Adult Mental Health Centre Consultation

Northern Territory Lived Experience Network

August 2020

Experts by Experience

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Executive Summary

As part of the 2019-20 Budget, the Australian Government announced it would invest $114.5 million over five years to undertake a trial of eight Adult Mental Health Centres (Centres), with one to be established in each state and territory. Through the 2019 Mid-Year Economic and Fiscal Outlook process, funding was brought forward to enable the South Australian Centre to be established mid-2020, and to enable the remaining seven Centres to be established from 2020-21, with service delivery to commence in 2021-22.

To support this process in July 2020, the Australian Government undertook a national consultation regarding the proposed service model for the Centres. The resulting consultation paper described four core elements of the proposed service model:

1. Provide a central point to connect people to other services in the region, including through offering information and advice about mental health and alcohol and other drug (AOD) use, service navigation and warm referral pathways for individuals, their carers and families.
2. Provide in-house assessment, including information and support to access services.
3. Provide evidence-based and evidence-informed immediate, and short to medium term episodes of care, including use of digital mental health platforms.
4. Respond to people experiencing a crisis or in significant distress, including people at heightened risk of suicide, providing support that may reduce the need for emergency department (ED) attendance.

In response to the national consultation, the Northern Territory Lived Experience Network (NTLEN) convened a Lived Experience consultation in Darwin on the 23rd of July 2020. The purpose of the Darwin consultation was to inform the Australian Government, Northern Territory Government and Northern Territory Primary Health Network (NTPHN) about the establishment of the NT Adult Mental Health Centre in the Greater Darwin region.

The Darwin Lived Experience Consultation report includes:

1. An introduction to the Northern Territory Lived Experience Network.
2. An overview of the mental health and suicide prevention needs in the Northern Territory and where available, within the Greater Darwin region.
3. A description of the Darwin Lived Experience Consultation on the 23rd of July 2020.
4. A thematic analysis and discussion of the experience and perspectives of participants at the Darwin Lived Experience Consultation.

In addition to this report, the NTLEN made a submission to the Australian Government for the national consultation on the 29th of July and a two-page overview of the experiences and perspectives gathered at the Darwin Lived Experience Consultation to share with local stakeholders (refer to Attachment 1).

The overarching themes from the Darwin Lived Experience Consultation highlighted the importance of:

- The functional layout of the Centre with a physical environment that is safe, comfortable, therapeutic, and private.
- A central location for the Centre, with options for transport, 24-hour access, and broad promotion of the Centre within the community.
- Skilled and qualified staff providing a safe and person-centred service.
- Holistic and non-clinical supports delivered as part of multi-disciplinary teams.

During the Consultation, it emerged that most participants' first attempt to find and access a mental health service in the Greater Darwin region was during a time of crisis. Participants recounted help seeking attempts that were unsuccessful and/or unnecessarily traumatic, with recurrent experiences of stigma from care providers and generally unfavourable experiences of care accessed through clinically dominated supports.

Participants were asked to reflect on their personal experiences to inform the establishment of the Centre. Their responses underscored the importance of the physical environment and functional design of the Centre, particularly the area that will operate as an alternative to ED for people experiencing a crisis or significant distress.

Overall, participants welcomed the opportunity to use their knowledge and expertise to inform the establishment of the Centre. Most expressed a desire to be engaged for the next stages of Centre planning and co-design. They were grateful that one of the eight proposed Adult Mental Health Centres would be established in the Greater Darwin region and valued the expanded and enhanced quality of care that the Centre has the potential to provide.

Concerns were raised about the historically low level of engagement of people with lived experience in the Northern Territory to inform commissioning priorities, program planning, design, and research. For this reason, the NTLEN advocated strongly to include measurable Key Performance Indicators (KPIs) for the meaningful engagement of people with lived experience in the national evaluation for the Adult Mental Health Centres.

Lastly, participants expressed concern that the $5 million dollars to be provided by the Australian Government would be insufficient to develop the four core service elements described in the national consultation paper.

