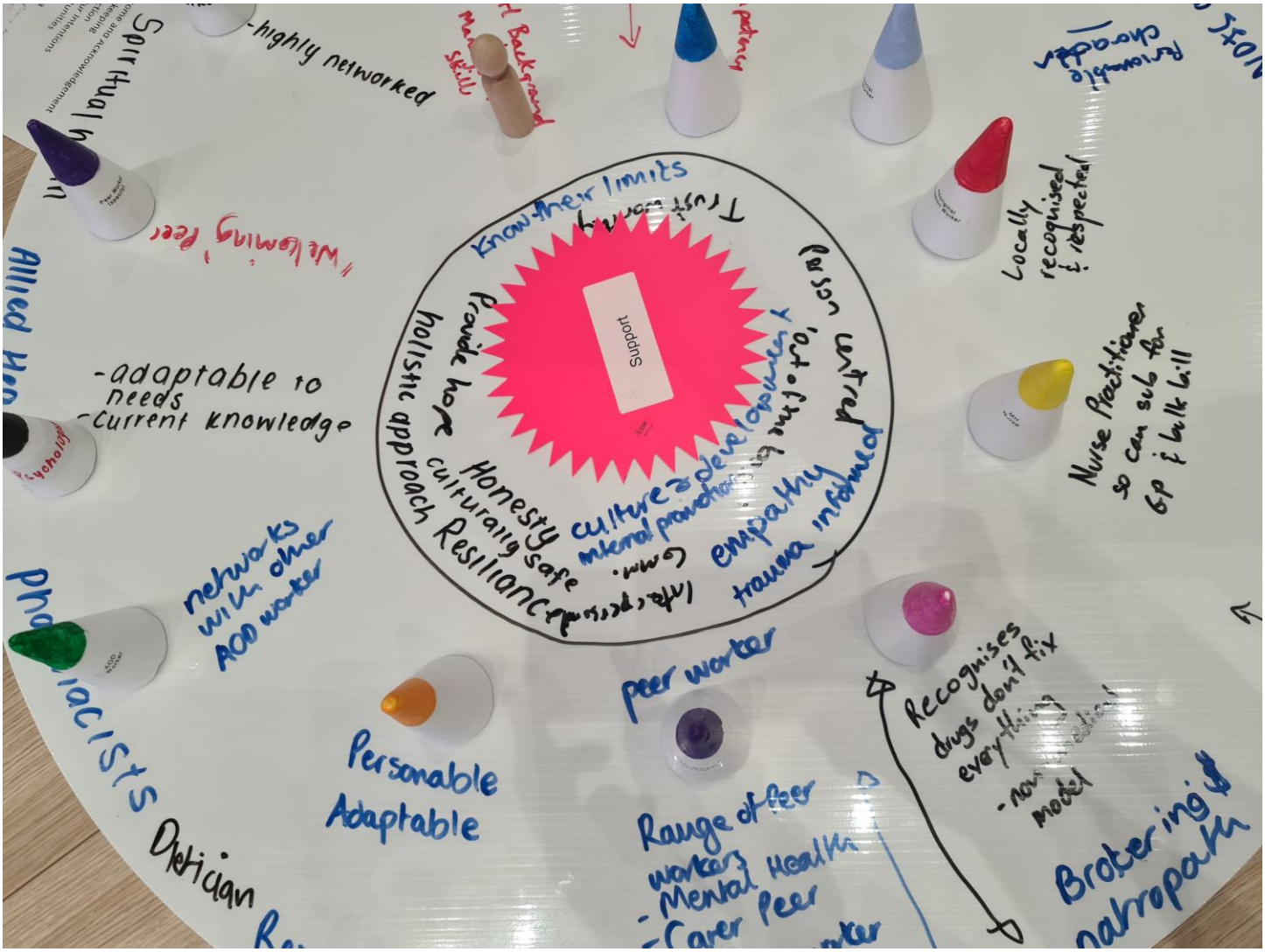

Adult Mental Health Centre - Midland

Primary Phase of Co-design Final Report

Acknowledgement of Traditional Custodians:

We acknowledge the Whadjuk Noongar people as the traditional custodians of this land and pay our respects to Elders past and present.

We also wish to relay our deepest gratitude to the Aboriginal people who have supported these workshops and to those who attended.

Gratitude:

We would like to extend our gratitude to all of the people who attended these workshops in personal and/or professional capacity, your participation and knowledge is humbling, thank you.

We would also like to thank Denese Griffin and Robert Morrison from the East Metropolitan Health Service for their support in developing and facilitating workshop 4.

Disclaimer:

This report represents a summary of the information recorded during the Primary Phase of Co-design. This information is not the information of the co-design team. The information is provided to WA Primary Health Alliance (WAPHA) and St John of God Social Outreach, to support their process of co-designing the Adult Mental Health Centre, Midland.

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Executive Summary

As part of the 2019/20 Department of Health budget, the Australian Government announced the allocation of $114.5 million to trial eight adult community mental health centres, allowing one centre to be funded in each state or territory.

The centres are intended to:

- Ensure that people are provided appropriate immediate support and are connected to pathways of less urgent longer-term care by integrating with other local community services.
- Assist people to access related health and social services.
- Reduce the number of emergency department presentations by providing a more accessible entry point to the mental health system.

The service model was established through a Technical Advisory Group. This was made up of, clinicians, service providers, and people of lived experience. The model was also open to a process of national public consultation, with the final version endorsed by the Department of Health in September 2020.

WAPHA and St John of God Health Care

WA Primary Health Alliance (WAPHA) was appointed by the Department of Health (Commonwealth), to oversee the establishment of the Adult Mental Health Centre (AMHC) in Western Australia. The Perth North Health Network was chosen by the Department of Health as the location to trial the service, and following advice provided by WAPHA, the Midland region was accepted as the area for the trial site.[1]

In March 2021, WAPHA appointed St John of God Health Care (SJGHC) to lead the co-design of the AMHC.

Primary Phase of Co-design

This co-design process is led by WAPHA and SJGHC and facilitated by wellrounded. The co-design process will be an ongoing and iterative one, however this primary phase was conducted through four workshops. These co-design workshops will support WAPHA and SJGHC find balance between the Australian Governments established Clinical Services Plan and the local context of the Midland region.

The four workshops in the primary phase of engagement were:

1. Service Providers and Health Advocates
2. Consumers, Carers, and Family
3. Consolidation of Groups 1 and 2 (this looked at the findings of previous workshops and the potential for ongoing stakeholder advisory groups)
4. Listening to Elders and the Aboriginal Community (it is agreed, listening to the knowledge of the Elders and the Aboriginal community will be an ongoing process, informing the cultural strength of the service throughout the trial. This cannot be captured in one workshop.)

[1] WA Primary Health Alliance and St John of God Healthcare New Adult Mental Health Centre for Midland 19 March 2021at: https://phexchange.wapha.org.au/amhc

This summary report consolidates all information from the Primary Phase of Co-design. There are further reports detailing each of the four workshops. All reports will be made available on the WAPHA website.

Primary Phase of Co-design - By the Numbers

In total, 183 people participated across three venues, 168 directly engaged in co-design. This number includes facilitators, supports, and members of the St John of God and WAPHA Teams.

Workshop	Number of Attendees
1	49 (43 directly engaged in the conversation*)
2	54 (50 directly engaged in the conversation*)
3	54 (49 directly engaged in the conversation*)
4	26 (All directly engaged in the conversation*)

*Some participants were intentional roles as tables mentors/listeners to support participants, all were encouraged to participate as community members or service providers in their own right.

Overview of Workshop 1: Service Providers and Health Advocates

This workshop took place at the Stan and Jean Perron Child Advocacy Centre in Midland. A location close to the town centre and the St John of God Public Hospital.

Primary Focus

The primary focus of this workshop was to bring together stakeholders from interested service providers and health advocates, including lived experience advocates, and gain a collective sense of their views on how the service would best work for Midland, opportunities to address potential challenges, and their commitment to an ongoing process, including their involvement in the success of the service into the future.

Interested participants, committed to further co-design and opportunities for co-production, were invited to register their interest in participating in Workshop 3. This workshop will zoom in on the service model for Midland, as well as opportunities for stakeholder involvement during the trial.

Agenda

A brief introduction was provided by St John of God Social Outreach CEO, Susan Cantwell. The agenda for the day used four key design questions to achieve the desired outcome. The questions were themed under the headings, Opportunities, Access, Multi-disciplinary Approach, and Collaboration.

The design questions to facilitate the co-sensing of opportunities, were:

- Q1: What are the opportunities for the people of Midland?
- Q2: What are the main barriers for people? (Digging deeper: How might we address these barriers?)
- Q3: Who do we need to hold the space? (Digging deeper: Who are the people/team? Who might co-locate or in-reach and add value?)
- Q4: How might we partner or collaborate to support continuity of care?

Theme 1: Opportunities

- Key question: What are the opportunities for the people of Midland?

Summary of Key Insights: Opportunities

All tables discussed, as a priority, the need for the AMHC to be **culturally appropriate and respectful,** there was also a general insight relating to, ensuring staff provided a service to the customer/client **without them having to prove eligibility or worthiness** to receive services. It was also clear, participants rejected the use of 'Adult Mental Health' in the title, preferring '**Wellbeing**' or a local name.

Sensory Segment	Insight	Supporting Information/Further Questions Generated

Looks Like 'Welcome'	• Adding Value: Ensure resources are adequate to relieve existing services, not add-to existing pressures.
	• Inclusive Data Collection: Find ways to include people in data collection, instead of excluding due to literary or other challenges, e.g., verbal, pictures, creative methods, etc.
	• Welcome: Good behaviour re-enforcement, no rejection posters (i.e., no 'violence will not be tolerated'), no barred windows, rainbow flags & welcome posters, Aboriginal and Torres Strait flags & welcome posters/art.
	• Inclusive of Supports: Kids, family, pets, friends, carers, etc.
	• Inclusive spaces: Different waiting spaces, no desks, soft chairs, open spaces, outdoor areas, multi-purpose zones, car parking, plants, colour schemes etc.
	• Staff profiles: Promoting a human connection beyond roles, also, have staff from the local area.
	• Power balance: Working physically alongside, i.e., not behind a desk.
		• Inclusive of supports –
		  ○ People unlikely to be able to attend without their children.
		  ○ pets was a popular answer, unlikely to be accommodated in this space.
		• Immediate needs – a lot of discussions talked about to meet the immediate before treatment response (e.g., safety, food, shower, clothing, etc).
		• Hospital Look: Participants suggested avoiding the hospital look, in terms of waiting in rows of plastic seats, smell of the wait room, lighting, news on the television, negative messaging on posters, etc.
		• Security: If security is required, it was suggested they be non-uniformed and blended in. Also, alternate entrances/exits for rapid exit in cases of FDV.

Sounds Like 'Listening'	• Calm: No TV news, gentle voices, calming sounds of nature, compassionate tones, open sensitive/respectful questions, quiet spaces, listening. • Welcome: 'How can I help?' instead of assessing eligibility, knowing people by names not roles, 'thanks for coming, happy to see you'. No handballing as in people receive supports now, not when it is convenient or easier. • Validating and curious: Customer is expert by experience and in their experience,	• Name: Using language other than 'Adult Mental Health.' • Dadirri: The qualities of Dadirri were mentioned, a sense of deep listening, i.e., 'listening with me', understanding the impact of trauma, not waiting to solve the problem or insert knowledge. • Listening genuinely: A participant described years of pain trying to find support for a child, being handballed between health and mental health.

	honouring their feelings, accepting their reality, hearing what they are saying. • Voice and Choice: Recovery oriented practices listening to the person and building them up through offering choices. • Language: Non-clinical language, no acronyms, recovery-oriented and strengths based, human, conversation rather than assessment.	• Assessment: This is contentious, assessment seemed to be seen as a way of keeping people out or gatekeeping rather than welcoming in. • Feedback: Clear and safe methods to provide compliments, complaints, and suggestions in an inclusive way.
Feels Like 'Silk'	• Safety and respect: People should feel safe, physically, emotionally, mentally, and culturally, and have their experiences respected, their journey to the centre acknowledged. • Waitlisting: Service connection in real time, as the need or opportunity arises. • Co-morbid means co-morbid: Some participants felt AOD would creep in as an informal exclusion factor. • Foundation: AMHC supports people through setting the foundation for a longer-term journey. • Open door: It should feel like there are no doors closing, and feel like a cultural shift from hospital-based service provision. • Peers: Connecting with people while they wait, rather than waiting to be seen. A concierge type approach was also mentioned.	• My Place: This phrase 'My Place' was mentioned a number of times, as in, it should feel almost like it is the customers place. • Trauma informed practice, Recovery-oriented practice, and Culturally aware practice, were all mentioned as non-negotiable, not just trained but lived. • Missing Middle: A place for the 'Missing Middle'[2] was mentioned.

Common Threads:

1. Non-hospital/Clinical Environment

People do not want the AMHC to look like, sound like, feel like, or smell like a hospital environment.

2. Customer Service Approach - Welcome vs Assessing Eligibility

Welcoming people to the service and being curious about how they can be supported instead of whether they are eligibility.

3. Wait Lists and Wait Times

Avoid unnecessary waitlists, or at the very least set realistic expectations from the start, e.g., offer support with immediate needs, support access to other services. Also, respect peoples' time, do not have people waiting when they have arrived on time for an appointment.

[2] https://www.livedexperienceaustralia.com.au/missingmiddlemedia

Innovative Threads:

1. Inclusive methods of data collection

It may be worth exploring the Department of Communities 'No Wrong Door Approach Co-design'[3] and discussions relating to data transfer.

- This seems to be an opportunity to potentially use new technology or be creative in how to capture the data of participants.
- It could lead to an innovative way of preventing the re-telling of challenging stories and challenges for the customer, as well as a 'warm' continuity of care pathway from one service to the next.

2. Connecting with people while they wait, rather than waiting to be seen/processed/triaged, etc.

There is plenty of information supporting the idea of peer support in clinical settings, for instance, Mental Health America Peer Support: Research and Reports[4], often the focus of this support starts upon admission to service or 'in service'. The idea of supporting people while they wait, means that navigation of supports, even via telehealth methods, starts when people come through the door or connect for the first time. It is a simple innovation with potential to address many of the barriers outlined in Theme 2, and prevent challenging behaviours.

[3] https://www.communities.wa.gov.au/strategies/homelessness-strategy/no-wrong-door-approach-co-design/
[4] https://www.mhanational.org/peer-support-research-and-reports

Theme 2: Access

- Key question: What are the main barriers for people? (Digging deeper: How might we address these barriers?)

Summary of Key Insights: Access

The barriers to access for most have a lot of commonality, however some cohorts experience different levels of disadvantage and vulnerability when trying to access services.

Cohort	Barrier	Strategies to Respond
People with Mental Health Challenge	• People may not be aware of the service and what it has to offer. • People may be afraid due to previous rejections, or abuses experienced at MH services or Emergency Department. • Word of mouth creates concerns about accessing the service. • Concerns for people in employment about being seen accessing the service.	• Positive promotion of the service through community and lived experience channels. • Potential to support access through an online support group or Recovery College. • Peers with lived experience. • Recovery oriented practice embedded. • Spaces for people to feel safe and be safe. • Co-location at a library or community space, somewhere that does not look like a MH service.
People with AOD Challenge	• Support for AOD challenges in a MH setting usually leads to judgement and rejection.	• Specialist AOD supports/advocates at the AMHC. • Welcome people. • Acceptance, focus on the behaviour not the substance use, look for the unmet need. • Low barrier service provision. • Harm reduction focus, provide brief intervention respectfully.
People experiencing Homelessness	• Level of immediate need exceeds ability to access MH support.	• Lockers or storage area to store personal belongings during support. • Meet immediate needs for food, shower, clean clothes, sleep, etc. • Offer spaces that allow someone to sit in privacy and with dignity.
People experiencing FDV	• Will they be able to access the service safely and confidentially and at a time that suits their needs, i.e., during school hours. • Victims of FDV may have felt judged or shamed by clinical services in the past. • Victims of FDV may experience further powerlessness when accessing clinical services.	• FDV informed responses universal to all members of staff to avoid missed opportunities for safety and prevent victim shaming. • Different entrances to building. • Potential for specific safe access times. • Understanding of the Common Risk Assessment and Risk Management Framework.[5]

[5] https://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Documents/2015/CRARMFFinalPDFAug2015.pdf

		• Choice and control needs to be in the hands of the victim. • Links to FDV corridor services.
Aboriginal and Torres Strait Islander people	• Building on a meaningful site for the community. • Clinical space and philosophy that does not include a definition of mental health that is meaningful to the Aboriginal community. • Clinical staff can be dismissive and judgemental of presenting behaviour, and fail to connect to the underlying need.	• Use of local language blended with service language. • Culturally safe and family inclusive practices. • Ensure the site is approved by the local Elders. • Options or Aboriginal and non-Aboriginal supports. • Ensure is not just providing services through a clinical lens, look to the provide services consistent with Aboriginal ways of social and emotional wellbeing. • Visual displays acknowledging the challenges experienced by Aboriginal people, e.g., Uluru Statement promoted, etc. • Ensure self-determination is central to approach.
Culturally and Linguistically Diverse people	• The concept of Mental Health may be unclear or carry shame in the individuals culture.	• Including free Translation and Interpreting Services. • Include CaLD specific service support. • Accepting of diverse needs.
LGBTQIA+ people	• Values, attitudes, and beliefs of staff and customers outdated and stigmatising. • Faith based lead agency, i.e., St John of God. • Toilets, paperwork, language reject diversity, e.g., binary responses. • Rejected from the start due to poor response from reception.	• Inclusive messaging and communications. • Inclusive signage, flags, toilet spaces. • LGBTQIA+ informed staff or peers with lived experience. • Seek advice from LGBTQIA+ services. • Use of gender-neutral language and all staff complete LGBTQIA+ training. • Rainbow tick accreditation. • Acknowledge expertise by experience, but also be prepared and aware of best practice.
People with Disabilities	• The building design can reject people before they see anyone. • NDIS is beginning to grow its provision of mental health support, but it is still a process requiring someone to meet eligibility requirements. • Often people with Disabilities can be overlooked for mental health supports, due to failure of service providers to make the effort to communicate effectively.	• Ensure universal design process is right from the start. • Specific windows for access for people with sensory challenges, e.g., exposure to music.

