size was good, enabled people to all have opportunities to speak and a sense of camaraderie developed, allowing people the safety to speak
- Good size group and balance of perspectives
- Group size was great but we should know earlier what capacity we each represent (e.g. carer, peak body etc.)
- There was a good blend between consumer and peak body; I liked the way the consumers were acknowledged for their skills despite not having the rhetoric of the peak body people
- Perhaps representatives from service providers at one session

**Takeaway:** *Maintain the group size of 20 individuals maximum with similar balance of lived experience and peak bodies; establish clearer and more visible roles for peak bodies or specific sessions dedicated to peak body / service provider input and networking.*

- Enjoyed the diversity of experience
- A lot of new consumer and family faces around the table which reflected a thoughtful EOI process
- Perhaps more representation of men
- Diversity was somewhat limited
- Aboriginal, LGBTIQ+ and youth need to be present around the table
- In some discussions (especially workshop 1), the peak body voice dominated, leaving less room for the consumer and family voices
- Group size was good, as was the balance of consumers to peak bodies, however the voice, inclusion and participation of Indigenous, CALD, LGBTIQ+, Rural & Remote and other diverse groupings must be included in the conversations
- Payment is appreciated and appropriate

**Takeaway:** *Maintain the diversity of experience (MH, AOD, Consumer, Carer, Family) in the group but make a significant effort to increase the participation of diverse minority groups such as Aboriginal, CALD, LGBTIQ+, Rural & Remote and Youth service users.*

## Group dynamics and learnings

- Challenged in a good way, it was a compassionate and understanding group
- Felt I was able to ask questions and receive clarity on any areas I was unsure about
- Learnt a lot from the process and heard many different perspectives I would not normally be privy to and even had my mindset altered in some areas
- Extremely informative; new understanding of the process and MHC positions and issues that all come across in putting services into motion
- Everyone in the room was understanding
- Great relationship building and content
- Learning in perspectives and seeing the wider view and new concepts
- Feels like a good solid safe space
- Would like to see our performance noted for learning and education for all MHC involvement in the future

**Takeaway:** *Acknowledge the positive and significant learning component of participating in a Co-Review process and formally recognise the individuals' completion for future reference.*

## Facilitation, Discussions and Exercises

- Happy with how the group process was presented and facilitated
- Having a facilitator worked well
- Opportunities for all participants to contribute were excellent and the facilitator did a professional job
- Facilitator was approachable and accessible
- Facilitator managed the group well and his preparation and guidance throughout the process was excellent
- Facilitation was well done
- Facilitation and group size was great
- Facilitation and MHC responses to requests from this group has been fantastic
- Quality of facilitation and content is good

**Takeaway:** *Maintain a designated facilitator role (whether MHC, contracted or consumer) to design and oversee participative process and specific discussions.*

- Didn't particularly like some of the 'getting to know you' exercises but overall, they were ok. Most enjoyed the 'first album, first concert' exercise as it gave me a different insight into my new friends' lives rather than the usual topics
- Connection activities were good; always good to spend time 'landing' as a group
- Discussion and exercises were relevant and creatively done; perhaps heard more from the peak body representatives than consumers at times
- Tighter facilitation needed to manage the few people who continued to interrupt and sometimes derailed the conversation at hand
- Good balance of loose vs structured facilitation
- I wonder at the depth of these discussions and indeed how many of the ideas have potential to be explored further. The risk is that a superficial 'take' on concepts is accepted; this may actually harm services, either by requiring changes by them or indeed not purchasing services just because the understanding is not comprehensive
- Well-structured discussions and exercises; I found the peak bodies were a little bit 'talked down' to by the MHC when they were raising extremely valid and poignant issues

**Takeaway:** *Continue to refine facilitation approach and exercises to balance the diversity of views and comfort within the group.*

## MHC staff involvement

- MHC staff in the room to clarify things was great (usually never happens elsewhere)
- Good to see the MHC in the room and seeking alternate views
- MHC participation was genuine, encouraging and empathetic
- MHC attitude was heartening and should be congratulated
- Big applause to the MHC for undertaking this process; transformation takes courage, leadership, humility and willingness to stay in discomfort and ambiguity
- Really liked the staff's summing up / key takeaways in the last workshop and the transparency and honesty with which these comments were made
- Grateful for discussions and feedback from MHC staff and their reflections and validation around learnings, perspectives and openness to grow engagement