Based on the outcomes arising from the Darwin Lived Experience Consultation, the NTLEN recommends that:

<u>In the immediate term:</u>

Recommendation 1:

The NTPHN establish a steering group to oversee the design and establishment of the Centre and the development of an evaluation framework. Membership should include representatives from local key stakeholders, including members representing

the clinical and non-clinical sectors. The NTLEN should form part of the Steering Group.

Importantly, the Steering Group should have a composition that includes at least 30% representation by independent people with lived experience recruited through a skills and experienced based Expression of Interest process. The NTLEN has knowledge and expertise it can share with NTPHN to support the establishment of an appropriate Expression of Interest and selection process.

Even with 30% lived experience representation, the Steering Group would have less than the recommended 50% for co-production. However, 30% representation promises genuine engagement and significantly more value for the Steering Group.

Recommendation 2:

The NTPHN should undertake a comprehensive review of the sentinel enquiries and reports for the Steering Group to consider. The review should include (but not be limited to) findings and recommendations from the following sources:

- Contributing Lives Review - National Review of Mental Health Services and Programmes, 2015[1]
- Mental Health Productivity Commission (final report due September 2020, draft report available)[2]
- Senate Inquiry – Accessibility and quality of mental health services in rural and remote Australia, 2018[3]
- Royal Commission into Victoria's Mental Health System (in progress, interim report available)[4]
- NT Coroner and Inquests related to suicide[5]

Recommendation 3:

The NTLEN should be supported and engaged to complete a broad survey of people with lived experience in the Greater Darwin region. The survey should solicit consensus for the community's preference, including:

- The location of the Centre, particularly in relation to population distribution and growth, other community services and transport options.
- Operating hours for the four core service elements.
- Ways that the community can engage with the service and pathways in/out of the Centre.
- Staffing composition and service provision within the four core service elements.
- Co-located and/or in-reach services working in partnership with Centre services.
- Operating principals for potential service collaborations operating from the Centre.

- The functional layout and physical environment for the Centre, particularly the community's preference for
    - an alternative to ED for people experiencing a crisis or in significant distress,
    - the provision of short-to-medium term mental health supports, and
    - co-location of complementary services.

Recommendation 4:

The NTPHN should review mental health, suicide and related data to estimate the projected demand on the four core service elements proposed for the Centre.

This should include consultation with people with lived experience to review the underpinning assumptions when calculating demand. e.g. The NTLEN believes that Australian Institute of Health and Welfare data relating to Emergency Data presentations at Royal Darwin Hospital likely underestimates the demand that will be placed on the Centre. This is because many people in the lived experience community have learnt ED presentations are unlikely to result in admissions, so will avoid the additional distress of seeking support and being denied service.

In the near term:

Recommendation 5:

The NTPHN should commission an appropriately skilled organisation to develop an accurate estimate for capital funding required to establish and fit out the Darwin Centre. The cost to maintain the facility and pay for services each year should also be calculated. All estimates should be made publicly available and align with the projected demand and lived experience community priorities for functional layout and physical environment.

Recommendation 6:

The NTPHN should commission an appropriately skilled organisation to develop an accurate estimate of the annual service delivery cost for the Centre. All estimates should be made publicly available and align with the projected demand and priorities identified by the lived experience community.

Recommendation 7:

The NTLEN should be engaged to research, review and present recommendations to the Steering group, in relation to

- Peer models and trends across Australia, and
- Service collaboration models / collective impact approaches to support people with mental health conditions and multi-agency needs relating to the social determinants of health.

Recommendation 8:

Recognising the importance of the Centre to the mental health and wellbeing of people in the Greater Darwin area, the NT Government should be approached to co-contribute the balance of capital funding and annual operating funding required to establish and operate the Darwin Adult Mental Health Centre.

The co-contribution should align with the estimates calculated at Recommendations 5 and 6 and be committed without impacting the delivery of existing mental health and suicide prevention services in the Northern Territory.

In the medium term:

Recommendation 9:

The NTPHN should co-design and implement a comprehensive resource to navigate the NT mental health system. This should be undertaken with the support of the Steering Group and people with lived experience more broadly.