	• Complicated streams of funding make it unclear for people accessing the NDIS to know what services they can or cannot access in the health system.	
Senior Citizen/Older people	• Older Australians report being told 'At your age….' From GP's, labelling them with unchangeable conditions, not consistent with Recovery-oriented service delivery. • Mental health for a long time has carried stigma for Older generations. Some of these barriers have been broken down recently, but promoting mental health support to Older people, especially men, is still a challenge.	• Staff with knowledge of supporting Older Australians with MH challenges, as well as knowledge of navigating challenges faced by Older people, e.g., homelessness, access to Aged Care, income, etc.
Other (People leaving prison)	• Many people coming from a prison stay have been impacted heavily by the trauma of that experience, but often do not know where to go, they are at high-risk of suicide or other negative outcomes, e.g., AOD overdose.	• Create awareness and connections to the local prisons in the area and the services supporting people to transition to the community. • Families and Carers supported and validated by the team.

Common Threads:

1. Stigma

Using positive communication strategies to promote the service and the opportunities it provides to the whole community. Looking at each cohort and learning with them on how to reduce stigma prior to access, during access, and after they have accessed the service, i.e., people often do not return due to ruminations on shame. By working with people to prepare for these feelings this may reduce the failure to return.

2. Safety/Fear

As with stigma, people need to feel culturally, emotionally, physically, and mentally safe before, during, and after they access this service. Ensure rights of individuals are maintained, in terms of confidentiality and privacy, and any fear of conflict of interest with family members is addressed.

3. Access

Locating the service close to public transport, offering opportunities for people to access via brokerage for Smart Riders from Transperth, or parking vouchers via the City of Swan.

4. Language

Creating a style guide for language within the service to be accessible and non-medical. Removing jargon and acronyms from use, and getting creative about new ways to communicate to diverse groups.

5. Training:

Core training for staff and service providers in Recovery Oriented Practice, Trauma Informed Practice, Cultural Awareness, LGBTQIA+ Training, and Supporting Co-occurring Challenges.

Innovative Threads:

1. Naming

There was an underlying discussion about how the name of the centre could present as a significant barrier, there was a feeling that including 'Adult' or 'Mental Health' in the title would not work for a large amount of the target cohort.

2. Elders in the service

Referred to as 'Elders in residence', perhaps that is not appropriate, but there may be an opportunity to include Elders in how services are delivered to all people, for example, monthly morning tea or yarning circle.

3. Hello Cass[6]

The Hello Cass service is a chatbot that supports people experiencing family domestic violence to have access to information and support that is localised. Perhaps, this model of service could be an opportunity to promote access to the AMHC, where people hesitant about access can message a chatbot and receive support and encouragement to attend.

[6] https://hellocass.com.au/

Theme 3: Multi-disciplinary Team

- Key question: Who do we need to hold the space? (Digging deeper: Who are the people/team? Who might co-locate or in-reach and add value?)

Summary of Key Insights: Multi-disciplinary Team

This table relates to the team directly employed at the AMHC. Cultural knowledge and safety was seen as a key for all of the roles, as well as universal commitment to the values of the AMHC.

A number of tables had a commitment to values as well as statements on staff roles, e.g. All workers need to be, open-hearted to work here, collaborative, friendly, share the load, etc.

In general, it seems discussions were less concerned about roles specifically, but the approach of the whole team and all services at the AMHC.

Role	Insight	Supporting Information/Further Questions Generated
Manager	• Small 'P' and 'C': Not just profession and not just clinical. • High social/emotional intelligence. • Cultural responsiveness. • Commitment to values/lead by example. • Enable effective community partnerships. • Recovery oriented and trauma informed.	• Aboriginal person as Manager: The idea was flagged that having a person from the Aboriginal community is a demonstration of change in this space. • Lived Experience Manager: Similar to above, acknowledging lived experience as a strength in the recruitment of a manager demonstrates change. • Collaborative Leadership: The ability to manage and empower all stakeholders was valued across participants.
Psychologist	• Coming in on a 'as-needed' basis. • Recognizes 'drugs don't fix everything' and engages with non-medical supports.	• 'Social Psychiatrist' with availability to support 'all', e.g., co-occurring needs. • Demonstrated recovery oriented and trauma informed knowledge, and ability to work 'with' lived experience.
Mental Health Support Worker	• Non-judgemental, wants to be there, a people person.	
Peer Worker	• Acknowledged that there are many types of Peer, an individual peer cannot provide meaningful peer support to everyone, but can apply a peer approach. • A team is much stronger than an individual approach. • Promotes empathy within a multi-disciplinary team.	• One definition of peer work relates to the idea, that in order to be a peer worker, the customer or client must see you as their peer. • Lived experience 'alone' is not enough, it needs to be provided within a supportive and respectful framework.

Aboriginal Support Worker	• Seemingly no specific mention of this role.	• There was no specific reference to this role, it was acknowledged that a culture was central to the success of the AMHC in Midland. • An Aboriginal Manager would demonstrate change.
Social Worker	• Reference to Applied Social Work in Case Management	
AOD Worker	• Provides opportunity to connect with AOD specific services. •	• AOD is the poor cousin of mental health often leading to rejection.
General Practitioner	• Having a Nurse Practitioner was seen as an opportunity to provide links to GP's.	
Other – Care Coordinator	• Other models of care have worked well when using a 'Care Coordination' role, someone with the knowledge and ability to navigate complex services and systems with the customer. • Ability and knowledge to understand the needs of the person and what it takes to navigate services.	
Other – Prison or Corrections Informed Support	• This could be an existing service in-reaching when needed, or ensuring someone in the team was nominated, resourced and skilled to manage people coming out of prison with a welcoming and respectful approach.	• Anecdotally, it would seem Midland is a drop off point for many people leaving Acacia and Wooroloo prisons, and many present directly to ED for support.

Summary of Key Insights: Co-located or In-reached Services.

This relates to partner or sub-contracted services in-reaching to provide supports from other agencies.

Service	Insight	Supporting Information/Further Questions Generated
Psychologist	• As with GP services, it was suggested that due to cost and need, this could be something that was in-reached.	• This is not a surprise, even predictable response from a largely non-clinical group of service providers and health advocates.
AOD Worker	• Wungening was mentioned as a potentially culturally appropriate AOD service provider.	• AOD supports can provide access to ongoing counselling and connection to detoxification and rehabilitation services. • Having AOD services providers supports the breaking down of barriers faced by people with AOD challenges accessing 'apparent' co-morbid enabled services. • Connecting with the new Midland Intervention Centre run by Cyrennian House.
General Practitioner	• As with a Psychologist, it was suggested that due to cost and need, this could be something that was in-reached.	• We heard at the workshop that GP's in Midland are challenged, potentially overwhelmed by the needs of the area, anecdotally, we heard GP's sometimes transport their patients to mental health supports directly.
Other - Aboriginal Community	• Elders involved in the service as Carers, advisors, and Spiritual Carers. • Derbarl Yerrigan was mentioned as a potential in-reached support.	
CaLD Services	• ISHAR were mentioned as a potential partner to the AMHC.	
Other – Co-response	• Collaborative response from Police liaison, job service providers, NDIS providers, alcohol and other drug supports, and psycho-social supports.	
Interpreter, Translation, AUSLAN and Cultural Services	• Services that can support communication and respect, especially in terms of Aboriginal and Torres Strait Islander people and Culturally and Linguistically Diverse people.	• We heard insights on providing choice in the translator and interpreter services received, as a generic response may overlook a conflict of interest.
National Disability Insurance Scheme Providers	• Many of the people presenting will have little awareness or understanding of the NDIS system, though the AMHC is not too duplicate NDIS service provision, it should provide 'no wrong door' access to providers.	• It is not clear whether this was seen as a particular provider or an NDIS informed response through care coordination.
Sexual Health	• Supporting a harm minimisation approach. • Supporting family planning.	

Other – Prison or Corrections Informed Support	• This could be an existing service in-reaching when needed, or ensuring someone in the team was nominated, resourced and skilled to manage people coming out of prison with a welcoming and respectful approach.	• Anecdotally, it would seem Midland is a drop off point for many people leaving Acacia and Wooroloo prisons, and many present directly to ED for support.
Other – Creche	• It was mentioned that partnering with a creche or other services to support people attending to manage/juggle responsibilities caring for children may be beneficial and respectful.	
Other – On a needs basis	• Alternatives to Suicide Program, Carers WA, Alternative therapies, Art therapies – specialised not general, occupational therapists, play therapy, yoga, mindfulness, yarning.	

Common Threads:

1. Manager:

The manager was seen as a values driven position, not necessarily clinical, with knowledge of the recovery, trauma, diversity, and inclusive practices, as well as a commitment to genuine partnership with staff and customers.

2. Diversity of Peers:

There was an understanding of the diversity of peer roles and what genuine commitment to peer support can bring to this space.

3. Strength in Culture:

It was acknowledged at almost every table that culture needed to be at the centre or heart of everything at the AMHC. Not just in tokenistic employment, but in the holistic application of the model. There was some discussion on the significance of Midland to the Noongar community.

4. Clinical Roles – Psychology and General Practice

There was a general sense that these roles were not embedded but ones that were brought in on a needs basis.

5. Foundational Practice

All staff to have a foundation in values drive practice, recovery-oriented practice, trauma informed practice, cultural awareness, and LGBTQIA+ practice.

Innovative Threads:

1. LGBTQIA+:

It is important to highlight the apparent lack of participation in this workshop from leading services and advocates from the LGBTIQIA+ community. There may be a better way of reaching this group, e.g., through an online meet-up.

2. Care Coordination

This role seems like something that could cover a multitude of functions, someone who knows how to navigate the system, and bring in the 'right people at the right time'.

Theme 4: Collaboration

- Key question: How might we partner or collaborate to support continuity of care?

Summary of Key Insights: Collaboration

Generally, all pathways should have a recovery orientation. The abiding question is how we might create a **simple referral** process for people that is seamless and easy, and **genuinely feels like continuity for the care** received at AMHC.

Mechanisms such as a **single shared care plan** and **data sharing** need to be explored in terms of the **risk or benefit** to both the service provider and the customer.

Pathway	What Needs to Happen	Actions to Make it Happen
Community Mental Health Services	• Genuine embedded co-production approach. • Increased sharing of information. • Informed consent. • Detailed and clear understanding of what the AMHC does and does not do. • 'Warm' referral pathways. • Awareness of mental health services available. • Understanding of rights and responsibilities to Consumers and Carers. • Be aware of barriers and solutions identified in Theme 2.	• Formal Memorandums of Understanding or Service Level Agreements with clear accountability processes. • Specific designated liaison or point of contact. • Case management and follow ups. • Arrange advocates or supports to attend with person. • Provide a call to support and encourage person to attend.
Homelessness	• Awareness of the AMHC and eligibility conditions. • Opportunities to access accommodation, understand pathways, e.g., Entrypoint, etc. • Build strong network with service providers. • Opportunities to meet immediate needs, e.g., food, shower, clothing, Centrelink, etc. • Access to Street Doctor and/Mobile GP. • Connections to existing outreached MH and AOD services. • Empathy and understanding for difficulties in meeting set appointment times.	• Create awareness amongst new funded Housing First Homeless Initiative services and other homeless services, e.g., 50 Lives 50 Homes. • Value feedback loops to find out what works and what does not.
Disability Services	• Focus on strengths-based communication, informed by lived experience expertise, e.g. People with Disabilities WA. • Create awareness amongst service providers. • Assess needs relating to disability. • Identify what services are supporting people and what is available to support.	• Have service information available at the AMHC. • Formal Memorandums of Understanding or Service Level Agreements with clear accountability processes. • Support access to NDIS, as applicable, advocate with the person to ensure need is met. • Connections to Disability Advocates. • Identify a Disability Service lead to have competency in this area.

Cultural Services	• Promote via trusted cultural networks. • Understand who lives in the community via demographic mapping. • Have clearly communicated terms of engagement and be accountable to them. • Culturally safe recruitment processes. • Clear understanding of culturally safe services available to support. • Treat the whole person in the context of their social and emotional wellbeing needs, and in the context of family, land, culture, etc. • Open ended appointment times, with a non-punitive approach to non-attendance. • Community leaders and Elders invited to co-design workshops and meetings, with ongoing engagement in service delivery.	• Mapping and gapping exercise to see services that can support in this area. • Build a culture of inclusion. • Stakeholder engagement. • Listening to the customer, taking time to get to know them. • Flexibility in approach to appointment times. • Invite and meet with Elders and community leaders over lunch. • Provide access to free translation and interpreter services.
AOD	• Competency to support dual needs of MH and AOD. • Clear and simple referral pathway into AMHC. • Informed consent. • Customer or client led service response, i.e., what the customer wants.	• Follow up after engagement. • Support attendance at referred to services. • Maintain 'open-service' file until person is seen. • Single shared care plan.
LGBTQIA+	• There was no clear responses here, mainly generic, this highlights a gap in the co-design process. There was no specific services in attendance, this may need following up.	
Health/Medical Services	• Effective sharing of information. • Build strong relationships. • Awareness of bulk-billing service options and access to walk in service. • Actively reduce waiting times.	• Proper inter-agency meetings to support handover of customer. • Follow up with person.
Welfare Services	• Relationship with providers within the community. • Centrelink in-reached. • Access to ID Clinics to support people to be document ready.	• On site or in-reached services with a regular and predictable timetable.
Others - Carers	• Be prepared to support Carers who have lived and living experience of service rejection when they 'have nowhere else to go' for support. • Validation of their experience.	• Draw on the expertise and strength of Carers WA to build an appropriate response.
Other Prison/Corrective Services	• A need to liaise with Transitional Managers at prisons, especially Acacia and Wooroloo to ensure they were aware of the AMHC as a potential point of support for people leaving prison and their supports.	

Common Threads:

1. Formal Agreements

As expected, most people talked to the need to have formalized agreements, including; Service Level Agreements and Memorandums of Understanding. Accountability was a key theme in these discussions.

2. Co-occurring Challenges

There was a lot of compassion for the experience of people who are active in the AOD use but need holistic support, especially with their mental health. It would appear a culture of acceptance is needed in order to connect and sustain treatment with this cohort.

3. Specialist Knowledge

For all target groups, there was a sense that there needs to be specialist knowledge within the team or a specialist response, prioritising a need for genuine empathy and understanding of diverse experiences, e.g., mental health, prison release, AOD, LGBTQIA+, older adult mental health, etc.

Innovative Threads:

1. Co-production – Shared Care with Integrity

The opportunity to embed principles of co-production in how the AMHC is delivered was raised by a representative of Mental Health Matters 2, and other health advocate participants. It seems this method would support the idea of a 'Shared Care' arrangement with real integrity from the start.

The co-production principles[7] discussed were:

- Recognising people as assets.
- Building on people's capabilities.
- Developing two-way reciprocal relationships.
- Encouraging peer support networks.
- Blurring boundaries between delivering and receiving services.
- Facilitating not delivering to.

[7] https://www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/co-production/In-more-detail/what-is-co-production/

Overview of Workshop 2: Consumers, Carers, and Family

This workshop took place at the Ascension Hall, 17 Spring Park Road Midland WA 6056. While predominantly attended by Consumers, Carers, and Family, some service providers attended as supports on the day.

Primary Focus

The primary focus of this workshop was to learn from the 'expertise by experience' of all of the participants in the room, many of whom will be customers, or support customers, of the new service. This workshop was attended by a diverse array of people with invaluable knowledge of what is needed.

All participants of Workshop 2 will be invited to continue the co-design journey by attending Workshop 3, taking place on the 13th of May 2021. This workshop will zoom in on the service model for Midland, as well as opportunities for stakeholder involvement during the trial.

Agenda

Once again, a brief introduction was provided by St John of God Social Outreach CEO, Susan Cantwell. The agenda focussed on the real knowledge of customer journeys within the room through three core themes, Why, Welcome, and Kind Referrals, with three key design questions. The design questions for this workshop were:

- Q1: Why does this service matter to Midland?
- Q2: Two Parts
    - Part 1: How will people know they are welcome, and it is safe to access?
    - Part 2: What are three strategies the team could apply to make these people feel and be welcome?
- Q3: What is a kind approach to connect people to future supports? (Digging deeper: How could referrals be as kind and stress free as possible?)