**Takeaway:** *Continue participation of MHC procurement staff in empathetic and non-defensive observer / clarification roles; also continue to the practice of MHC staff providing their key takeaways and learnings on the content in the last workshop.*

## Timing and spacing of workshops

- Enjoyed a 4 workshop process instead of 1 long running meeting that gets nowhere; maybe even a fifth meeting for more reflection time
- Timing and space of the workshops was good; any longer than 4 hours and people become tired and lose concentration
- Timing and spacing of workshops was good
- 4 hours starting at 9am is good and one week apart worked well
- Timing and spacing of workshops has been challenging (too quick and too close together); a bit demanding for people juggling multiple things
- Less time between workshops 3 and 4 and an extra hour per session to elucidate more information
- Timing was good but perhaps the break between workshop 3 and 4 was too long, would've been happy with no break

**Takeaway:** *Sequential half day (4 hour) workshops at one week intervals were well accepted and longer breaks may contribute to a loss of momentum.*

## Information and pre-reading

- More information on the current state, including layman's descriptions of what the MHC does and where they believe they have deficiencies
- A little more scene setting to get up to speed with the MHC business

- Pre-reading by participants should be essential
- Prereading about the purpose of the convened group and followed with home work at the first engagement
- Prompt surveys and reviews offered online before each session to reengage people and jog memories would have been great
- Good pre-reading and evaluation
- Readings were fine as long as participants were competent readers and able to process the language that is embedded in this space
- Felt first workshop was somewhat wasted when we were discussing language, definitions and National Standards which could have been circulated prior to the first workshop
- Need for clearer definitions in the pre-reading as this took some time in workshop 1; it is a mind-blowing experience for newer people to understand the new language, acronyms and service types
- Need for an information session before the EOI process to explain some of the processes, language and concepts
- Limit opportunity for timewasting in the first workshop by prepping everyone for solely active listening

**Takeaway:** *Provide much clearer and simpler information on the group's purpose, the proposed Co-Review journey and the MHC Procurement Schedule / Program Area's context and language prior to the first workshop through pre-reading and/or information sessions etc.*

## Capture of outputs

- Our suggestions were excellently captured and easy to read
- Background commentary to inform the suggestions was really helpful
- Synthesis of materials has been excellent

**Takeaway:** *Continue to synthesise and provide the group's outputs iteratively between sessions in the current format (suggestions supported by commentary)*

## Catering and venue

- The food and hospitality was fab
- Catering was brilliant
- Need more low sugar options even though the cakes and fruit were lovely
- Wonderful catering but need more savoury, healthy or fruit options
- Less sugar and more healthy options

**Takeaway:** *Catering and hospitality was well received; provide more healthy and low sugar options in the future.*

- Need adequate room sizes to make sure conversations are held in a space that feels safe (no cramped), particularly given these are 'big' conversations that people feel strongly about
- Group size worked but need sufficient space
- Consistency in the workspace is vital

**Takeaway:** *Ensure workshops are held in a consistent room with adequate space for varied formats of participation (individual reflection, small group exercises and whole of group discussions).*



# APPENDICES

## List of Participants

The Co-Review group consisted of 20 participants (12 lived experience and 8 peak body).

Certain peak bodies that presented a conflict of interest for a particular service stream did not attend those workshops.

- Andris Markov
- Bruce Wiltshire
- Marisha Gerovich
- Matthew Ryan
- Michelle Coster
- Rachel Dixon
- Rebecca Graham
- Robert Blakeman
- Shelley Morrel
- Gail Sherback
- Severia Romeo
- Juanita Koeiiers
- Sean Gardyne CarersWA
- Richard Bostwick HelpingMinds
- Antonella Segre Connect Groups
- Jill Rundle WANADA
- Rhianwen Beresford COMHWA
- Margaret Doherty Mental Health Matters Rep
- Chelsea McKinney WAAMH
- Pip Brennan Health Consumers Council

## Co-Review Process Undertaken

The Co-Review undertaken throughout July to August 2019 was designed to maximise lived experience input to the review of the program area and included the following components:

1. An **Expression of Interest** process to seek applications for participation in the Co-Review of up to 16 consumers, family members and carers with a lived experience of a mental health distress and/or AOD use.