The navigation resource should support the Centre to act as a central point to connect people to other services in the region and undertake in-house assessment, including information and support to access services. It should align with the stepped care model (per Commonwealth Guidelines for Initial Assessment and Referral[6]) and be publicly accessible online to reduce demand on the Centre by facilitating self-referral and referral by other agencies.

The navigation resource should incorporate eligibility and exclusion criteria where relevant, and provide guidance that supports access to:

- Commonwealth and NT Government funded mental health, suicide prevention, AOD and related services that support people to address the social determinants of health,
- Medicare funded mental health services including support to locate a local or telehealth mental health practitioner,
- Digital self-help options, online mental health resources, national telephone and web-based support services, and
- Consumer and carer resources relating to rights, responsibilities, and complaints processes (e.g. Hospital Charter, NT Health Consumer and Carer Guides, Community Visitor Program, Health Complaints Commission).

The NT Lived Experience Network has existing knowledge and expertise it can provide the NTPHN to support the development and implementation of the navigation resource.

Recommendation 10:

The NTPHN should engage an external evaluator and with the support of the Steering Group, apply program logic to co-design an evaluation framework for the Darwin Centre that aligns with the desired impacts and outcomes. The evaluation framework should encapsulate:

- Key Performance Indicators for the meaningful engagement of people with lived experience, including
    - design and establishment of the Centre,
    - co-design of the service delivery model,
    - establishment of a peer workforce within the operating model, and
    - participation of people with lived experience in the Steering Group and governance arrangements when the Centre is operational.
- Outcomes and experience of people accessing Centre services.
- Experience of family members / friends providing care and support to people accessing Centre services.
- Experience of personnel working at the Centre.
- Population health outcomes with the Greater Darwin region once the centre is fully operational.

Recommendation 11:

The NTPHN and NT Government should support and participate in a NT Peer Workforce Advisory Group. The Advisory Group should include stakeholders from the mental health and Vocation Education and Training sectors and provide guidance to the NTPHN and NT Government for the co-commissioning of:

- Activities that support the establishment of accredited vocational pathways for people with lived experience to enter the peer workforce (with a view to ensuring a local lived experience workforce is skilled and oriented to commence working at the Centre once operational).
- Capacity building activities and shared resources for clinical and non-clinical organisations for the purpose of embedding peer workers safely and effectively within recovery-oriented practice and multi-disciplinary care teams.
- A review of national best practice guidelines and recommendations by the National Mental Health Commission to develop commissioning guidelines for the NTPHN and NT Government. Commissioning processes should encourage the implementation of peer models, yet ensure organisational structures and processes are in place for safe and effective participation of the peer workforce.
- A comprehensive Northern Territory Peer Workforce Strategy.

NT Lived Experience Network

In other states and territories, mental health funding bodies have a history of supporting people with lived experience to develop and maintain networks by financing carer and consumer peak bodies, and/or integrated lived experience peak bodies.

The peak bodies use their lived experience networks to operate in partnership with governments and funding bodies to inform policy development and how services are planned, developed, delivered and evaluated.

There is at least one peak body representing the interests of mental health carers in every state and territory. Except for the Northern Territory, all states and territories are supporting and/or have an extensive history of supporting the interests of mental health consumers through peak bodies. (Refer to Attachment 2 for an overview of interstate consumer peak bodies and related peak bodies in the Northern Territory.)

In June 2020, a group of Territorians with lived experience instigated a volunteer driven Working Group with the objective of establishing the Northern Territory Lived Experience Network (NTLEN).

The vision for the NTLEN is to provide a collective, independent voice for people with lived experience of issues related to suicide, mental illness, trauma or alcohol and other drug use.

Individual experiences of the collective group are diverse and wide ranging. Yet co-occurring issues related to suicide, mental illness, trauma, alcohol, and other drug use are relatively common and require a whole person approach to address.

Therefore, the NTLEN applies the term 'lived experience' to include:

- People who are living with (or have lived with) issues related to suicide, mental illness, trauma, alcohol and other drug use, and
- Family members or friends who provide care and support (or have provided care and support) to a person living with (or has lived with) issues related to suicide, mental illness, trauma, alcohol and other drug use.