Theme 1: Why

- Key question: Why does the service matter to Midland?

Summary of Key Insights: Why

This was clearly a group made up largely of Midland people, who have an acute sense of what their people need in this space, as well as their own lived and living experience of not having access to the right people at the right time.

Sensory Segment	Insight	Supporting Information/Further Questions Generated
Looks Like	• Non-clinical – soft furnishings, warm, not a hospital feel, no white coats, calm happy feel, kind faces. • Cultural Curiosity – Ask the Aboriginal community what they want it to look like in this area. • Inclusive to all people. • Sensory Responses – Sensory room, weighted blankets, soft stress release balls, soft music, aroma's, and lighting. • No Barriers – Screens, desks, etc. • Name – The name to be something welcoming, not Adult Mental Health Centre.	• Collaboration between clinical and non-clinical. • 'No perfect people allowed.' • Creche • 'Peer first, peer last.' • See myself in the service, i.e., see people that look like me. • Good parking facilities. • No standing in line. • Designing the environment to connect with nature. • Choice in who cares/supports you.
Sounds Like	• Positive – Affirmative and validating, consistent with trauma informed and strengths-based approaches. • Opportunity – to have your needs met, and to be heard. • Language – Avoiding the use of labels, knowing people by names	• 'What has happened, not what's wrong…' • Quiet, calm, soft noise. • Hopeful tones. • Choices offered.
Feels Like	• Cottage-like/Homely – Warm, familiar, comfortable, low key, respectful, safe, gentle, happy, etc. • Everyone is welcome and referrals are warm and comfortable. • Comfortable – Safe, non-threatening, no violence, soothing and friendly. • Power – No power imbalance, shared community, acknowledging the struggle and the strategies people have developed. • Access and Inclusion – Multiple ways to access information.	• 'You've come to the right place; how can I help?' • 'Not waiting for ages' – good referrals to service providers and medical providers. • 'I am visible.' • 'Not a number.'

Common Threads:

1. Non-hospital/Clinical Environment

Many references were made to a 'cottage' or 'homely' feel, without any feel of a hospital, smell seemed very important, smiling, and welcoming faces too.

2. Listening

There seemed to be a palpable feeling from some in relation to the need to be listened to, and feel listened to, especially in the case where it is supporting a vulnerable loved one. A service like this, needs to sense where people are at, and work with them to take the next step forward. There were a number of people who shared the sense of desperation when supporting a loved one close to suicide. This skill goes beyond listening, it feels like receiving.

3. Welcome

This group of people were acutely aware of what it feels like in an unsafe environment, such as that experienced in an emergency department setting, or mental health ward. Many people expressed the need to feel real balance of power in the service, for someone to feel like they could go there, take time to settle in, and work with the team to find what they need. Simple things were important, like a cup of tea being offered, engaging resources while you wait (not just old magazines). An authentic peer approach seems vital here.

Innovative Threads:

1. Good Technology

Be innovative about the use of smart technology to support the idea of only having to tell your story once. Look at new health apps, trial something different. The use of telehealth and 'e-health' methods also seemed popular.

Theme 2: Welcome

- Key question: This question had two parts -
    - Part 1: How will people know they are welcome, and it is safe to access?
    - Part 2: What are three strategies the team could apply to make these people feel and be welcome?

Summary of Key Insights: Welcome

A universal principal highlighted was being grateful for someone coming to the service and thanking them for coming. It was also common for the discussion to suggest most of the strategies applied to everyone, not just a specific cohort.

Cohort	Part 1 – Insights on how people will know it is safe to access	Part 2 – Insights on strategies to respond
People with Mental Health Challenge	• Peer support available. • Recovery stories visible on walls. • Space to chill out.	• Intentional Peer Work – Ensure people are aware of lived experience workforce, recruit people with professional base in peer work, i.e., lived experience alone is not enough. • No Labels – People are not their diagnosis, treat people with humanity. • Felt Experience – No blame no shame. • Acceptance of Carers and their journey.
People with AOD Challenge	• Information available on the service. • Staff Profiles – seeing there is a designated support for AOD. • Access to peer services, or stigma busting services, e.g., Peer Harm Reduction WA.	• Knowledge – real knowledge of supporting AOD and co-occurring challenges, lived experience if possible. • Navigation – understand choices of services available, explore do not push. • Customer Focus – See the person not the behaviour. • Follow Up – Check-in post appointment, draw them back.
People experiencing Homelessness	• Word of mouth • Ability to engage people in the streets so they feel comfortable to come. • Space to store belongings. • Ability to bring pets.	• Offer – Tea/coffee/water, practical supports, e.g., food, clothing, etc. • Equal – Sit next to them not in front of, or standing over, trauma informed body language.
People experiencing FDV	• Supported referral (coming through trust of others) • Physical layout. • Creche/Childcare options.	• Re-assure – Through opportunities for privacy, anonymity, and safety (multiple exits, or exclusive appointments). • Continuity of care. • Assistance for the whole family.

Aboriginal and Torres Strait Islander people	• Word of mouth, community trust in supports available. • Yarning Space (Open to all). • Elders present in the service. • Display of local Aboriginal art, investment in the local community.	• Access – through interpreter. • Lived Experience – offer access to Aboriginal or non-Aboriginal supports. • Culturally responsive training • Culturally Informed – See the person in context of their family, culture, community, etc. • Awareness of Shame – Use of open-ended appointments, no shame or power-over, self-determination at the centre of practice, decolonise the approach, etc.
Culturally and Linguistically Diverse people	• Culturally informed and curious.	• Access – through interpreter, information in variety of languages or access via 'e' resources.
LGBTQIA+ people	• Overt displays of welcome, e.g., flags, posters, paperwork, website, etc. • Support through offering your pronouns, e.g., ID badges. • Diverse staffing group.	
People with Disabilities	• Pro-active support ahead of visits, reaching out to support access, e.g., pre-appointment phone-call to the person not their support. • Transport options are available. • People with disabilities are employed.	• Access through universal design, get it right from the start, including parking. • Do not look at the NDIS as a way of excluding me. • Sensory responses, e.g., sensory room, low or no music times.
Senior Citizen/Older people	• Groups and activities to invite people in. • Ensuring they know the service is for them, e.g., through mailouts.	• Awareness – Many people seek support from peers in relation to grief and loss, of partners, children, family, friends, connections, etc.
Other/General Points	• Be curious - Ask people what they need to be safe, ask them about their strategies, offer to support these. • Group Options – People may adjust and build confidence to explore 1:1 options, e.g., Recovery College, Seniors Group, etc. • Service is Recovery-oriented or at the very least informed and supportive of recovery-oriented practice.	• Validation – Be aware I am aware, congratulate me on being here. • Strengths Based – Inform, suggest, do not tell or push decisions, do not assume I need help, give when I ask, etc. • Time and Space – Give me time, allow space before engagement, i.e., it may take some people time to adjust, process, etc. • Friendliness – No judgement, eye contact. • Continuity – Remember their name, one record, designated support person, etc. • Communication - Calm voices/tones, clear and honest, ask me, do not assume, non-confrontational approach.

		• Acceptance – Accept me! • Privacy – Assure me of anonymity or consent over who is involved. • Technology – Offer opportunities for different access to care, including telehealth, online groups, etc. • Wait times – keep people informed about wait times.

Common Threads:

1. Working with the person

Genuine partnership with people and treating people with humanity seemed to be common across participants, ensuring power is shared, otherwise why would people want to come back if they feel invalidated or controlled.

- Deliberative democracy was raised as a way of balancing power.

2. Demonstrated Inclusion

The employment of a diverse group of peer workers would seem to be an opportunity to promote inclusion, as does the simple display of inclusion through flags, posters, language, accessible spaces, etc.

3. Waiting

As with participants in workshop 1, having empathy for the experience of people waiting is important to people. One participant described as a feeling of powerlessness, as you sit and wait for someone to provide a service, instead of valuing your time, and the emotional energy it takes to come for support, for you or a loved one.

Innovative Threads:

1. No Diagnosis or One Diagnosis

Not making assumptions on first contact, no labels.

2. Congruence

Drawing from Rogerian thinking, unconditional positive regard, words match your actions, and your actions match your words.

- This seemed to match with ensuring authentic and robust governance structures, that are practiced and visible, and informed by consumer feedback.

3. Managing Closure Times

How do you manage presentations prior to closing time? This seems like a key issue, for the people who attend in need of service, and for the staff who may have to turn someone away. It seems like communication needs to be clear on the scope of the service and the hours of operation, through multiple sources, including the after-hours phone message.

Theme 3: Kind Referrals

- Key question: What is a kind approach to connect people to future supports? (Digging deeper How could referrals to other services be as kind and stress free as possible?)

Summary of Key Insights: Kind Referrals

This is a summary of the key insights from this question, the common and innovative threads are picked out below the table. A sentiment from one of the arrows talk to the view that a 'A kind referral looks like…' being given the tools to live your life the way you want to.

Theme	Insights on how to identify future supports needs	Insights on a kind/warm referral process
Immediate Needs	• Always ask if there is anything you can do for them or anything they need, 'I/We can help with that…' • When they come to the centre and are invited to talk, if they say 'no', do not pressure them, give them time. • Ensure there are easy to use supports set up in the waiting area, e.g., colouring books, calming furnishings, mindfulness apps, etc.	• Consumer choice in the options for the next service. • Face to face meeting with the service being referred to, when referring on to a new service.
Alcohol or Other Drugs	• An expectation the team understand illnesses or challenges and co-occurring or co-existing diagnosis. • Understanding of referral needs for multiple needs co-occurring needs	• Keeps track of referrals. • Multiple Connections: Support if there is need to go to multiple locations to cover holistic needs, e.g., transport.
Clarity	• Be clear on what you can and cannot do. • Be realistic, know what is available, do not refer for the sake of it, e.g., housing waitlists. • Do what we say, no empty promises.	• Support customer to communicate their expectations clearly to referred to agency. • If it does not worked out allow people, the safety of coming back.
Person-centred	• When talking about support options, talk about connecting to a person, not just a service, i.e., the customer can tell you have a strong relationship with the service because you know them by name. • One person from the AMHC stays with you to navigate the journey. • Promoting consistent health and wellbeing through building capacity and reviewing goals.	• Face to face talk with organisations, support worker follow-ups, good information. • Slow Transition: Check-in to see if things are moving too fast for someone. • Welcoming and respectful • Sensitive and responsive. • Steady personnel, not 'circular doors'. • Follow up supports, phone calls, texts.
Self-Agency and Choice	• Explore the options the customer already has. i.e., do not assume they need to know a solution, they might just need support to do it.	• Based on what the person need. • Receiving support when you walk in.

	• Ensure the person is at the centre of all decisions made. • Ensuring the tools for self-agency are available. • Consider 'Dignity of Risk' concept. • Access to internet, printer, charging station, etc. • Provide peer based and self-directed options. • Response to need could be outside of the box, for example, not just mental health care, but a job to life self-esteem, easy money stress, etc.	• Telephone Support if on a waiting list.
Relationship	• Keep connected with the person. • Support their voice to advocate where needed. • Follow up to check-in how things are going, ensure people know someone cares how they have gone with the referral. • Affirmation from all of their stakeholders, acknowledging courage in taking responsibility.	• Following up with people to check-in seems to have potential to mitigate challenges with wait times, it seems to reduce the potential for feeling rejected or passed around.
Mental Health Perspective	• Actively listen to the needs of the customer and what they feel they need. • Explore social and community options, e.g., lived experience support groups on Facebook. • Ensure information is available on these supports, and the team supports customers to access them as well as formal supports.	• Suggest appropriate services. • Refer to Peer-led responses, e.g. The Wellness Initiative.
Culturally Appropriate	• Ensure the identification of needs starts with acknowledging their strength in their culture. • Ensure referral options have culturally appropriate standards of service delivery. • Offer choice, e.g., Aboriginal, and non-Aboriginal referral options, same for CaLD and non-CaLD options.	• Ensure person has opportunity to explore potential shame when being referred to community-led services. • Ensure person has opportunity to express concerns in relation to how they will be treated in services, e.g., where community or cultural law may be applied.
Family and Carer Support	• The Carer experience in crisis is hard, often people ask you not to tell others close to you. • Ensure options are available to explore the use of family and Carers in support pathway, not just organisations. • Explore potential enablers for this support, e.g., mediation with family. • Social interactions or group therapies. • Help to find the right Psychologist, it can be expensive and difficult.	• Gentleness, inspire confidence.

Aged Care or Dementia Care	• Support workers that know the services available and are easy to talk to. • Easy to talk to Doctor. • Lists of services and something to read about them. • Respite support for Carers.	• Support examples: People Who Care and Rise. • Example: A participant drew a 'All about my services' pocket card, for the person to know who they are connected with.
Payment	• No charge for services at the AMHC	• No charge for services referred to.
Others	• Counsellors or chaplains as interim supports until they can access services (managing wait ting time). • Timely follow ups • Link people with services they are not aware of. • Do not duplicate services. • Avoid duplicating paperwork. • Connect people to services. • Ensure comprehensive information is available on services being referred to.	• As much as possible, have accountability in relationships with services, e.g., MOU's. • Social meetups, e.g., Activate Mental Health and Befriend.

Common Threads:

1. One Person or Navigator:

Where possible, one person or a familiar face should follow the customer on their short journey through the AMHC to longer term supports.

2. Collaborative Relationships and Service Mapping

This service is going to need strong relationships with providers within the community to make kind referrals happen. To do this well there needs to be a mapping and gapping exercise of the 'Kind' and responsive pathways vs. the 'Unkind' and unresponsive. Also, professional networking between staff and these referral partners is seen as an opportunity.

3. Avoiding Rejection (in service and in referral)

People should receive the care they came for at the AMHC (within scope), or at least leave with some sense that it has been worthwhile. Referrals outward should have reduced risk of rejection, i.e., check the service the person is being referred to has availability.

4. Simple Things – Doing the simple things well

- Access: Reduce barriers, ensure the person can get to the service on an ongoing basis, e.g., explore online or telehealth options, travel and transport options, place-based responses.
- Patience: Allow the person time to process how they would like to engage, e.g., ask them what they would like, and if they are ready proceed, but reassure them if they are not, you will be ready when they are.
- Security: Support people to trust they can move forward because they know they can come back to AMHC for more support if needed.
- Follow Up: Participants really supported the feeling of being cared for that came from their case manager checking-in to see how they went with an appointment.

Innovative Threads:

1. Lived Experience Support Groups

There is a plethora of lived experience support groups available, however accessing these groups is often through peer-to-peer referral. Customers would benefit from a kind referral process to these support groups.

2. Volunteer Drivers

Transport needs to and from referrals is a common thread, a pool of volunteer drivers has been suggested as a possible solution.

3. One Stop Shop

Where possible try to make connection points 'come to' the AMHC rather than the customer 'go to' referral points. Start with the point of view of meeting the needs of the customer through the AMHC, then think about referrals.

Overview of Workshop 3: Bringing it all together.

This workshop took place at the Stan and Jean Perron Child Advocacy Centre, Midland. Largely, attendance was made up of participants from workshops 1 and 2, however, there were some participants attending for the first time.

Primary Focus

Participants were provided with the key reports and parking sheets from the first two workshops prior to Workshop 3. The primary focus areas of this workshop were:

- Bring participants from workshops 1 and 2 together to reflect on the broad information explored in those workshops,
- Further explore key information from the WAPHA Clinical Services Plan, and the three Care Pathways identified by SJGHC,
- and really focus in on what is most important for the provider of this service to know.

The themes for this workshop were:

- Paving the Pathway to Success – Exploring the three care pathways derived from the Clinical Services Plan.
- Steering the Ship – Trying to gauge interest from people to participate in ongoing discussions about the implementation and operation of the service.
- Mindful of the Gap – Looking at specific strategies to support people while they wait for longer term support, or manage a wait time to access services they may be referred to.
- Effective Partnerships - Asking participants to nominate the key services needed to support the success of the service and the client's journey.

Figure

Theme 1: Paving the Pathway to Success

- Key question: What are the key features of each pathway?
    - Features of each pathway
    - Best staff to support the pathway
    - What success might be from the perspective of a customer?

Introducing the Pathways

On the day participants were given a brief sense of what the pathways have been considered to be in the Clinical Services Plan and in other co-design process

Pathway 1 – Care Navigation

- This is the first step for the client (and their family) and goes from first contact through to assessment.
- This stage offers immediate response to access the help they need.
- They will be welcomed to the centre and helped to link up to the right service or resource for their unique needs.
- Most clients will get a 'mini-assessment' of around half an hour which helps to fully understand what is going on for them.
- They will then get an 'interim care plan', which is an agreed plan for next steps.
- That might be referral to a specialist service straight away, or to come back for a full assessment but either way there will be a plan and not just a referral.

Pathway 2 – Care Support

- Care support starts with a full assessment.
- Continuing with the same worker who saw them at Care Navigation wherever possible, mental health and wellness workers (including co-locators and private practitioners) will support the client in developing and delivering their care plan.
- Care Support is Recovery based – client driven and responsive.
- In most situations, this will involve 'brief intervention' based counselling and support – the evidence is that the vast majority of people will benefit from this time-limited and structured treatment (up to 10 sessions).
- But it is not just about counselling - Care Support at the Centre offers a more holistic response to the client's recovery that is inclusive of their mental health, physical health, alcohol and other drugs and social/welfare needs.