Requirements for applicants were:

- Be a consumer, family member, carer or community member who has been able to integrate their experiences of mental distress and/or AOD use into their lives, retain value from their lived experience and have wisdom to share with others.
  - Be able to listen respectfully and objectively, give constructive input, maintain good working relationships with others and make reasoned judgements.
  - Be able to contribute a consumer, family, carer or community perspective into discussions and decision making.
  - May be required to consult with their relevant networks (formal or informal) and express or represent others views.
  - Understanding, knowledge, skills or experience of non-Government mental health and AOD community services specifically:
    - Family and carer support;
    - Group Support activities;
    - Individual advocacy;
    - Mutual Support and Self Help; and
    - Personalised Support linked to Housing (excluding Supported Landlord Services).
  - Understanding, knowledge and/or experience with co-design or co-production.
2. **12 successful lived experience** applicants formed the Co-review Group and were provided **participation payments** for their contributions.
  3. The lived experience members were supported by **8 peak body representatives**, also part of the Co-Review group.
  4. The Co-Review process **occurred in parallel** to a number of separate system, service provider and MHC internally focused review processes of the program area including, but not limited to, a WAAMH survey of relevant contracted service providers and ongoing contractual reviews between MHC contract managers and contractors

5. **Four workshops** were held to conduct the Co-Review and reflect on / co-design the process; these four hour workshops were held on:
  - 09 August – Welcome and Building the Knowledge Base
  - 16 August – Group Support and Mutual Support & Self Help
  - 23 August – Family & Carer Support, Personalised Support linked to Housing and Individual Advocacy
  - 13 September – Review of Suggestions and Process
6. A separate **ATSI Yarning Session** was held with a group of five members of the Noongar and Yamatji language groups on 17 September 2019 to review the program area.
7. **Workshop One** included the following activities:
  - Welcome and warm up exercises,
  - Provision of contextual information on the current procurement and contracting practice for the MHC and program area, and
  - Mapping of individual experiences and journeys through the WA mental health and AOD system.
8. **Workshop Two** included the following activities:
  - Discussion of further contextual and systemic information requested by participants, and
  - Deep dive discussions on Group Support and Mutual Support & Self Help.
9. **Workshop Three** included the following activities:
  - Reflection on the draft suggestions of Workshop Two, and
  - Deep dive discussions on Family & Carer Support, Personalised Support linked to Housing and Individual Advocacy.
10. **Workshop Four** included the following activities:
  - Reflection on the draft suggestions from Workshops Two and Three, and
  - Reflection on the overall Co-Review process and contributions for refinement.

# Final Workshop Review sheets

Scope / Program Area	Topic	Suggestion
Group Support and Mutual Support & Self Help	The Distinction Between 'Group Support' and 'Mutual Support & Self Help'	The Mental Health Commission considers removing the distinction between paid staff and unpaid peer workers that may cause confusion across the two service streams, as these two streams are not mutually separate <i>THIS IS A CONCERN FOR THE HELP STREAM IF THE HELP STREAM WILL BE AND FUNDED</i> <i>or just pay peer workers ???</i> <i>THE WILL ESSENTIALLY NOT HAPPEN? WHY CREATE A WORKFORCE THEN?</i> <i>and strengthen co-design in prevention stream</i> <i>prevention is also welfare, ie food/shelter/education</i> <i>programs that work with people not only</i> <i>5</i>
	Wider Prevention Focus	The Mental Health Commission increases investment in the prevention program areas of the Procurement Schedule (include access and promotion strategies). <i>Primary School Prevention + Promotion + De-stigmatization children to be</i> <i>action healthy coping skills as a result</i> <i>Tertiary prevention of physical health + other social determinants</i> <i>Early intervention &amp; prevention. More money directed into this!</i> <i>5</i>
	Earlier Intervention and Support	The Mental Health Commission seek procurement and contracting arrangements and mutual support & self help that better link with earlier intervention services. <i>defined as 'earlier intervention' of each experience vs. early experience chronologically</i> <i>IT NEEDS ACCESS JOURNEY (should be for all)</i> <i>SUPPORT RARE ACCESS ALL STAGES</i> <i>These 2 may need to be together</i> <i>Not stigmatized by the medicalisation of M/H or AOD.</i> <i>5</i>
	Locations, Environments and Timing	The Mental Health Commission procures group support and mutual support & self help services that provide: <i>Opportunity to join an ongoing group rather than waiting</i> <ul style="list-style-type: none"> <li>welcoming, non-clinical and inclusive environments and processes, <i>Safe. home like environment</i></li> <li>a range of group sizes that cater to different needs for safety and anonymity, and</li> <li>after hours services, particularly evenings and weekends. <i>5</i></li> </ul> <i>peer</i> <i>+ Mobile services x pickup services (see access)</i> <i>Diversity - CALD, Aboriginal, youth.</i>
	Offerings and Models of Service	The Mental Health Commission procures group support and mutual support & self help that provides hopeful, flexible and strengths based contemporary practice and environments for a range of genders and cultures. Choice of offerings may also be provided in a range of locations and range of service providers - diversity is the key. <i>Diversity to have option of self-led or join mainstream</i> <i>Local community</i> <i>5</i> <i>4</i> <i>If in remote location be able to skype into a group</i> <i>Diverse groups to include LGBTQIA+, Refugees, Indigenous, Physically challenged.</i> <i>Diversity specific funding e.g. Aboriginal.</i>