The Working Group launched the NTLEN online in mid-July to coincide with the Lived Experience Consultation for the Darwin Adult Mental Health Centre on the 23rd of July 2020.

Darwin and the NT Health Context

Population Density and Diversity

The Northern Territory is a unique place to live and has many features that are favoured by residents, including its vast expanse, low population density and cultural diversity.

Yet these same features present barriers for the delivery of effective health care, given the expense and complexity of providing services to a small and culturally diverse population that is dispersed across a vast area.

The Northern Territory is the least densely populated jurisdiction in Australia.[7]

- Total Area of 1,348,094 square kilometres (18% of Australia's landmass)
- Population of 247,000 at the 2016 Census (1% of the Australia's population)
- Population density of 0.2 people per square kilometre

It is also the most culturally diverse jurisdiction in Australia.[7]

- 26% of the population are Aboriginal and Torres Strait Islander
- 31% of the population were born overseas
- 43% are non-Indigenous and Australian born

Within the NT, 58% of people speak only English at home, and 29% of people speak a non-English language.[7]

The Greater Darwin region is comprised of three local government areas: Litchfield, Palmerston and the city of Darwin (Figure 1).

Its population density is significantly higher than the jurisdictional average.[7]

- Total area of 3,164 square kilometres (less than 0.25% of the NT's total area)
- Population of 137,000 at the 2016 Census (55% of the NT population)
- Population density of 43 people per square kilometre

The demographic of the population in the Greater Darwin region is also less diverse.[7]

- 9% of the population are Aboriginal and Torres Strait Islander
- 28% of the population were born overseas
- 63% are non-Indigenous and Australian born