Pathway 3 – Care Coordination

- This is about interagency and community-based supports for people with more complex or severe needs.
- In Care Coordination, clients will have a single care plan that includes specialist services from other agencies, services, or individuals.
- The Care Coordinator might be the Centre's own staff, or staff from another partner service (for example if housing is the priority issue the homelessness service might be the coordinator).

- It is important that the client knows one person will help them and feels that they are not being bounced around.
- Care Coordination helps to deliver specialist supports and linkages to the broad community – recovery is across many domains.
- This stage relies on services collaborating for better care than any one agency or individual can achieve alone.

Summary of Key Insights: Paving the Pathway to Success

We have tried to theme the information under appropriate headings, and preference information that was specific and useable, while capturing the overall feel. The tables below show the key insights provided by participants.

Table 1 - Pathway 1: Care Navigation

Features of this Pathway	
How can we mindfully achieve Care Navigation for customers?	**Culture** • Aboriginal art and respect for culture apparent at the entrance and within. • There is a culturally appropriate space to wait and see someone. • An Aboriginal world view validating the cultural experience of mental health. • Having someone there to greet them that is from a similar cultural background. • Diversity 'all the way through'. • World languages represented in welcome messages. • Translation and Interpreter Services. • Yarning based assessment, circle, or story. **LGBTI** • Ensuring a strong welcome for people who have an overwhelming representation in mental health data, but an incredible stigma when trying to access supports. **Customer Service** • Concierge to acknowledge, welcome, and introduce people and ensure immediate needs are dealt with promptly. • If someone is in 'crisis' do not make them wait, respond immediately. • Concierge triages to best response. • Understanding when someone is in a 'window of tolerance'. • Ensure the person feels you are present and not rushed. • Expected timeframe to be greeted, e.g., KPI of within 5-10 minutes in person or through phone call back service. • Safety is paramount, ensure observation of interactions and effective de-escalation skills. **Listening to Understand** • Peer Support Workers to welcome, ensuring people are met by 'good listeners', and are supported to figure out what might be going on for them. • Using multi-sensory resources and colour. • Working over a cup of tea. • Figure out what people need to feel welcome. • Find out if people are comfortable with forms, try to avoid shame. **Resourceful and Responsive** • Avoid re-telling of stories.

	• Low intensity is responded to effectively, not dragged into higher needs, e.g., they may just need advice on what is available through pamphlets. • Varying levels are responded with the right level of resource or support. • Support emotional and psychological safety first before asking for details, e.g., how can we help today? • Support people to communicate, e.g., stickers for people to say they are okay to be talked to or just need some time. • Multi-disciplinary team available to respond. • Knowledgeable about local services and services in general. • Know what scares or frightens people off. • Awareness of the impact of noise for some, quiet spaces available when needed. **Family and Carers** • Families and Carers are seen and heard, treated with dignity and respect, asked if they would like support for themselves. **Clarity and Communication** • Strong communicated strategy supports people to be clear on what to expect from the service, what it is and is not. • Visible roadmaps of what to expect. • Staff photos, identifying who they are and who is on duty. • Being consistently open, honest, culture and gender safe, trauma-informed, and not always expecting an illness or a problem, wait before judgement. • Communicate inclusively. **Referrals** • When a person is referred, be ready, be informed, be appreciative.
Who are the best staff to support this pathway?	**Welcome – Feel Safe and Trust** • **Concierge –** How we are greeted sets the tone for how welcome we feel. • **Greeter/Mental Health Worker –** Aware of services, easy to relate to, can de-escalate emotions, care navigation. • **Peer Worker –** Care navigation, because they are aware of what it is to be welcomed (or not), non-threatening and non-judgemental approach. **Continuity of Care** • **Peer Worker –** Throughout the journey, build trust and rapport early, and continue through. • **1st Contact –** This person connects with the clients, then remains their key contact throughout the process. **Specialised** • **Family Peer Worker –** Carer Support • **Older Person Support –** Someone who older people can identify with, someone who understands older person's needs, able to understand challenges and conditions, works at a different pace. • **Security –** When necessary, but not in uniform. • **Psychologist –** Skills to provide treatment, single session, or ongoing counselling. • **CaLD –** Someone to talk to and listen, reduce fear, and ensure people are heard the way they want to be.

	• **Aboriginal Cultural Engagement –** Floater to increase ease of access for Aboriginal people to feel culturally safe, support and advocate, welcoming, empathetic. • **Mental Health Nurse –** Assess and triage immediate needs, assess clinical risk and need for medical treatment. • **AOD Worker –** Floater across all pathways, AOD challenge will be common in presentations, and this will be crucial to enhancing a 'No Wrong Door' approach. **Other** • **Volunteer –** Someone to transport to other services. • **Social Work –** Across all domains.
What are some of the indicators of success?	**The customer might feel like…** • Empowered, less stigma, a sense of self-efficacy, taken seriously. • Welcomed, heard, relieved, valued, validated, calm, supported, hopeful, less invisible, included. • Supported to seek other services for recovery. • It is private, confidential, and safe. • Given the right advice, sent to the right place, given the right support. • A growing and deepening therapeutic relationship. • I was not just a number; I can stay as long as I need. • Finally, there is a place for me, there were others there like me. **The customer might say…** • Felt safe, listened to, understood, and I had choices. • I know who to talk to if I feel unsafe. • I will tell my friends it was awesome, helpful, I got help here, the people were personable, and I found a way forward. • Recommend it to my friends. • The service was well signed, close to public transport, and easy to access. • It felt inviting, I did not have to wait long before things were explained to me. • I was spoken to straight away and given a timeframe of when the next staff member would connect with me. • I was able to speak to a person on the day, people asked what I needed. • I will continue to engage with the service, I would usually leave or cease contact. • Things were clear and I did not feel rushed. • My family were able to support me and felt included. • Good feedback to others on social media platforms. • I was offered a cuppa and a Tim Tam. • I am not alone anymore. I feel connected to the wider community.

Table 2 - Pathway 2: Care Support

Features of this Pathway	

How can we mindfully achieve Care Navigation for customers?	**Engagement**
	• Actively identify barriers to engagement and achieve meaningful engagement:
	  ○ look at practical and emotional levels,
	  ○ look to recruit customers, acknowledge their strengths, knowledge, and resources.
	  ○ Offer resources to promote engagement, e.g., online modules, broad therapist problem solving sessions (online/podcast/media).
	• General questions, e.g., how are you? What brings you here?
	• Welcome person/Concierge can book appointments with co-located services.
	• Multiple options to engage, e.g., telehealth for those who have childcare needs.
	• Peer support, people with lived experience.
	• Curiosity, every drop-in is an opportunity to connect.
	• Trust is built over time; person might need multiple attempts to truly engage.
	
	Therapeutic Response
	• One worker to reduce duplication of stories.
	• Matching clients and professionals.
	• Everyday language, culturally appropriate, continuously explore meaning for people, ensure they understand treatment in their way.
	• Structured counselling, links to longer term treatment.
	• Co-location of services to meet as many needs as possible.
	• Staff stay calm when a client is upset, respond to where the client need is at.
	• Trauma-informed, compassionate connection, person-led, unmet and client needs focus.
	• Flexibility, multiple ways of meeting the support needs of the client.
	• Amplify and support early gains to support someone to feel it is worthwhile, gain confidence.
	• Care plan, multidisciplinary reviews, as needed.
	• Options to change worker if there is an issue or lack of connection.
	• More than counselling, wraparound, or holistic support.
	• Listening deeply, validating, valuing, support with compassion, taking time.
	• Awareness of people time vs paper time.
	• Family and/or Carers are welcome and actively validated and included.
	
	Environment/Approach
	• Runs like a community centre with weekly activities, e.g., meditation, yoga, sound baths, sausage sizzle on the weekend.
	• Homely feel, non-clinical, non-surgical.
	• Water cooler, tea, coffee, etc.
	• Spaces to connect with others, and other services.
	• Drop-in user-friendly space, where people can access tea, coffee, Wi-Fi, computers, while waiting for someone.
	• Encourage community feel, people can drop in with queries.
	• Parent room.
	• Quiet spaces for people to use grounding exercises before and after engagement.
	
	Knowledge
	• Staff are continuously updating their knowledge of what is available.
	• Up to date service information, i.e., regular audit of pamphlets and resource sheets.

	Warm Referrals • Working relationships and MOU's with other agencies. • If referring someone, know the person you are referring them to. • Calling services with the client, ensuring the client knows the service is welcoming to them. **Group Activities** • Not just mental health, talking groups, community space, community kitchen, self-regulation workshops, art, etc. • Yarning Circle with tactile 'stuff'. • Specialist workshops run as 'one off's' by community groups. **Safety** • Privacy and confidentiality, informed consent. • Clear guidelines on rights and responsibilities, as well as what is and what is not offered. • Time-outs, when necessary, but with opportunity to learn, not just bar. **Other** • A place to have a shower and have something to eat. • Ensure resources are available and inclusive, options for translations, braille, vision aids, infrared aids, etc. • Shared access to one system, e.g., Psolis. • Stickers for identification.
Who are the best staff to support this pathway?	**Care Coordination** • **AOD Worker –** After the initial triage, floating to support co-existing needs. • **Mental Health Nurse -** Clinical knowledge, assessment and triage, awareness of treatment services, knowledge of health systems and referral pathways, provide referrals, de-escalation skills, etc. **Group** • **Group Facilitators –** Therapeutic and non-therapeutic groups, focussed on connection and engagement. **Specialist** • **Medical Doctor –** Drop-in sessions to support physical or co-occurring needs. • **AOD Worker –** Providing specialised AOD supports, understanding and lived experience, provide connection, ensure referral to the right services, respectful treatment. • **Psychologist –** To support treatment or therapy for people who have barriers to access existing programs, like Dialectical Behavioural Therapy, etc. **Other** • Guest from local community sport or social clubs to help connect people to community. • Partnership with Child Care service provider – Person may come with children and have needs that need to be met, children will need an initial support before other care can be arranged with family or others, etc. • Occupational therapist. • Social Worker.
What are some of the	**The customer might feel like…**

indicators of success?	• Cared for, felt empathy, were not judged, hopeful and well-informed, heard, included, safe, engaged, respected, listened to, valued, included. • I am in charge of my recovery I feel treated as an equal. • I know what is happening and why, they know me and understand what I need. • Validated, listened to, not rushed, empowered, calm, less stressed. • Simple referral system, I will not have to repeat myself. • I have a future and plan to go forward. • I have a better understanding of my challenges; I know what might help. • Easy to navigate, no barriers to the service. • Cultural needs genuinely respected. • There were no uncomfortable or irrelevant questions. **The customer might say…** • Received the services they needed and some they were not aware of. • I was connected to someone who understood my needs and they had good knowledge. • They understood me, took things slowly, understood the bouncing around of services, listened wholeheartedly. • Confidence to relay their knowledge of other services and services that work well for them. • Process was transparent, I was involved and respected. • Thank you, I feel heard and supported, I am hopeful, this is different to what I have experienced before. • Wow! This is the first time someone really understood me. • I know who I will speak to if I return, when I go there, they know my name. • They knew what they were on about, they were respectful, gave me time, made appropriate treatment decisions. • I know what to do, where to go. • Guided to find positive support to move forward, I am achieving my goals.

Table 3 - Pathway 3: Care Coordination

Features of this Pathway	
How can we mindfully achieve Care Navigation for customers?	**Care Coordination** • Empower the customer to lead their coordination of services, do not fix, create opportunities for self-determination. • Maintain relationship with initial support staff. • One person or case manager throughout, so the person does not have to repeat their story. • Same person where possible, but specialist assessment and triage. • Identify barriers to continuity of engagement, test other avenues, e.g., online via telehealth or by phone, etc. • 'Ready Reckoner' check list to get a snapshot of supports needed. • Actively identify co-occurring challenge, ensure needs are supported holistically. **Customer Led** • Customer has autonomy, the service responds to them, at their pace, not a dictated timeline. • Lead from the strengths of the customer, do not assume, be curious. • Customer empowered in their healing and their recovery. • Customer nominates supports they have and strategies they have. • Customer is at the centre of everything, the client is in charge. • Customer acknowledges services they do not want to work with at the start. • Always ask, do not assume. **Multidisciplinary Approach** • Assessment through domains of care, from physical, psychological, spiritual, financial, social, risk, etc. • Knowledge of local supports, who and what is available. • Daily handover promoting continuity, structures to support communication. • Systems that capture the person's story across the team. • Ability to support all demographics, all presentations. • Connected to opportunities to keep up to date with information, e.g., WA Peer Supporters Network. • Listen and validate customers other supports, their information is valued, include them in care plan development. • No handballing between the team. • Ensure opportunities for feedback are maximised and valued. • Trained hearing or sight impaired staff, with time to sit and explore customer needs compassionately and effectively. • See the care plan as an opportunity to co-design and co-produce. **Clear Communication** • Systems to prevent the need to re-tell their story. • Some sort of information passport, 'My Health Passport' to prevent re-telling, right through to referred to services. • Good, secure, consented messaging system. • Shared understanding of the care plan, and if there is a 'relapse signature' included and shared. **Referrals**

	• Ensure the customer is comfortable with the process and pace, and it is implemented with their permission always. • Warm referrals supported by peer staff. • Regular meetings with partners to ensure capacity is still there. **Follow Up** • Do you have everything you need? Do not rush people out the door. • Follow up as much as possible. • Doors always open if the customer progresses but needs to come back. **Other** • Smooth, good back of house support. • Secure database, e.g., Psolis. • Trial what works, do not just stick with it. • Offer tea or coffee before they leave, so if there is anything they need to process, or anything they forgot or are worried about, they may have time to talk about this.
Who are the best staff to support this pathway?	**Specialist Coordination** • **Care Coordination Facilitator –** Specialised in managing different agencies and disciplines. • **Mental Health Specialists –** Decision maker under the Mental Health Act, provide assessment, clinical guidance, oversight of care planning, major decisions points, supports and supervises other staff. • **Social Worker –** Person they trust, can attend appointments with them, help them to navigate the system, referrals to different agencies, arrange meetings, bring multidisciplinary team in, etc. • **Therapeutic Response Staff –** Coordinate or uphold the therapeutic environment, attend to basic needs, promote, and enhance safety. • **Peer Support Care Coordination –** Address ongoing and holistic needs with the person, understand where someone is at, promote confidence and safety with clinicians. **Other** • **Physio/Occupational Therapist –** Groups, exercise, relaxation. • **Community Members –** Sports coaches and others who can establish community connection.
What are some of the indicators of success?	**The customer might feel like…** • I feel supported and connected to the wider community and not alone anymore. • Feel like I will not have to repeat my stories. • Supported, not alone, encouraged, included, safe. • Empowered, hopeful and positive, for the future. • Technology was easy to use. • Simple/Uncomplicated. • They remember the connection and feel like connecting. • I have clear goals and a plan. • Included, the environment and the physical layout were accessible. **The customer might say…** • They sent me to the right services.

	• All of my supports were included. • Continuity, I was referred to the right people. • It is nice to have one person coordinating my supports. • This was a good experience, I have goals. • They did not need me to repeat my story over and over. • Great service, they totally got me, and supported me to link with the services I needed, were flexible, and they followed up. • I do not need this service anymore. • I am grateful. • They made it easy to arrange appointments. • The crisis was resolved. • Great to see ACROD parking.

Common Threads:

1. Floating Staff

There were a lot of references to staff floating across all care pathways, having competency to work throughout.

Floating Staff Suggestions:

- GP – To meet needs across all paths, provide assessment and treatment, and connect back to general practice.
- Peer Worker – To meet people at the point of presentation and explore options that have worked for them, provide comfort, provide examples of strategies etc.
- Mental Health Nurse – Triage, assessment, care coordination, and on-call as need arises.
- Support or Crisis Intervention Officer – Connecting people from the Emergency Department.
- AOD Worker – High level of presentations, likely to be needed at all points.
- Aboriginal Engagement Officer – Supporting culture, people can see that there is someone they can talk to in 'their way'.
- Family Support – Carers and family often go unseen; they may not be aware of their needs or what supports are available.
- Psychologist – Providing brief interventions and supports at key points, supporting staff understanding and action.

2. Focus on Care Navigation

Simply by looking at the feedback generated, there was a lot of focus on the idea of the care navigation pathway, it seems like, this is about getting it right from the start.

Innovative Threads:

1. Communication Stickers

One suggestion seemed like a 'do not disturb' sign in a hotel, the participant suggested supplying people with stickers if they need time to process before being engaged with, e.g. 'I am not ready to talk yet'.

2. Concierge

This was mentioned at least 20 times. The concept of having someone who can think on their feet, welcoming people effectively, but also functioning in a triage role. One comment said this role would need a strong connection with clinical support, also would need to be valued and validated by this support.

Theme 2: Steering the Ship

- Key question: Who is best to steer the ship?
    - How might we engage representatives from services and the community as guides?

Summary of Information: Steering the Ship

Any **specific names or contact information of individuals will need to be removed for external sharing** of this report. The information has been shared with St John of God and WAPHA for follow up. The exercise seemed to have missed the mark as a lot of the information would seem to be just naming services without any relating them to steering the service.