Groups should be community-facing not provider-facing  
in terms of access, promotion

KISS Navigation Layman terms  Directory for Carers/Consumers GPs, Therapists	Social Connection (5) +++	The Mental Health Commission procures group support and mutual support & self help that provide opportunities for social activities and settings to build interpersonal skills and friendships, improve community connectedness and complements therapeutic offerings.	(5) Consumer Respite - Not Focusing on MH Cafe (5) Rooze free Bars
	Promotion, Outreach and Access	The Mental Health Commission procures group support and mutual support & self help that may include providing: <ul style="list-style-type: none"> <li>creative, clear, wide reaching promotion strategies, <i>in vulnerable areas</i></li> <li>dedicated and co-designed promotion strategies and pathways, <i>to vulnerable groups (Youth, CALD, ATSI)</i> and appropriate staff resourcing (mac/tranz/staff)</li> <li>active outreach models, including transport and pick-ups, and <i>(as a short-term/initial possibility for engagement)</i></li> <li>(5) peer champion, buddy or mentor type roles to attract and retain people. <i>low not dependency</i></li> </ul>	(5) Communities of Support - Supporting Communities - Consider 'LIGHT TOUCH' Procurement Processes (& support) for smaller groups. Adult & older adult prevention, in TV Adverts (No stigma) who don't go out to access services + no internet
	Peer Support Opportunities (5)	The Mental Health Commission considers more equitable procurement and contracting structures for unincorporated volunteer peer support groups to access funding. (5) The Mental Health Commission procures group support and mutual support & self help that provides genuine opportunities for peer training, development and ongoing support as a critical recovery step.	
	Referrals and Ongoing Recovery Support (4) Having access to a peer navigator within all medical centres	The Mental Health Commission procures group support and mutual support & self help that actively demonstrates a culture and practice of recovery by: <i>(Outside the Bio-medical Model.)</i> <ul style="list-style-type: none"> <li>effective referral so people receive the services because often these services are full</li> <li>referring people to more suitable services, where appropriate,</li> <li>provide opportunities for peer training, development and transition to paid roles, and</li> <li>supports self forming peer support groups to establish around ongoing recovery needs.</li> </ul>	By what means?

→ or Socio Connection & wellbeing centres (like Nat Mental Health Commission 2630 mental wellbeing feedback WA)  
 → Welcoming for community  
 → Volunteering for groups are a key barrier to group establishment  
 ↑ centres will increase groups  
 # peer groups in WA