Table 4 – Steering the Ship

Name (Service/Individual)	Additional Information Provided
Alison Seifer	AA Midland – Interested in Peer Work
Autism West	
Centre for Social Impact	Indigenous Team in Perth
CoMHWA	Care Hub and Lived experience on governing board.
Derbal Yerrigan Health Services	Aboriginal and Torres Strait Health services.
Indigo Junction	Midland Service Provider
Jethro Sercombe	Innovation Unit
Kristina Edleman	Sacred Butterfly
Mental Health Advocates	
Mental Health Law Centre	
MIFWA	Key community provider
Pat Duff	Peer Worker
People with Disabilities WA	
Phoenix Support and Advocacy Service	Phoenix Support and Advocacy Services Inc. provide counselling and support to survivors of child sexual abuse, their non-offending family, friends, and significant others.
Rick Dean	Peer Worker
Rise Network	Range of services
Shelter Plus	
Spectrum Space	
The Wellness Initiative	Peer Led Workforce
Vinnies WA	
Yokai Aboriginal Corporation	Healing and Wellbeing
Yorgum Aboriginal Corporation	Healing Services
360 Health and Community	Alive and Street Doctor Programs

Theme 3: Mindful of the Gap

- Key question: What are clear examples of supports, strategies, and resources we can offer, or suggest to people, while they are waiting to access further services?

Summary of Key Insights: Mindful of the Gap

One recurring theme throughout this co-design process has been the concern about waitlists. From the provider perspective, moving people through the service effectively, and connecting to longer term supports is essential to enabling access for as many people as needed.

From the Consumer perspective, it is about acknowledging there will be waitlists when referred on, but the AMHC providing or showing care until this connection is achieved. The participants of workshop 3 generated a vast array of information about opportunities and strategies to manage 'the gap' created by waitlists.

Table 5 - Mindful of the Gap

Service/Suggestion and Further Information	Service/Suggestion and Further Information
Act Companion The Happiness Trap App www.actcompanion.com	**Kupu Kupu** No information available.
Activate Mental Health Meet Up And Social Events www.activatemh.com.au/	**Laughter Yoga** www.perthunderground.com.au/post/laughter-yoga
After Hours Support Numbers *Resource list for the AMHC to develop	**Lifeline** www.wa.lifeline.org.au/
Alternatives To Suicide - Mercycare www.mercycare.com.au/alternatives-to-suicide	**Meerillinga Youth Foundation** www.meerilinga.org.au/
Alternatives To Suicide WA Alliance - Connect Groups www.connectgroups.org.au/ats-partners-and-supporters/	**Meetup** Social connection in person or online. www.meetup.com/
Befriend Social connection and Meet Up. https://befriend.org.au	**Men's Health Website** https://www.menshealth.com.au/
Best Beginnings Best Beginnings is a home visiting service for families of new infants. www.dcp.wa.gov.au/SupportingIndividualsAndFamilies/Pages/BestBeginnings.aspx	**Men's Shed** www.mensshedswa.org.au/
Beyond Blue Social And Emotional Wellbeing Platforms	**Moorditj Djena** Podiatry and diabetes outreach. www.emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/Moorditj-Djena
Black Dog Social And Emotional Wellbeing Platforms	**Midlas** Legal centre and advocacy. www.midlas.org.au/
Blue Knot www.blueknot.org.au/	**MIFWA** https://www.mifwa.org.au/
Calm Support With Self Harm www.au.reachout.com/tools-and-apps/calm-harm	**Moorditj Koort** Aboriginal health, wellness, and community support.
Care Hub WA Association Of Mental Health	**Mr Perfect** https://mrperfect.org.au/
Carers WA Gateway	**Multicultural Services Centre** https://mscwa.com.au/

hwww.carerswa.asn.au/our-services/carer-gateway-services/	
Carers WA **https://www.carerswa.asn.au**	**Neami National Groups** https://www.neaminational.org.au/
Child And Parent Centre For People With Young Children And Family Wellbeing	**Pat Giles Centre** https://www.patgilescentre.org.au/
Child And Parent Centre Midvale And Koongamia	**Peer Led Groups** *Resource list for the AMHC to develop.
City Of Swan Volunteering Centre	**Peerzone** Peer-made resources. https://www.peerzone.info/
CoMHWA The Life Launchpad https://comhwa.org.au	**People With Disabilities WA**
Community Garden Fresh Produce For Clients www.wacommunitygardengathering.com.au/	**Personal Options** No further information.
Community Kitchens **No further information.**	**Ports** Assessment and treatment for 16+ who have mild – moderate symptoms of anxiety, depression, or substance use problem. https://ports.org.au/
Cottesloe Clinical Interventions CCI www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Anxiety	**Post Cards** *Resources for the AMHC to develop.
Crooked Spire Local Midland Café. http://www.crookedspire.net/	**Recovery Colleges WA** https://warecoverycollege.org.au/
Customised Resource Sheets *Resources for the AMHC to develop.	**Redschool.Net** Menstrual cycle awareness.
Cyrennian House https://cyrenianhouse.com/	**Roses In The Ocean** https://rosesintheocean.com.au/
DBT Teen Lifeline https://wa.lifeline.org.au/services/prevention-services/dbteen/	**Ryde** 50 hours of supervised driving experience with one of our Volunteer Mentors. https://ryde.org.au/
Depression.Org Depression awareness. http://www.depression.org/	**Richmond Wellbeing** https://www.rw.org.au/
Derbarl Yerrigan Health Service Aboriginal and Torres Strait Islander health service. https://www.dyhs.org.au/	**Rootd** Panic and anxiety relief. https://www.rootd.io/
Dilary App No further information.	**Sacred Butterfly** https://www.meetup.com/en-AU/Sacredbutterfly/
Dream Builders **https://www.dreambuilders.church/**	**Sacred India** http://www.sacredindia.com.au/
East Metro Mental Health Services Website https://emhs.health.wa.gov.au/Hospitals-and-Services/Mental-Health	**Safe Haven** https://rph.health.wa.gov.au/Our-services/Safe-Haven
Emergency Resource Sheets *Resource lists for the AMHC to develop.	**Sahaja Yoga** https://www.sahajayoga.com.au/
Even Keel	**SBS Japanese**

Bipolar Disorder Support Association https://www.evenkeel.net.au/	https://www.sbs.com.au/language/english/podcast/sbs-japanese
Family Support Networks WA https://www.wafsn.org.au/	**SECCA** Sexual health and relationships support for people with disability. https://www.secca.org.au/
FDV Accommodation *Resource lists for the AMHC to develop.	**Slow** Online app to support movement.
Financial Aid Supports *Resource lists for the AMHC to develop.	**Smiling Minds** Mindfulness. https://www.smilingmind.com.au/
Follow Up Or Check	**Street Doctor**
Free Meals Lists *Resource lists for the AMHC to develop.	**Support Significant Others** *Resource lists for the AMHC to develop.
Fremantle Mind Inc. FremantleMind Inc. is a grass roots community wellbeing initiative. https://www.mylocalmind.org.au/	**Telehealth Information** *Resource lists for the AMHC to develop.
Haircuts 4 Homeless **https://www.haircuts4homeless.com/**	**Templates For Journaling And Problem Solving** *Resource lists for the AMHC to develop.
Head To Health Digital mental health resources. https://headtohealth.gov.au/	**The Grief Centre WA** Support and Recovery to people experiencing grief. https://www.griefcentrewa.org.au/
Headspace App https://www.headspace.com/headspace-meditation-app	**The Wellness Initiative** Peer led services. https://wellnessinitiative.com.au/index.html
Headspace Midland https://headspace.org.au/headspace-centres/midland/	**This Way Up** Online courses and tools to support mental health. https://thiswayup.org.au/
Heart Foundation https://www.heartfoundation.org.au/	**Trilllion Trees** To bring people together to plant and grow trees to achieve a healthy and biodiverse environment. https://trilliontrees.org.au/
Hello Cass Hello Cass is an SMS chatbot providing discreet access to localised, accurate information and support for people experiencing or affected by family and sexual violence. https://hellocass.com.au/	**Unsight** No further information.
Helping Minds Mental Health Carer Support Services. https://helpingminds.org.au/	**Volunteers For Basic Supports** *Resource lists for the AMHC to develop.
Holyoake https://holyoake.org.au/	**WA Connect** Emergency services directory. www.waconnect.org.au/
Hugs With Mugs www.facebook.com/HugsWithMugsCafeAUS/	**WANSLEA** Promoting the wellbeing and development of children and families https://www.wanslea.org.au/
Indigo Daya **Lived experience blog.**	**Weekend Moles** No further information.

http://www.indigodaya.com/	
Indigo Junction **https://indigojunction.org.au/**	
Information Provided About Community Services *Resource lists for the AMHC to develop.	
Koya Aboriginal Corporation https://koya.org.au/	

*Suggestions of resources for the AMHC to develop.

Theme 4: Effective Partnerships

- Key question: What specific services should we now approach?
    - Who (Name of the service)
    - To (do what – be as clear as possible)
    - Because (why them or this service)
    - Contact (who should we talk to)

Summary of Key Insights: Effective Partnerships

This service will support people to navigate their challenges, connect with initial supports, and look at sustainable supports in their community. In order to do this well, the AMHC must identify services that work well for the people of Midland currently across all of the potential areas of support, and areas the AMHC cannot support. The service provider will need to maintain effective partnerships to ensure effective flow through and continuity of care.

Participants identified a wide range of services, including online and web-based supports. Most areas were covered well, however, there was distinct lack of information for areas such as, LGBTQI+, CaLD, and supports for people. There was also a lack of information in the 'Because' column. We have added clarifying information or web address where available.

Table 6 - Effective Partnerships

Who	To	Because/Contact
Cultural Support		
Buddhist Society	Meditation Classes	
Centrecare	Family Support Network	Early Intervention Parenting
Derbarl Yerrigan	Medical Supports	Specialist Aboriginal Health
EDAC	Service All Perth	
Indigo Junction	Housing, Fathers Program, Financial Support, Inclusion Program, Street Law, Mooditj Maaman Women's Art	Place based services
ISHAR Mirrabooka	Multicultural Services for Women	
Karnany Drop In	Karnany is a resource centre providing services to both Aboriginal and non-Aboriginal people.	
KM Noongar Consultancy	Yarning Circles	
Koya Aboriginal Corporation	Funding for families and support	
Moorditj Koort	Aboriginal Allied Health	
Moort Booditj Mia	Pregnancy Services	
Shaun Nannup	Culturally Secure Recovery, Wisdom in Your Life	

Southwest Land and Sea Council	Noongar Support	
St John of God	Aboriginal Health Team	Based at the hospital.
WANSLEA	Counselling and Services	
Wungening Aboriginal Corporation	Family services, AOD services, Adult Justice, Housing and Homelessness	
Yokai Healing	Yokai is a Noongar call to action – enough is enough! In an organizational context it is a significant human rights initiative developed by the Bringing Them Home Committee (WA) and the WA Stolen Generations Alliance.	
Disability		
Autism Association	Providing services to people with Autism.	https://www.autism.org.au/
Carers WA	Support and respite for Carers.	https://www.carerswa.asn.au/
Hearing Australia	Prevention, early detection, and treatment of hearing loss in Aboriginal and Torres Strait Islander children.	https://www.hearing.com.au/
MIFWA	NDIS Psychosocial	https://www.mifwa.org.au/
Mission Australia	No specific information	https://www.missionaustralia.com.au/
Mosaic	Intellectual Disability Service	https://www.mosaic.org.au/
MSWA	Supporting West Australians with Neurological conditions.	https://mswa.org.au/
Parkinson's	No specific information	
PwDWA	Suits Me App	https://www.pwdwa.org/
Richmond Wellbeing	NDIS Supports	https://www.rw.org.au/
Rise Network	NDIS Supports, Social Supports, Accommodation, etc.	https://www.risenetwork.com.au/
Spectrum Space	Formerly Autism West.	https://www.spectrumspace.org.au/
Synapse	Acquired Brain Injury Service	https://synapse.org.au/
TADWA	Technology for Ageing and Disability	https://tadwa.org.au/
The Wellness Initiative	Psychosocial Recovery Supports, Support Coordination	https://wellnessinitiative.com.au/index.html
Alcohol and Other Drugs		
Alcoholics Anonymous	12 Steps	Local Groups
Cyrenian House	Access to detox and rehab, and Midland Intervention Centre, Serenity Lodge	Options for children to access with parents
Holyoake	Peer Groups, Counselling, detox, NEMCADS, Drumbeat	

Next Step	Specialist Detox	https://www.mhc.wa.gov.au/about-us/our-services/next-step-drug-and-alcohol-services/outpatient-services-east-perth/
Palmerston Association	SMART Groups, Counselling, Therapeutic Community	https://www.palmerston.org.au/
Shalom House	AOD Services.	https://www.shalomhouse.com.au/
Women's Healthcare Place Midland	AOD Support Group	https://www.mwhcp.org.au/
Wungening Aboriginal Corporation	Walk-in AOD Support, Day Rehab, AOD Outreach, others use, counselling support.	Community led, free, local.
Mental Health		
Activate Mental Health	Social Connection and Events	https://www.activatemh.com.au
Angel Hands	Trauma recovery support.	https://angelhands.org.au/
Black Swan Health	Allied Health Services	www.blackswanhealth.com.au
Carers WA	Carer support and advocacy	
CoMHWA	Specific support groups	www.comhwa.com
Community Mental Health Unit	Community mental health.	
Connect Groups	Specific support groups	
Cygnet	No information available.	
Eclipse Program	Training and education.	https://www.eclipseeducation.com.au/
EPYCENTRE Cockburn	Ruah Early Intervention Service for Young People	https://www.ruah.org.au/services-support/mental-health-and-wellness/epycentre/
Even Keel	Peer to Peer Support, especially for people living with Bipolar, in Freo, Yokine, Midland.	https://www.evenkeel.net.au/
Friendline Perth	Helping people connect phone service.	https://friendline.org.au/
GROW Midland	Mental Health Groups.	https://grow.org.au/group-locations/midland-grow-group/
Headspace Midland	Youth and young adult mental health.	https://headspace.org.au/headspace-centres/midland/
Helping Minds	Carer's support and respite.	
Lifeline	Suicide Support and Recovery	https://wa.lifeline.org.au
Midlas	Advocacy	https://www.midlas.org.au/
MIFWA	Choices Peer Support	

Mission Australia	NDIS	https://www.missionaustralia.com.au/publications/ndis-resource-page-wa/
Moorditj Koort	Integrated Team Care Support	moorditjkoort.com.au
Pat Duff	Peer Mentor	Experienced lived experience support based in Midland.
People Who Care	Aged and Aboriginal supports	https://www.peoplewhocare.org.au/
Purple Patch Therapy	Purple Patch Therapy aims to support people with disability and their families to live a great life in an inclusive community.	https://purplepatchtherapy.com.au/
Richmond Wellbeing	MH Connext	GP Connection, Continuing Care, Case Management
Rise Network	Community Mental Health, NDIS, Partners in Recovery, Housing.	https://www.risenetwork.com.au/
Roses in the Ocean	Suicide support and recovery	https://rosesintheocean.com.au
Ruah Community Services	Community Mental Health	Personalized Recovery Support
Sacred Butterfly	Peer Support, Spiritual Support, Sound Healing	
St Bart's	Mental Health Accommodation	https://stbarts.org.au/
The Wellness Initiative	Mental Health Peer Support	https://www.thewellnesssinitiative.com/
Vinnies Mental Health	Support Accommodation and Recovery Support	https://www.vinnieswa.org.au/
WAAMH	Specific support groups	www.waamh.org.au
360 Health and Community	ALIVE Program, NDIS Support	https://www.360.org.au/services/mental-health/alive/
Housing and Homelessness		
Access Housing	Community Housing Organization	https://www.accesshousing.org.au
Dream builders	Church collections and support	https://www.dreambuilders.church/collections/perth
Entrypoint (Centrecare)	Crisis accommodation and referral service	https://www.entrypointperth.com.au/
Foundation Housing	Community Housing Organization	https://www.foundationhousing.org.au/
Homeless Healthcare	Mobile GP Support for Homeless People	Medical Respite Centre
Indigo Junction	Homelessness Supports	
Mobile Clinical Outreach Team	Mobile Mental Health Support for Homeless People	Effective
Noongar Mia Mia	Moorditj Mia Housing First Homelessness Initiative	Aboriginal-led Housing First Program
Orange Sky	Homeless Support with Hygiene	https://orangesky.org.au