Family and Carer Support	Overarching Support	The Mental Health Commission considers procurement of personalised and overarching support services for specific families (i.e. Strong Families model) through the family and carer support services stream or as a wraparound package in conjunction with other personalised mental health and AOD service streams.	Specific family => multiple agency involvement. Keep things that work. Share / teach working with all services or not involved - important to adhere to rigorously. Can be counter-productive. But consumer has an option to include family later and disconnect at any time.
	Different Family Units	The Mental Health Commission seeks providers to demonstrate sophisticated and nuanced of the diverse range of family groupings and kinships (not just nuclear) in models of service and governance for family and carer support <i>(AND FUNDING TO SUPPORT SERVICES TO DEVELOP THIS CAPACITY)</i>	1 = LOW IMPACT 5 = HIGH
	Diverse & Collaborative Options	The Mental Health Commission continues to procure a diverse range of family and carer support services that provide access through: <ul style="list-style-type: none"> <li>standalone family and carer support options not linked to other individualised services and supports,</li> <li>connected family and carer support options that provide holistic and connected options with individualised services and supports in the same organisation (noting that privacy and governance are of critical importance),</li> <li>family peer-led options</li> </ul> The Mental Health Commission incentives for procurement of services that demonstrate collaboration with other services to provide family units with the most appropriate care to their needs (i.e. all together or separate supports) <i>AND THAT THE COSTS OF COLLABORATION ARE RECOGNISED &amp; FUNDED</i>	5+ - Expose models that are not so Eurocentric / monocultural. - More focus on children / child care & youth care. - family. 5
	Family & Carer Designed Resources and Capacity Building	The Mental Health Commission considers greater levels of family & carer capacity building opportunities and family & carer produced resources in family and carer support services	Young carers training to know how to access. Including ATSI + LOSTI + CALD families Rural
	Contemporary & Practical Support	The Mental Health Commission considers family and carer support services that encourage family led solution finding and problem solving through contemporary language and understandings rather than solely medical information sessions; the provision of practical and small grants or rebates (e.g. \$500 respite funding or childcare vouchers) is important to increasing access and family empowerment.	Lack of 'empowerment' for leadership by families. Still a sense of 'supporting families' ✓
	Social + Empowerment Opportunities & Space	The Mental Health Commission continues to procure family and carer support services that provide social opportunities for family and carers to connect, share information, empathise and build knowledge with other peers in similar situations. - Aim to reduce social isolation!	Opportunities available for families & individuals to share social opportunities. Eg. M/Health Cafe
Design to Empower Consumers		Design evaluation incorporates consumer perspective & in later process. Recovery-focused approaches now respected & consumers' notion in service provision, capacity building, etc.	



1 = LOW IMPACT      5 = HIGH

Housing Providers to strengthen sense of community  
 eg/ everyone knows that's the homeless area stay away so put in a cafe or other community offering, gestures to involve community outside of homeless patrons

As per MASLOW'S hierarchy of needs

Personalised Support Linked to Housing	Family inclusivity (3)	The Mental Health Commission procures personalised support linked to housing services that include family, carer or neighbour involvement and education (where appropriate) to build stronger protective supports and options around the core service	Define Housing services more than a roof over someone's head co-ordinating availability + transport routes = safety utilities
	Awareness and Access (4)	The Mental Health Commission considers the lack of access to personalised support linked to housing services due to low promotion, unclear offerings and models or inconsistent options dependent on location; sophisticated and locally knowledgeable peer navigators will improve access where services currently exist. More funding is needed!	Location/Geography matters. - Rationale is good but how will you implement? Unfortunately... Co-ord + Advocacy services is low. (5) Youth specific housing support is needed. Prisons are used as de facto mental health facilities
	Multiple, complex needs inc AOD (5)	The Mental Health Commission acknowledges the complex, multi-system needs of a majority of the individuals accessing personalised support linked to housing including (mental health, AOD, justice and welfare systems etc.) and considers services that: • identify and target this specific group of complex multi system individuals and their families • demonstrate trauma informed understandings and approaches to dealing with complex needs (AOD usage in particular) • demonstrate joined up and sophisticated ways of working with other services to provide multiple system interventions, and • utilise peer workers with similar complex experiences and peer language to provide really great behavioural interventions. - It is up to the individual to define what is really great behavioural interventions.	Need to be shared peer led service The MHC processes, as a priority, services that demonstrate joined up and sophisticated ways of working with other services to provide multiple system interventions, and to improve engagement + outcomes great behavioural interventions
	Homelessness and Step Down Housing (2)	The Mental Health Commission considers personalised support linked to housing provides smooth access options for individuals in a range of housing situations (step down from accommodation settings, homeless seeking housing). How? Peer navigation	step down not always available → Ensure equal access to SPSD for people who are homeless eg in accommodation allocation priorities
	The Distinction Between 'Navigation' and 'Advocacy'	The Mental Health Commission acknowledges that navigation of mental health services and supports is problematic and individual advocacy is inextricably linked to mental health navigation and therefore difficult to 'exclude' this component from service delivery in practice.	High demand for individual advocacy support - related to DISRUPT, RIGHTS & ACCESS
Individual Advocacy	GP Navigation (4)	The Mental Health Commission works bilaterally with WAPHA to improve the understanding of GPs in mental health service navigation and the rights of individuals. in Partnership with peers.	GPs are often not even part of the equation
	Family, Carer and Supporter Advocacy (5)	The Mental Health Commission considers targeted advocacy training aimed at building the capacity of families and carers to navigate multiple systems (e.g. AOD, MH, Housing) and advocate for individuals, as an effective upstream measure prior to accessing individual advocacy services.	Any family, carer or education - need to increase advocacy education, so they can self-advocate. peer groups can also assist.
	Promotion and Understanding of Advocacy	The Mental Health Commission considers increased promotion and awareness of individual advocacy services and incentivises advocacy that occurs across multiple systems, institutions and advocacy bodies. → consider holistic rather than siloed advocacy contexts. → consider no partners/models that enable people to access their advocacy where	FUNDING FOR MH INDIVIDUAL ADVOCACY