Rise Network	Mental Health and Homelessness	https://www.risenetwork.com.au/
Ruah Community Services	Housing First Homelessness Initiative, Zero Project, Ruah Centre, Safe Spaces, etc.	www.ruah.org.au
Second Bite	Food Support through Coles	https://www.secondbite.org/
Shelter WA	Housing and Homelessness Advocacy	https://www.shelterwa.org.au/
St Andrews Medical Centre		https://standrewsmedicalgroup.com.au/
St Bart's	Lime and Kensington Street	https://stbarts.org.au/
St Pats Community Centre Freo	Homeless Services, Meals, Outreach, Accommodation, AOD.	https://stpats.com.au
Street Doctor	360 Street Doctor is a mobile GP clinic aiming to improve the health & wellbeing of homeless, transient & disadvantaged people in identified suburbs around Perth, WA.	https://www.360.org.au/street-doctor/
Uniting WA	Homelessness services.	https://unitingwa.org.au
Vinnies	Housing and homelessness support, Housing Plus Program	Tom Fisher House low threshold accommodation.
Zonta House	FDV Support and Accommodation	
360 Health and Community Services	Outreach and in reach Services	Already in Midland and established.
55 Central	Accommodation and Street to Home	
Physical and Emotional Health		
Derbarl Yerrigan Health Services	Specialist for Aboriginal Health	www.dyhs.org.au
Eating Disorders Families Australia	Parent and Carer Support	www.edfa.org.au
Moorditj Djena	Podiatrist	https://emhs.health.wa.gov.au/Hospitals-and-Services/Aboriginal-Health/Moorditj-Djena
Recovering Smiles	Subsidized or Free Dental	http://www.recoveringsmiles.com/
SARC	Sexual Assault Resource Centre	
Silver Chain	Primary Care at Home	https://www.silverchain.org.au/wa/
Strive	Eating Disorder Support Group Online	No information available.
WAEDOCS	Clinical Consultancy on Eating Disorders	https://scghed.com/wp-content/uploads/2016/09/WAEDOCS-Service-Brochure.pdf
Black Swan Health	GP Services	Local Bulk Billing

North Street Medical Practice		Local Bulk Billing
Derbarl Yerrigan Health Services		Local Bulk Billing
High Wycombe GP		Local Bulk Billing
Morrison Road Practice		Local Bulk Billing
Swan Medical		Local Bulk Billing
Helena Valley Estate		Local Bulk Billing
Mundaring Super Clinic		Local Bulk Billing
LGBTIQ+		
Freedom Centre	LGBTIQ+ Support	https://www.freedom.org.au/
Other		
Dungeon Youth Centre	Youth Drop in Ballajura	https://www.yacwa.org.au/ways/service/dungeon-youth-centre-2/
Koolkuna	FDV Housing Support	https://mjlh.org.au/koolkuna/
Living Longer Living Stronger	Act Belong Commit Mental Health awareness and strategies.	https://www.actbelongcommit.org.au/
Midvale Hub	Parenting Classes	https://www.midvalehub.org.au/
National Debt Helpline	Financial supports.	https://ndh.org.au/
Parkerville	Therapeutic child and family services.	https://parkerville.org.au/
Ruah Legal Services	Not for profit legal and non-legal support.	https://www.ruah.org.au/services-support/specialist-legal-services/
Vinnies WA	Financial Counselling,	www.vinnies.org.au
Youth Focus	Youth and Young Adult Support	https://youthfocus.com.au/
Youth with a Mission	Youth With A Mission is a global movement of Christians from many cultures, age groups and Christian traditions, dedicated to serving Jesus throughout the world.	https://ywam.org/

Overview of Workshop 4: Listening to Elders and the Aboriginal Community

This workshop took place at Midland Sports Complex, Patterson Drive, Middle Swan

Primary Focus

The primary focus of this workshop was to listen to the people present, clarify information about the AMHC and process to this point, and ensure people were aware this co-design process would continue throughout the pilot of the centre.

The themes for this workshop were:

- Why? (Why would you want to go to the AMHC?)
- What? (What or who makes it safe for people to go there?)
- Where? (Where to from here – Health Journey Connections)
- Location

Figure 1

Attendance

In total, 26 people were in attendance and directly engaged in the conversation. This included staff facilitating and supporting on the day.

Reporting the Data

As with previous workshops, participants were incredibly generous with their knowledge on the day. All data is respectfully acknowledged and analysed in the creation of this report; however, this report attempts to summarize the information in a way that is easily accessible to the user. For the most part we have used the term 'Customer' in relation to the people who will access the service.

Theme 1: Why? (Why would you want to go to the AMHC?)

- Key question: What would you be looking for at the AMHC?
    - What would be your need?
    - Why would you want to go there?

Summary of Key Insights: Why would you want to go to the AMHC?

The idea of 'why someone would want to come here?' was a really strong one, some people said the service would have to earn the right for people to come, prove it was a good place through actions. Others commented on the need for Aboriginal people to be involved throughout the planning and delivery of the service.

Table 1 – Why would you want to go to the AMHC

Rationale	Description

Carers	• Support for the support
	  ○ A lot of families are constantly dealing with people on the edge and need support for themselves as well as the person they are caring for.
	  ○ They need to be respected when they come, staff need to know the effort that goes into supporting family and the community.
	  ○ Need help with our family and wider family.

Suicide Prevention	• Suicide is huge in the community; the community needs to be listened to on this. • Suicide is killing our young people and men, every week. • We need help to do something about this when it is happening.
Loneliness and Safe Place	• A meeting place for our mob going through a tough time. • Yarn with groups, you get lonesome… • It needs to be a place where our mob can come and have a yarn with each other. • This is how we heal and feel together, find solutions.
Alcohol and other Drugs	• Alcohol and Meth are big issues for the community. • We need support with Alcohol, Meth, and prescription misuse. • Support needs to consider how hard it is to stop and break it down with us. • Access to detox, rehabilitation, or support even when still active in using drugs or alcohol. • How will the service support people when they are 'intoxicated or high'?
Interim Supports	• Support for us while we are waiting for other professional services. • Support to figure out the right or next steps/
Seeking Help	• We might be looking for someone to talk to or open up.
Homelessness	• Homelessness is an issue we might need crisis beds or somewhere safe to stay.
Basic Needs	• Might need a feed and a shower and someone to talk to, or just to be seen.
Family Domestic Violence	• It needs to be a safe place for women to find support safely and without the community knowing (through the grapevine), this can be really dangerous. • There also needs to be some realisation that some of our men are victims of violence in their homes too.
Justice	• A lot of Aboriginal people are in a cycle in and out of prison, often needing immediate support once they are released or they will re-offend, or their mental health will decline.
General	• Mental health crisis • Drug and alcohol challenges • Family Domestic Violence

Common Threads:

1. A place to see people and yarn.

There was a real sense that there needed to be places for people to come together and connect together, the sense of 'it takes a village to raise a child', or in this case to support someone to heal. Aunty Joan talked about it being a place to 'see people' and get away from home, an opportunity to get away from loneliness and be with people.

2. Immediate need to be met.

Sometimes people will come because they have been told to go to this place, but they will have an immediate need to be met, overwhelmed by what is going on for their loved one, i.e., thoughts of suicide. In this instance, the family will not let the person out of their sight, and will need to be seen as quickly as possible or they may leave or become angry, as the need is so painful.

Innovative Threads:

1. Midland as a Gateway

A number of people talked about how Midland has always been seen as a gateway for Aboriginal people, coming to, or going from Noongar country. Some people likened this idea to the proposed service model of the service, a gateway to services to meet your needs. There was concern that with some people transient 'on' and 'off' country, how would the service maintain a link?

Theme 2: What? (What or who makes it safe for people to go there?)

- Key question: What makes it safe for people to come here?
    - What or who makes it okay?

Summary of Information: What? (What or who makes it safe for people to go there?)

A key theme here is for the service to acknowledge the traditional owners in Midland, and include this knowledge in the design and delivery of the service. People were appreciative of this workshop and having the opportunity to talk to the St John of God Social Outreach CEO openly and straight. Another key was the need to include Aboriginal people in the delivery of the service, and look to include people who know how to keep a space safe, and are calming.

Table 2 – What? (What or who makes it safe for people to go there?)

Name (Service/Individual)	Additional Information Provided
After Hours	• There is a need for a 24-Hour Support Line by 'blackfellas for blackfellas'. ○ Any kind of phone or text support might encourage people, especially men, to try the service out.
Client Feedback	• Needs to be easy to use.

Community Led	• Noongar people are 'sick' of people dictating to them.
	  ○ The wider 'hegemony' holds the power.
	  ○ Will there be an Aboriginal Manager or Practice Leader?
	• Will the service listen to the local community on what is needed?

Cultural Co-design	• The centre needs to be co-designed (looks like, etc) with us mob. • Culturally appropriate artwork, fire, bush tucker, plants. • The service needs to have a cultural audit and regular smoking ceremonies to manage any bad spirits that can be felt.
No Catchment Area	• Having no defined catchment area means if people trust the service, they will come or bring someone here.
Outside Space	• Outside space that is kin friendly with a family area. • The verandah needs to have seating, benches, real trees, prevent people from seeing in.
Practices	**One Story** • Not having to tell your story to different people over and over, as above, we chose who we want to be supported by. • A good way to share information with other services that we trust. **Choice** • Providing choice for people in who they come to see and be supported by. **Trauma Informed Practices** • Understanding trauma in the context of culture. • Understanding healing, spirituality, values, beliefs, and ideas of people. **Supportive Referral Process** • Connected to services that will support Aboriginal people. • Warm referral from Emergency Department, when needed. **Cultural Awareness in Practice** • All staff need to be committed to this and be trained in this.

	Yarning • Understanding a practice of yarning to bring people together and connect to each other, especially at the start, 'how do we trust you if you won't sit and share with us'. **Smoking Ceremonies** • Not just at the start of the service, use this to repair the environment when challenges occur for the people that access the service. Some people suggested it might need to be every week.

Safety	• Security by the community
	  ○ Older people or Elders with knowledge
	  ○ Calm presence
	  ○ People like 'Aunty Joan', they do not need to do much, their presence is enough sometimes.
	• Secure and private exit.
	• Confidentiality to avoid news travelling through the grapevine.

Self-service	• Resources we can access ourselves.
	  ○ Food, tea, coffee
	  ○ Computers
	• Flyers (accessible, not just words, non-written information)

Signage	• Signage is really important in supporting people from all backgrounds to feel welcome and safe. • The positioning of this signage needs to be considered so it promotes people to engage. • Appropriate images and stories of our ancestors that help us to remember. • Displaying healing words in languages, providing an interpreter, being careful of different dialects, being aware of all tribes and countries.

Self-service	• Resources we can access ourselves.
	  ○ Food, tea, coffee
	  ○ Computers
	  ○ Flyers (accessible, not just words, non-written information)

Staffing	• Aboriginal Triage Nurses (Male and Female) • Medication needs to be observed, we need more than GP's prescribing medication to our people, we need to look at alternative options, our ways. • Chaplain. • Noongar workers and support people, e.g., employ Elders or look for them to volunteer. • Aboriginal Health Workers and Peers. • FDV Support Workers. • Peer Workers – Aboriginal people who know what it is like. ○ People you can yarn to. • Someone to talk to about financial challenges, relationships, housing, etc. • Translation and interpreter services.
Transport	• Transport to the centre needs to be available. • Location needs to be near public transports.
Waiting Time	• Have to avoid waiting times, or have something in place for people to feel like it is safe for them to wait. • Tea and coffee are important.
Other	• Djerapin (Happy) Moort (Family) • Kin friendly, family areas. • Cultural healing blended with *whadjella* (white fella) way.

Common Threads:

1. Security by the Community

Most people felt it was important to include the knowledge and experienced of the local Aboriginal community in keeping this space safe. The inclusion or advice from Elders in keeping the space secure was a common theme. It was also suggested, having people like 'Aunty Joan' in the space, would keep people calm, even if she were just sitting in the corner doing art.

Innovative Threads:

1. Sunflowers

There was a great example of 'Sun Flowers' and native plants, so people can get a sense of staying still and not being so busy.

Theme 3: Where? (Where to from here – Health Journey Connections)

- Key question: How can we get others to support you on your journey?
    - Who is best to support you?

Summary of Key Insights: Where to from here – Health Journey Connections

Most of these services have been picked up in earlier workshops, however, there are some new additions and the case for the inclusion of Aboriginal people in the team is much stronger.

Table 5 - Mindful of the Gap

Service/Suggestion	Further Information
Aboriginal Legal Service	Legal support and advocacy.
Allawah Grove	Aboriginal hostel.
Anawim/Kambarang Refuge	Women's refuge delivered by Ruah Community Services.
Arche Health	Aboriginal health program, in-focus mental health support.
Centrecare	Parenting and child development.
Coolabaroo Housing Services	Housing
Derbarl Yerrigan Health Services	Aboriginal health services.
Dreambuilders	Welfare services
Entrypoint	Referral service for accommodation.
Indigo Junction	Homeless services, Strong Fathers Men's Group, Karnany Resource Centre.
Mercycare	Housing
Midlas	Financial counselling, tenancy advocacy, disability advocacy, limited legal service, etc.
Moorditj Koort	Aboriginal allied health support
Naala Djookan Healing Centre	Access to family and domestic violence and trauma with informed therapeutic services through a range of integrated and evidence-based services in one safe, inclusive, culturally responsive, and welcoming location.
Noongar Outreach	After hours outreach service for homeless people.
Orange Sky	Mobile laundry and shower services
People Who Care	Aboriginal and Torres Strait Islander programs
Ruah Community Services	Choices' mental health peer program in hospitals.
Salvation Army	Harry Hunter AOD rehabilitation
St Bart's	Homeless Accommodation.
Staffing	Aboriginal health workers, social workers, welfare workers, liaison officers, nurses, clinical psychologist, and Elders as volunteers. All staff need great cultural knowledge.
Southwest Aboriginal Land and Sea Council	Advocacy and empowerment of Noongar people and culture.
We the People	Midland based advocacy
Wungening Aboriginal Corporation	AOD Outreach
Yorgum	Counselling for men and women, transport provided, support groups, sharing stories and histories
Other	Healing trips on country for men and women
	Locate a Prisoner Service
	Community advocacy for our people (our mob) in this area
	Aboriginal Pastor
	Young men need support with men's business, need mentors from the community.

	Flags displayed out front to welcome people in, let them know this is a place for them.
	Referrals to halfway houses.
Process or Practice	Know me so I do not have to repeat my story
	Simple referral system to support access to services
	Build strong networks to increase access to service that will support us.

Theme 4: Location

- Key question: Who can advise us?
    - What do you think of this location?
    - What is important here?

Summary of Key Insights: Location

The potential location of the service was discussed with the participants. This part of the workshop was an open discussion with the CEO of SJGSO. At the end of the discussion the participants all agreed that this location has a lot of strengths and if the provider takes on board some of the key suggestions it could be a real success.

Table 6 - Location

Theme	Suggestion
Authenticity	• Do not provide token or replacement options for things that have cultural meaning.
Cultural Connection	• There is some connection and knowledge in this site or building, Aboriginal people have worked there and go there for services.
Cultural Design	• You have to have Whadjuk Noongar people the whole way through the process – not just at the end.
Frontage	• The current street front is not right, it does not allow private entry and exit.
Imagery	• There will be sunflowers somewhere, images to help us all slow down a bit.
Kitchen	• Need to have a kitchen to feed people.
Location	• This location is already part of the community, you will be in a place that is already part of the community.
Maximize Place in the Community	• Library – Work with the City of Swan to use the library as an extension space.
Safety	• Has to be safe.

Space	• Ensure the spaces are open and not enclosed.
	• There would be a lot of shame and stigma.
	• Being located next door to the Department of Housing is not ideal.
	• Some sort of corrugated iron or other fence to provide light but maintain privacy, an example was given of the walkway outside of Optus Stadium, where there are iron leaves.
	• Being located next door to the Department of Housing is not ideal.
	• Being located across from a tavern is not ideal, however: noted by participants that:
	  ○ Provided good meals.
	  ○ Family friendly
	  ○ Supports community groups by providing access to function area i.e., Binar Sports

Common Threads:

1. Imagery from Ancestors and History

Including Aboriginal art, but not just any, being aware of what may be triggering or harmful to people. Instead, include images of Aboriginal people and their ancestors to remind them of happy and good times.

Innovative Threads:

1. 'If you provide fake things… you will get fake people'.

One of the real take-aways from this discussion was the need to be genuine in what is offered to support the Aboriginal community, and also the need for the provider to be informed by the local Whadjuk Noongar community, before, during, and after the lease and design of the building occurs.

There were two standout comments that will serve as a reminder to be genuine and authentic.

- 'we want to feel the fire…' In a discussion about having a fire at the service, it was said, strongly, there is no point having a fake fire, if you are going to have one, it needs to be real, people need to be able to feel it.
- 'If you provide fake things… you will get fake people…', a follow-on point from a participant following the fire discussion, a reminder that people need this service to be real and genuine in the relationship.

Common Threads

Each workshop report highlighted 'Common Threads' that seemed to be prevalent across multiple groups of participants, implying a shared consensus. The below is a list of all of these threads highlighted in each of the reports. These threads are all listed against their individual themes in the workshop summaries earlier in this report, however the below they are listed collectively.

1. Non-hospital/Clinical Environment

People do not want the AMHC to look like, sound like, feel like, or smell like a hospital environment.

2. Customer Service Approach - Welcome vs Assessing Eligibility

Welcoming people to the service and being curious about how they can be supported instead of whether they are eligibility.

3. Wait Lists and Wait Times

Avoid unnecessary waitlists, or at the very least set realistic expectations from the start, e.g., offer support with immediate needs, support access to other services. Also, respect peoples' time, do not have people waiting when they have arrived on time for an appointment.

4. Stigma

Using positive communication strategies to promote the service and the opportunities it provides to the whole community. Looking at each cohort and learning with them on how to reduce stigma prior to access, during access, and after they have accessed the service, i.e., people often do not return due to ruminations on shame. By working with people to prepare for these feelings this may reduce the failure to return.