5 More funding is needed in individual advocacy (holistic, advocacy is currently delivered in siloed contexts non-statutory, MH + AOD)

\* SERVICE PROVIDERS' Collaboration - ACCESS BOARD.

1 = LOW IMPACT  
5 = HIGH

Stop compartmentalising people's needs. It's all about INDIVIDUALS!

"Recovery" and "Recovered" are not synonymous. Some PSW promote word some like to say they well!

All MHC Procurement and Contracting	Language	The Mental Health Commission reviews and considers the language it uses in procurement, policy and strategic processes to remove stigmatising and dehumanising terms like mental 'illness' and other restrictive language. Strengths based, recovery oriented should be encouraged. The term 'mental health issues or at risk of developing a mental health issues' is suggested.	+ To include 'relational' recovery + A (most more than language) Challenge to dominant BioMedical Approach
MHC - before the tender process to ensure diversity & options for LE input into what is needed.  Need for the MHC to invest capacity - funding for co-design & co-production in the tender processes.  This needs to be what have a say people who have had experience in programs / tried to access to give feedback.	Co-design and Co-production  This is all at tender process - after the Specs have been designed.	The Mental Health Commission incorporates genuine co-design and coproduction into its procurement and contracting processes through: <ul style="list-style-type: none"> <li>requiring tender applicants to show evidence of co-design with consumers, families and carers during the tender submission phase, including co-design of evaluation</li> <li>requiring successful applicants to show evidence of coproduction upon service planning and delivery of the funding,</li> <li>providing ringfenced funding for investing in co-design skills building for the service's staff and lived experience members, required to include a report on a budget line for LE partnership.</li> </ul> The MHC Engagement Framework and Toolkit should guide applicants throughout this process. <ul style="list-style-type: none"> <li>a requirement for service agreements to include evidence of the use of the Engagement Framework and Toolkit in service delivery.</li> </ul> The Mental Health Commission extends the timeframe for tender applications to allow for more genuine co-design efforts from NGOs and to allow smaller groups adequate time to compete. The Mental Health Commission explores a 'conforming' and 'non-conforming' tender bids to drive innovation and equity between larger and smaller applicants.	State government policy requires that service providers also also engaged in co-design processes, bringing everyone together news learning together & direct feedback to providers.  (1) Ringfenced - money allocated to specific methods to do more things, dedicated funding for co-design approach (2) Skills building - just one form of capacity building - change to 'capacity building' (3) Also mentioned in some operational funds accepted building of capacity within local support for delivery (4) Evidence Framework implementation plan - evidence, funding & other stuff  CONSIDER HOW TO SURE THAT THE TIMEFRAME FOR TENDERS ARE AT LEAST AS LONG (IF NOT LONGER) AS THE 'INTERLUDE' PHASE OF THE PROCESS
Evaluation of the whole Service Stream - positive public commission process	Evaluation (5)	The Mental Health Commission considers incorporating greater lived experience, family and carer input into evaluation processes through the existing National MH Accreditation Process, adoption of the Patient Opinion website or mystery shopper type initiatives. + reviews	Incorporates & Authentically Values the VOICES in this space.  Transparency
Rural and Regional	Rural and Regional (5)	Acknowledgement that all of these comments apply to a factor of two in remote, rural and regional areas	at least (ATSI Suicide rates) are times 4
Peer-led approaches	Peer-led (6)	Acknowledgement that peer-led groups & organisations may be disadvantaged in tender processes. Building the and capacity of peer-led organisations may need targeted procurement routes like the ILC NPFA DPFQ grant	Aboriginal (5) YOUTH (5) OATD (5) LGBTIQ+ (5) People with disabilities (5) Pregnant Women (5) GADL