5. Safety/Fear

As with stigma, people need to feel culturally, emotionally, physically, and mentally safe before, during, and after they access this service. Ensure rights of individuals are maintained, in terms of confidentiality and privacy, and any fear of conflict of interest with family members is addressed.

6. Access

Locating the service close to public transport, offering opportunities for people to access via brokerage for Smart Riders from Transperth, or parking vouchers via the City of Swan.

7. Language

Creating a style guide for language within the service to be accessible and non-medical. Removing jargon and acronyms from use, and getting creative about new ways to communicate to diverse groups.

8. Training:

Core training for staff and service providers in Recovery Oriented Practice, Trauma Informed Practice, Cultural Awareness, LGBTQIA+ Training, and Supporting Co-occurring Challenges.

9. Manager:

The manager was seen as a values driven position, not necessarily clinical, with knowledge of the recovery, trauma, diversity, and inclusive practices, as well as a commitment to genuine partnership with staff and customers.

10. Diversity of Peers:

There was an understanding of the diversity of peer roles and what genuine commitment to peer support can bring to this space.

11. Strength in Culture:

It was acknowledged at almost every table that culture needed to be at the centre or heart of everything at the AMHC. Not just in tokenistic employment, but in the holistic application of the model. There was some discussion on the significance of Midland to the Noongar community.

12. Clinical Roles – Psychology and General Practice

There was a general sense that these roles were not embedded but ones that were brought in on a needs basis.

13. Foundational Practice

All staff to have a foundation in values drive practice, recovery-oriented practice, trauma informed practice, cultural awareness, and LGBTQIA+ practice.

14. Formal Agreements

As expected, most people talked to the need to have formalized agreements, including; Service Level Agreements and Memorandums of Understanding. Accountability was a key theme in these discussions.

15. Co-occurring Challenges

There was a lot of compassion for the experience of people who are active in the AOD use but need holistic support, especially with their mental health. It would appear a culture of acceptance is needed in order to connect and sustain treatment with this cohort.

16. Specialist Knowledge

For all target groups, there was a sense that there needs to be specialist knowledge within the team or a specialist response, prioritising a need for genuine empathy and understanding of diverse experiences, e.g., mental health, prison release, AOD, LGBTQIA+, older adult mental health, etc.

17. Non-hospital/Clinical Environment

Many references were made to a 'cottage' or 'homely' feel, without any feel of a hospital, smell seemed very important, smiling, and welcoming faces too.

18. Listening

There seemed to be a palpable feeling from some in relation to the need to be listened to, and feel listened to, especially in the case where it is supporting a vulnerable loved one. A service like this, needs to sense where people are at, and work with them to take the next step forward. There were a number of people who shared the sense of desperation when supporting a loved one close to suicide. This skill goes beyond listening, it feels like receiving.

19. Welcome

This group of people were acutely aware of what it feels like in an unsafe environment, such as that experienced in an emergency department setting, or mental health ward. Many people expressed the need to feel real balance of power in the service, for someone to feel like they could go there, take time to settle in, and work with the team to find what they need. Simple things were important, like a cup of tea being offered, engaging resources while you wait (not just old magazines). An authentic peer approach seems vital here.

20. Working with the person

Genuine partnership with people and treating people with humanity seemed to be common across participants, ensuring power is shared, otherwise why would people want to come back if they feel invalidated or controlled.

- Deliberative democracy was raised as a way of balancing power.

21. Demonstrated Inclusion

The employment of a diverse group of peer workers would seem to be an opportunity to promote inclusion, as does the simple display of inclusion through flags, posters, language, accessible spaces, etc.

22. Waiting

As with participants in workshop 1, having empathy for the experience of people waiting is important to people. One participant described as a feeling of powerlessness, as you sit and wait for someone to provide a service, instead of valuing your time, and the emotional energy it takes to come for support, for you or a loved one.

23. One Person or Navigator:

Where possible, one person or a familiar face should follow the customer on their short journey through the AMHC to longer term supports.

24. Collaborative Relationships and Service Mapping

This service is going to need strong relationships with providers within the community to make kind referrals happen. To do this well there needs to be a mapping and gapping exercise of the 'Kind' and responsive pathways vs. the 'Unkind' and unresponsive. Also, professional networking between staff and these referral partners is seen as an opportunity.

25. Avoiding Rejection (in service and in referral)

People should receive the care they came for at the AMHC (within scope), or at least leave with some sense that it has been worthwhile. Referrals outward should have reduced risk of rejection, i.e., check the service the person is being referred to has availability.

26. Simple Things – Doing the simple things well

- Access: Reduce barriers, ensure the person can get to the service on an ongoing basis, e.g., explore online or telehealth options, travel and transport options, place-based responses.
- Patience: Allow the person time to process how they would like to engage, e.g., ask them what they would like, and if they are ready proceed, but reassure them if they are not, you will be ready when they are.
- Security: Support people to trust they can move forward because they know they can come back to AMHC for more support if needed.
- Follow Up: Participants really supported the feeling of being cared for that came from their case manager checking-in to see how they went with an appointment.

27. Floating Staff

There were a lot of references to staff floating across all care pathways, having competency to work throughout.

28. Floating Staff Suggestions:

- GP – To meet needs across all paths, provide assessment and treatment, and connect back to general practice.
- Peer Worker – To meet people at the point of presentation and explore options that have worked for them, provide comfort, provide examples of strategies etc.
- Mental Health Nurse – Triage, assessment, care coordination, and on-call as need arises.
- Support or Crisis Intervention Officer – Connecting people from the Emergency Department.
- AOD Worker – High level of presentations, likely to be needed at all points.
- Aboriginal Engagement Officer – Supporting culture, people can see that there is someone they can talk to in 'their way'.
- Family Support – Carers and family often go unseen; they may not be aware of their needs or what supports are available.
- Psychologist – Providing brief interventions and supports at key points, supporting staff understanding and action.

29. Focus on Care Navigation

Simply by looking at the feedback generated, there was a lot of focus on the idea of the care navigation pathway, it seems like, this is about getting it right from the start.

30. A place to see people and yarn.

There was a real sense that there needed to be places for people to come together and connect together, the sense of 'it takes a village to raise a child', or in this case to support someone to heal. Aunty Joan talked about it being a place to 'see people' and get away from home, an opportunity to get away from loneliness and be with people.

31. Immediate need to be met.

Sometimes people will come because they have been told to go to this place, but they will have an immediate need to be met, overwhelmed by what is going on for their loved one, i.e., thoughts of suicide. In this instance, the family will not let the person out of their sight, and will need to be seen as quickly as possible or they may leave or become angry, as the need is so painful.

32. Security by the Community

Most people felt it was important to include the knowledge and experienced of the local Aboriginal community in keeping this space safe. The inclusion or advice from Elders in keeping the space secure was a common theme. It was also suggested, having people like 'Aunty Joan' in the space, would keep people calm, even if she were just sitting in the corner doing art.

33. Imagery from Ancestors and History

Including Aboriginal art, but not just any, being aware of what may be triggering or harmful to people. Instead, include images of Aboriginal people and their ancestors to remind them of happy and good times.

Innovative Threads

Similar to the process of collecting 'Common Threads', there were a number of 'Innovative Threads' that seemed to stand out and deserve some extra attention, opportunity to try something new. These threads are all listed against their individual themes in the workshop summaries earlier in this report, however the below they are listed collectively.

1. Inclusive methods of data collection

It may be worth exploring the Department of Communities 'No Wrong Door Approach Co-design'[8] and discussions relating to data transfer.

- This seems to be an opportunity to potentially use new technology or be creative in how to capture the data of participants.
- It could lead to an innovative way of preventing the re-telling of challenging stories and challenges for the customer, as well as a 'warm' continuity of care pathway from one service to the next.

2. Connecting with people while they wait, rather than waiting to be seen/processed/triaged, etc.

There is plenty of information supporting the idea of peer support in clinical settings, for instance, Mental Health America Peer Support: Research and Reports[9], often the focus of this support starts upon admission to service or 'in service'. The idea of supporting people while they wait, means that navigation of supports, even via telehealth methods, starts when people come through the door or connect for the first time. It is a simple innovation with potential to address many of the barriers outlined in Theme 2, and prevent challenging behaviours.

3. Naming

There was an underlying discussion about how the name of the centre could present as a significant barrier, there was a feeling that including 'Adult' or 'Mental Health' in the title would not work for a large amount of the target cohort.

4. Elders in the service

Referred to as 'Elders in residence', perhaps that is not appropriate, but there may be an opportunity to include Elders in how services are delivered to all people, for example, monthly morning tea or yarning circle.

5. Hello Cass[10]

The Hello Cass service is a chatbot that supports people experiencing family domestic violence to have access to information and support that is localised. Perhaps, this model of service could be an opportunity to promote access to the AMHC, where people hesitant about access can message a chatbot and receive support and encouragement to attend.

[8] https://www.communities.wa.gov.au/strategies/homelessness-strategy/no-wrong-door-approach-co-design/
[9] https://www.mhanational.org/peer-support-research-and-reports
[10] https://hellocass.com.au/

6. *LGBTQIA+:*

It is important to highlight the apparent lack of participation in this workshop from leading services and advocates from the LGBTIQIA+ community. There may be a better way of reaching this group, e.g., through an online meet-up.

7. *Care Coordination*

This role seems like something that could cover a multitude of functions, someone who knows how to navigate the system, and bring in the 'right people at the right time'.

8. *Co-production – Shared Care with Integrity*

The opportunity to embed principles of co-production in how the AMHC is delivered was raised by a representative of Mental Health Matters 2, and other health advocate participants. It seems this method would support the idea of a 'Shared Care' arrangement with real integrity from the start.

The co-production principles[11] discussed were:

- Recognising people as assets.
- Building on people's capabilities.
- Developing two-way reciprocal relationships.
- Encouraging peer support networks.
- Blurring boundaries between delivering and receiving services.
- Facilitating not delivering to.

9. *Good Technology*

Be innovative about the use of smart technology to support the idea of only having to tell your story once. Look at new health apps, trial something different. The use of telehealth and 'e-health' methods also seemed popular.

10. *No Diagnosis or One Diagnosis*

Not making assumptions on first contact, no labels.

11. *Congruence*

Drawing from Rogerian thinking, unconditional positive regard, words match your actions, and your actions match your words.

This seemed to match with ensuring authentic and robust governance structures, that are practiced and visible, and informed by consumer feedback.

12. *Managing Closure Times*

How do you manage presentations prior to closing time? This seems like a key issue, for the people who attend in need of service, and for the staff who may have to turn someone away. It seems like communication needs to be clear on the scope of the service and the hours of operation, through multiple sources, including the after-hours phone message.

[11] https://www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/co-production/In-more-detail/what-is-co-production/

13. Lived Experience Support Groups

There is a plethora of lived experience support groups available, however accessing these groups is often through peer-to-peer referral. Customers would benefit from a kind referral process to these support groups.

14. Volunteer Drivers

Transport needs to and from referrals is a common thread, a pool of volunteer drivers has been suggested as a possible solution.

15. One Stop Shop

Where possible try to make connection points 'come to' the AMHC rather than the customer 'go to' referral points. Start with the point of view of meeting the needs of the customer through the AMHC, then think about referrals.

16. Communication Stickers

One suggestion seemed like a 'do not disturb' sign in a hotel, the participant suggested supplying people with stickers if they need time to process before being engaged with, e.g. 'I am not ready to talk yet'.

17. Concierge

This was mentioned at least 20 times. The concept of having someone who can think on their feet, welcoming people effectively, but also functioning in a triage role. One comment said this role would need a strong connection with clinical support, also would need to be valued and validated by this support.

18. Midland as a Gateway

A number of people talked about how Midland has always been seen as a gateway for Aboriginal people, coming to, or going from Noongar country. Some people likened this idea to the proposed service model of the service, a gateway to services to meet your needs. There was concern that with some people transient 'on' and 'off' country, how would the service maintain a link?

19. Sunflowers

There was a great example of 'Sun Flowers' and native plants, so people can get a sense of staying still and not being so busy.

20. 'If you provide fake things… you will get fake people'.

One of the real take-aways from this discussion was the need to be genuine in what is offered to support the Aboriginal community, and also the need for the provider to be informed by the local Whadjuk Noongar community, before, during, and after the lease and design of the building occurs.

There were two standout comments that will serve as a reminder to be genuine and authentic.

- 'we want to feel the fire…' In a discussion about having a fire at the service, it was said, strongly, there is no point having a fake fire, if you are going to have one, it needs to be real, people need to be able to feel it.

'If you provide fake things… you will get fake people…', a follow-on point from a participant following the fire discussion, a reminder that people need this service to be real and genuine in the relationship.

Parking

In order to support participants to feel confident to ask questions, as well as to ensure participants received considered and accurate responses, the decision was taken to include 'Parking Lots' at each of the four workshops.

As expected, in the early stages of engagement, Workshops 1 and 2, the 'Parking Lot' was used heavily, while only one response, from Workshop 3, was received in the subsequent workshops.

All questions and/or statements from the first two workshops received a response from the St John of God and WAPHA, these were published on the WAPHA website. The item from workshop 3, was an interesting idea about bringing services and supports in on a regular basis to deliver a fair or forum for people to see what they have to offer. This was noted and included in the report for that workshop.

The Parking Lot(s) are available to view through WAPHA's Primary Health Exchange at the below URL:

https://phexchange.wapha.org.au/amhc

Recommendations

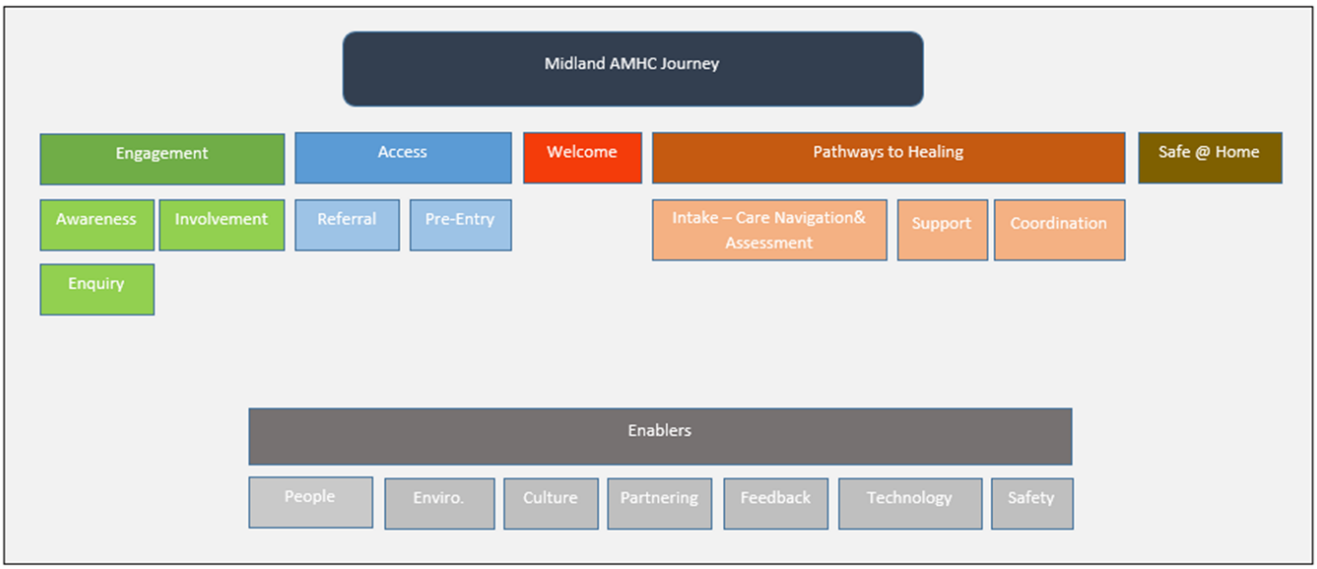
The recommendations from this primary phase of co-design are framed from the point of view of an expected journey of services offered through different points of interaction with the AMHC. Consistent themes have emerged throughout the process, and the ones we feel best represent the information gathered are:

- Engagement (Awareness, Involvement, Enquiry)
- Access (Referral, Pre-Entry)
- Welcome
- Pathways to Healing (Intake, Care Navigation and Assessment, Support, Coordination)
- Safe @ Home

Allied to these themes, there was a large volume of information relating to what would enable success, we have categorized these under Enablers. The key enablers identified are:

- People
- Environment
- Culture
- Partnering
- Feedback
- Technology
- Safety

Figure 2: Midland AMHC Journey



Phases :

Establishment Phase: Phase leading up to the opening of the centre.

Embedding Phase: After opening of the service and commencement of service delivery.

Table 7: Recommendations from the primary phase of co-design

Theme	What you said	Recommendation	Time Frame
Awareness	• There was an underlying discussion about how the name of the centre could present as a significant barrier, there was a feeling that including 'Adult' or 'Mental Health' in the title would not work for a large amount of the target cohort.		Establishment Phase
Awareness	• Strong communication – what the centre is not and what it is. • What to expect. Clear guidelines on rights and responsibilities. • Up to date service information. • Regular audit of pamphlets and resource sheets.	• Develop clear communication to referrers on referral criteria to the centre. • Service website articulates what the service does. • Develop a client brochure which includes rights and responsibilities	Establishment Phase
Engagement	• A number of people talked about how Midland has always been seen as a gateway for Aboriginal people, coming to, or going from Noongar country. Some people likened this idea to the proposed service model of the service, a gateway to services to meet your needs. There was concern that with some people transient 'on' and 'off' country, how would the service maintain a link.		Establishment Phase
Engagement - Involvement	• Most people felt it was important to include the knowledge and experienced of the local Aboriginal community in keeping this space safe. The inclusion or advice from Elders in keeping the space secure was a common theme. • It was also suggested, having people like 'Aunty Joan' in the space, would keep people calm, even if she were just sitting in the corner doing art - Elders in service.	• Need to be genuine in what is offered to support the Aboriginal community, and also the need for the provider to be informed by the local Whadjuk Noongar community, before, during, and after the lease and design of the building occurs.	Establishment Phase

Access - Pre-entry	• Proactive support for people with a disability such as calling before appointments.		Embedding Phase
Access	• Locating the service close to public transport, offering opportunities for people to access via brokerage for Smart Riders from Transperth, or parking vouchers via the City of Swan. • Volunteer drivers. • Acrod Parking.	• Facility should be close to public transport. • Facility must be fully accessible for people with disabilities. • Facility should consider transport options for those unable to access the centre. • Facility should include access to parking for clients.	Establishment Phase Establishment Phase
Access - referral	• Clear and simple referral pathways into AHMC.	• There should be two main entrance points to the AMHC – direct contact, either in person or online, and by a referral from a service provider.	Establishment Phase
Access	• 24-hour support line for aboriginal men by aboriginal men.	• Investigate phone support for Indigenous males.	Establishment Phase
Welcome	• Meet immediate needs before treatment. • Safety, food, shower, and clothing.	• Facility should include kitchen facilities, toilet with shower. • Provide clothes washing.	Establishment Phase Embedding Phase
Welcome	• People likely to be unable to attend without children. Suggestions of parent rooms, or childcare. • Be inclusive of supports such as pets, friends, and carers.	• Support and advice for families, friends, and carers to assist them in their role, and acknowledge their	Embedding Phase

	• Families and Carers are seen and heard, treated with dignity and respect, asked if they would like support for themselves.	social and emotional support needs. • Facility must have a warm/friendly feel catering for all ages and abilities. • Space for small children to play safely with parental supervision to enable parents/carers to meet / seek assistance from AMHC workers.	Establishment Phase
Welcome	• Welcoming people to the service and being curious about how they can be supported rather than eligibility. • Emotional and psychology safety first before asking for details.	• Centres will welcome adults experiencing emotional distress, crises, mental ill health, and/or addiction, and their families and carers through a 'no wrong door' approach that is consistent with the Mental Health Statement of Rights and Responsibilities.	Embedding Phase
Welcome	• Concierge • This was mentioned at least 20 times. The concept of having someone who can think on their feet, welcoming people effectively, but also functioning in a triage role. One comment said this role would need a strong connection with clinical support, also would need to be valued and validated by this support. • Connect with people whilst they wait.	• Front of house function where people can seek information and assistance navigating services. • Welcoming staff.	Embedding Phase
Welcome	• This group of people were acutely aware of what it feels like in an unsafe environment, such as that experienced in an emergency department setting, or mental health ward. Many people expressed the need to feel real balance of power in the service, for someone to feel like they could go	• Provide a peer approach to complement clinical service delivery	Embedding Phase

	there, take time to settle in, and work with the team to find what they need. • Simple things were important, like a cup of tea being offered, engaging resources while you wait (not just old magazines). An authentic peer approach seems vital here.		
Welcome	• Rainbow accreditation, • Strong welcome, • Seek advice from LGBQTIA services.	• Ensure that the LGBTQIA+ Community have the opportunity to engage in the establishment phase and provide feedback on service design and their requirements. • Investigate Rainbow Accreditation during the embedding phase.	Establishment Phase Embedding Phase
Pathways to healing	• Avoid unnecessary wait times, set realistic expectations from the start, respect people's times. • Open ended appointment times with a non-punitive approach to non-attendance.	• Develop procedures to minimise long waiting times in the centre.	Establishment phase
Pathways to healing	• Care coordination - This role seems like something that could cover a multitude of functions, someone who knows how to navigate the system, and bring in the 'right people at the right time' • Other models of care have worked well when using a 'Care Coordination' role, someone with the knowledge and ability to navigate complex services and systems with the customer. • Simply by looking at the feedback generated, there was a lot of focus on the idea of the care navigation pathway, it seems like, this is about getting it right from the start.	• The assessment and referral process will determine the level of service a person requires, and care to be provided. • A "front-of-house" function where people can seek information and assistance navigating services. • Provide a central point to connect people to other services in the region, including through offering information and advice about mental health and AOD use, service navigation and warm referral pathways for individuals.	Embedding Phase

	• There seemed to be a palpable feeling from some in relation to the need to be listened to, and feel listened to, especially in the case where it is supporting a vulnerable loved one. A service like this, needs to sense where people are at, and work with them to take the next step forward. There were a number of people who shared the sense of desperation when supporting a loved one close to suicide. This skill goes beyond listening, it feels like receiving.	• The centre should provide support and advice for families, friends, and carers to assist them in their role, and acknowledge their social and emotional support needs. • The centre should direct clients to specialised suicide prevention and suicidal aftercare services follow-up services.	Embedding Phase Embedding Phase
Pathways to healing	• Provide sensory responses like a sensory room, weighted blankets, soft stress balls, aroma, and lighting. • Colouring books, mindfulness apps in waiting rooms.	• Provide support for people with sensitive needs waiting in the centre.	Embedding Phase
Pathways to healing	• People should receive the care they came for at the AMHC (within scope), or at least leave with some sense that it has been worthwhile. • Referrals outward should have reduced risk of rejection, i.e., check the service the person is being referred to has availability.	• MOU/partnership agreements must be developed with key local referrers and service providers to enable an integrated/collaborative model of care for people who require a warm transfer from one service to another. • Clinician will support client to access recommended services (provision of care coordination), this may include telephone or video introduction/referral, and in some cases arrange support to client to physically attend appointments.	Establishment Phase

Pathways to healing	• Follow Up: Participants really supported the feeling of being cared for that came from their case manager checking-in to see how they went with an appointment.	• Following assessment and referral, the clinician is to follow-up with client and provide ongoing support until a transfer has occurred and be point of contact if needed.	Embedding Phase
Pathways to healing	• Patience - Allow the person time to process how they would like to engage, e.g., ask them what they would like, and if they are ready proceed, but reassure them if they are not, you will be ready when they are.		Embedding Phase
Pathways to healing	• Where possible, one person or a familiar face should follow the customer on their short journey through the AMHC to longer term supports. • Same person but specialist at assessment and triage. • No handballing.	• Clients should not be required to go through two stages of assessment, nor tell their story more than once within the AMHC.	Embedding Phase
Pathways to healing	• Therapeutic and non-therapeutic groups, focused on connection and engagement. • Guests from local community sport or social clubs to help people connect. • A place where our mob can yarn, a meeting place for our mob going through a tough time. • Groups and activities for the elderly.	• Connection to peer-led services such as peer networks, support groups, or phone lines. • Connection to group programs as a means of building social supports.	Embedding Phase
Pathways to Healing	• Homelessness is an issue. We might need crisis beds or somewhere safe to stay. • Create awareness among new funded housing first homeless initiative services and other homeless services.	• The assessment process should consider non-health factors which would both impact and be impacted by distress levels including a lack of adequate, stable safe housing. • Ensure agreements with local housing providers.	Embedding Phase Establishment phase

People	• Clinical roles – psychology and GP - There was a general sense that these roles were not embedded but ones that were brought in on a need's basis. • Social worker and OT. • FDV support workers • Someone to talk to about financial challenges, relationships, and housing. • Nurse Practitioner to engage with GP's. • LGBTQIA informed staff or peers with lived experience, all staff complete training • Social psychiatrist	• Establish partnership with GP provider.	Establishment Phase n/a
People	• All staff to have a foundation in values drive practice, recovery-oriented practice, trauma informed practice, cultural awareness, and LGBTQIA+ practice.	• Core training for staff and service providers in Recovery Oriented Practice, Trauma Informed Practice, Cultural Awareness, LGBTQIA+ Training, and Supporting Co-occurring Challenges	Establishment Phase
People	• The manager was seen as a values driven position, not necessarily clinical, with knowledge of the recovery, trauma, diversity, and inclusive practices, as well as a commitment to genuine partnership with staff and customers. • Lived experience.		Establishment Phase N/A
People	• Security to be non-uniformed and blended in • Staff badges, offering pro-nouns. • Staff photos identifying who they are and who is on duty.		Establishment Phase
People	• The employment of a diverse group of peer workers would seem to be an opportunity to promote inclusion, as does the simple display of inclusion through flags, posters, language, accessible spaces, etc. • There was an understanding of the diversity of peer roles and what		Embedding Phase

	genuine commitment to peer support can bring to this space. • Intentional peer work - recruit people with professional base in peer work. Lived experience is not enough. • Someone who older people can identify with, understands their needs as well as knowledge of navigating challenges faced by Older people. • Respite for carers of older persons.		
People	• There was a lot of compassion for the experience of people who are active in the AOD use but need holistic support, especially with their mental health. It would appear a culture of acceptance is needed in order to connect and sustain treatment with this cohort. • Ability to detox rehab or support even if they are actively using drugs or alcohol; how will the service support someone who is intoxicated or high. • AOD worker required, competency to support dual needs. Engage with AOD services. • Timeouts, if necessary, with the opportunity to learn and not just ban.	• Where substance use if a component of a presentation, must have professionals with competency in identifying and managing substance misuse issues. • Identify individuals experiencing heightened distress who are intoxicated or under the influence of licit or illicit drugs, and swiftly decide whether their needs can be appropriately and safely met at the AMHC.	Embedding Phase
People	• For all target groups, there was a sense that there needs to be specialist knowledge within the team or a specialist response, prioritising a need for genuine empathy and understanding of diverse experiences, e.g. mental health, prison release, AOD, LGBTQIA+, older adult mental health, etc. • Matching clients and professionals • Trained hearing or sight impaired staff, with time to sit and explore customer needs compassionately and effectively.		Embedding Phase

	• Disability services lead. Employ people with a disability. • Support or Crisis intervention to connect people from ED.		
People	• There were a lot of references to staff floating across all care pathways, having competency to work throughout.		Embedding Phase
People	• Aboriginal engagement officer to support culture. • Aboriginal Triage – male/female. • Aboriginal peer workers. • Aboriginal person as manager.	• Culturally safe services for Aboriginal and Torres Strait Islander people.	Embedding Phase
Environment	• Do not want the AMHC to look like, sound like feel like or smell like a hospital environment. • Different waiting spaces, no desks, soft chairs, open spaces, multi-purpose zones, no rejection signs. • Quiet spaces. • Drop in spaces where you can have tea or coffee and use computers. • Yarning spaces. • Outdoor space. Open and not closed. Fence for privacy but let light in, e.g., Walkway at Optus.	• Centre must provide computers on site and assistance accessing a range of digital information and mental health services. • Facility should have access to an outdoor area that is informal and could be used for 'yarning'.	Establishment Phase
Environment	• Including Aboriginal art, but not just any, being aware of what may be triggering or harmful to people. • Instead, include images of Aboriginal people and their ancestors to remind them of happy and good times. • Art with images of historical midland.	• Facility must have a welcoming environment for Aboriginal people, which includes information on place, history, and culture.	Establishment Phase
Environment	• 'we want to feel the fire…' In a discussion about having a fire at the service, it was said, strongly, there is no point having a fake fire, if you are going to have one, it needs to be real, people need to be able to feel it.		Establishment Phase
Culture - Language	• Creating a style guide for language within the service to be accessible and non-medical. Removing jargon and acronyms from use, and getting	• Centres must be safe and inclusive to all who present, including members of LGBTI communities and	Embedding Phase

	creative about new ways to communicate to diverse groups. • Use of other language than mental health. • How can I help rather than what is wrong? • Translator and interpreter services • Inclusive methods of data transfer, find ways to include people in data collection instead of excluding due to literacy e.g., pictures. • Inclusive messaging and signage for LGBTQIA. • World languages in welcome messages. • Healing languages. • Reduce stigma.	people from Culturally and Linguistically Diverse (CALD) backgrounds. • Centres should be promoted as supporting people at times of crisis and distress, and not in terms of language of mental illness.	
Culture	• Genuine partnership with people and treating people with humanity seemed to be common across participants, ensuring power is shared, otherwise why would people want to come back if they feel invalidated or controlled.		
Culture	• There was a great example of 'Sun Flowers' and native plants, so people can get a sense of staying still and not being so busy.	• Investigate the use of native plants in courtyard area	Establishment Phase
Culture	• It was acknowledged at almost every table that culture needed to be at the centre or heart of everything at the AMHC. Not just in tokenistic employment, but in the holistic application of the model. There was some discussion on the significance of Midland to the Noongar community.	• Centres must adhere to the principles of the Gayaa Dhuwi (Proud Spirit) Declaration in the development and delivery of services to ensure culturally safe services for Aboriginal and Torres Strait Islander people are included as part of the broader model.	Embedding Phase
Partnerships	• This service is going to need strong relationships with providers within the community to make kind referrals happen.	• A large volume of providers and support agencies were identified. It is	Establishment Phase

	• To do this well there needs to be a mapping and gapping exercise of the 'Kind' and responsive pathways vs. the 'Unkind' and unresponsive. • Also, professional networking between staff and these referral partners is seen as an opportunity. • Colocation as much as possible was suggested. • Warm referrals supported by peers. • Service Connection in real time • Know the person you are referring them to. Calling services with the client. Ensuring the client knows the service is welcoming to them. • Single shared care plan.	recommended that the centre develop a catalogue of these for caregivers to use, and clients to browse. • Establishment of a Stakeholder Reference Group to support the establishment and integrated service delivery. • Map of available services to ensure the core functions are provided in a way which makes the best use of available resources and avoids regional duplication.	
Partnerships	• Most people talked to the need to have formalized agreements, including; Service Level Agreements and Memorandums of Understanding. Accountability was a key theme in these discussions. • Proper interagency meetings to support handover of customer. • Add value to existing service providers and do not add to their existing pressures.	• Development of robust service level agreements with all providers and clear protocols. • MOU's/partnership agreements with key local referrers and service providers. • Agreements with service providers who will be providing a brokerage service.	Establishment Phase
Partnerships	• Work with City of Swan to use the library as an extension space.	• Discuss opportunities with City of Swan.	Establishment Committee
Partnerships	• Create awareness and connections to the local prisons in the area and the services support people to transition to the community. Families and carers supported and validated by the team. • This could be an existing service in-reaching when needed, or ensuring someone in the team was nominated, resourced and skilled to manage people coming out of		

	prison with a welcoming and respectful approach. • A lot of Aboriginal people are in a cycle in and out of prison, often needing immediate support once they are released or they will re-offend, or their mental health will decline.		
Feedback	• Clear and safe methods to provide compliments, complaints, and suggestions in an inclusive way. • Options to change worker if there is an issue or lack of connection.	• Development of a comprehensive safety & quality framework that includes feedback and complaints.	Establishment Phase
Technology	• Be innovative about the use of smart technology to support the idea of only having to tell your story once. Look at new health apps, trial something different. • The use of telehealth and 'e-health' methods also seemed popular. • Secure consented messaging systems. • Shared systems like Psolis. • Some sort of information passport – not telling story twice. • The Hello Cass service is a chatbot that supports people experiencing family domestic violence to have access to information and support that is localised. Perhaps, this model of service could be an opportunity to promote access to the AMHC, where people hesitant about access can message a chatbot and receive support and encouragement to attend. • Phone /text support would help people to try our service, especially men.	• Investigate the use of apps. • Investigate how information can be securely shared with other service providers. • Develop governance protocols for information sharing between service providers. • Consider the use of the My Health Record to facilitate communication and coordination between health providers. • The AMHC will support clients in accessing digital mental health services. • Investigate whether it is possible to access the AMHC through online sites.	Establishment Phase N/A Establishment Phase
Pathways to healing	• There is a plethora of lived experience support groups available, however accessing these groups is often through peer-to-peer referral. • Customers would benefit from a kind referral process to these support groups.	• Establish a map of all support groups available and ensure that this information is available electronically for all to access.	Establishment Phase

	• Explore social and community options e.g., lived experience support groups on FB.		
Pathways to healing	• Where possible try to make connection points 'come to' the AMHC rather than the customer 'go to' referral points. • Start with the point of view of meeting the needs of the customer through the AMHC, then think about referrals.	• Co-location where possible.	Establishment Phase
Pathways to healing	• One suggestion seemed like a 'do not disturb' sign in a hotel, the participant suggested supplying people with stickers if they need time to process before being engaged with, e.g. 'I am not ready to talk yet'.		Establishment Phase
Enabler - Safety	• People need to feel culturally, emotionally, physically, and mentally safe before, during, and after they access this service. • Ensure rights of individuals are maintained, in terms of confidentiality and privacy, and any fear of conflict of interest with family members is addressed. • Alternative entrances and exits for Family Domestic Violence.	• The centre is to have a separate entry and exit. • The centre must comply with the Australian Privacy Principles and Notifiable Data Breaches scheme.	Embedding Phase