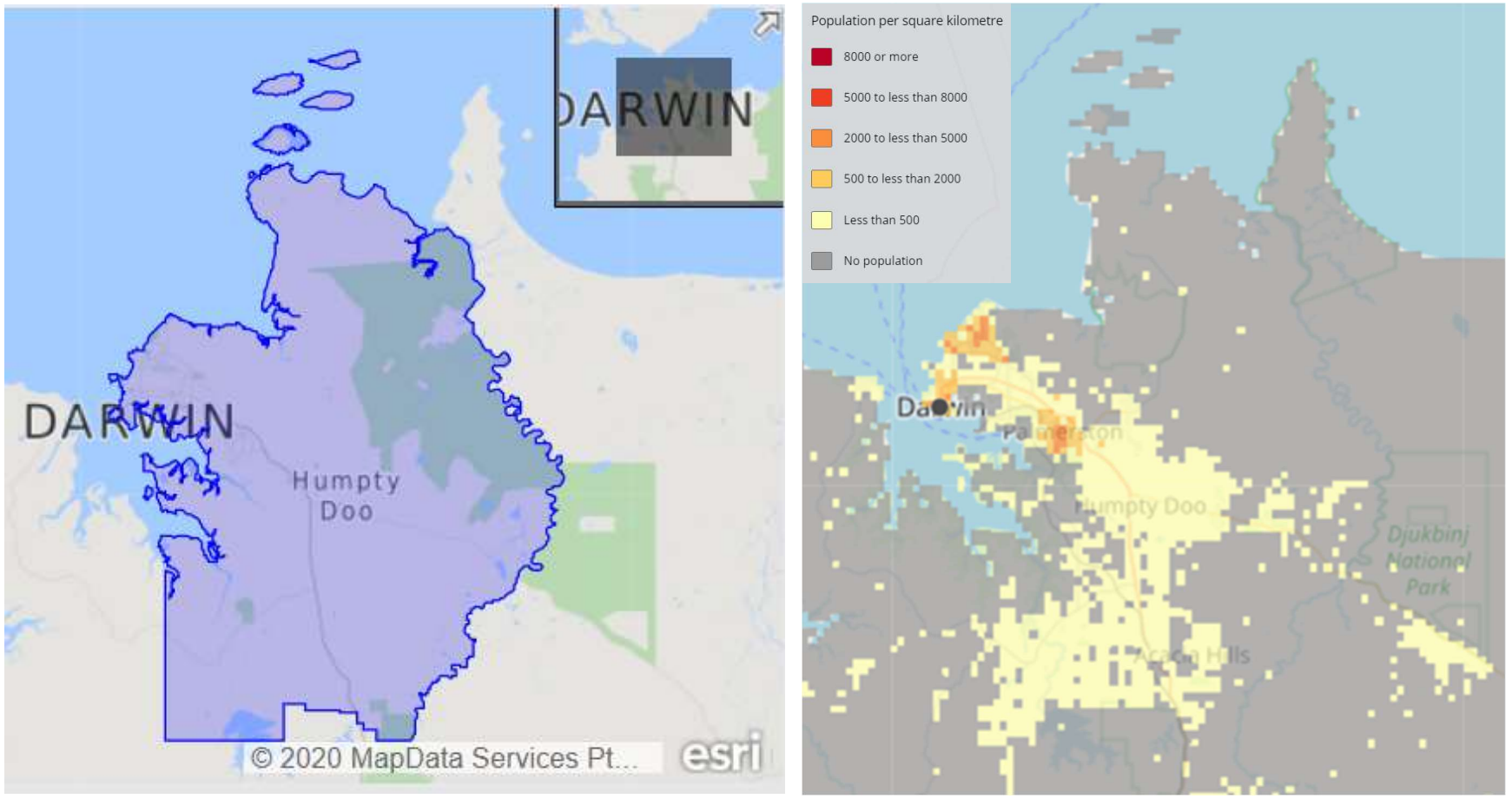


Figure 1: Greater Darwin region and Population Grid 2019[8]

Within the Greater Darwin region there is a larger proportion of people who speak only English at home (68% compared with 58% for the NT), and a smaller proportion of people speaking a non-English language either exclusively, or in addition to English (20% compared with 29% for the NT).[7]

Across the NT, the dominant languages other than English are Australian Indigenous Languages with an estimated 15% of the population speaking these languages at home. By comparison, speakers of Australian Indigenous Languages in the Greater Darwin region are estimated at 0.8% of the population. The languages of Filipino/Tagalog (3.1%), Greek (2.1%) and Mandarin (1.4%) make up the top three languages other than English spoken at home.[7]

Population Transience

The Northern Territory has a highly transient population, with 17% of NT residents during the 2016 Census reporting that they lived at a different address one year ago (compared with the national average of 15%).[9] The NTPHN, 2019 Population Needs Assessment describes two main types of population migration:[10]

- Transient movement, largely of Aboriginal people, to/from and between homelands, remote communities and regional towns (including Darwin). This movement is often seasonal and may involve cultural obligations, visiting kin, accessing services, climate-driven relocation, or a combination of any of these.
- Economic relocation of a short-term workforce who come to the NT for a specific contract or position and leave again after several months or years. These workers are often employed in the construction and mining industry, but many are health, other professionals, or in the armed forces. There are also a number of international backpackers who take short-term employment predominantly in the hospitality industry.

As the capital city and a major regional centre, the Greater Darwin region includes 2 out of 6 public hospitals and the only private hospital in the Northern Territory. Many Territorians travel to Darwin to access essential medical care including people who require treatment for chronic diseases. People with chronic diseases experience a higher prevalence of mental health related issues and for Aboriginal and Torres Strait Islander people, spending time away from Country and family can have further negative impacts to social and emotional wellbeing.

NT Mental Health Snapshot

This section provides a snapshot of the NT mental health population need and provision of services. Attachment 3 includes further information relating to at-risk populations.

Social Determinants

The social determinants of health impact people's ability to access health services in an equitable way. They have a major impact to mental health and wellbeing, as well as physical health more broadly.

The social determinants of health include housing, education, employment, social exclusion, and familial relationships. For Aboriginal and Torres Strait Islander people, the social determinants of health are intertwined with the legacies of dispossession and colonisation.

One of the measures used to represent the social determinants of health in Australia is the Socio-Economic Indexes for Areas – Index of Relative Socio-Economic Disadvantage (SEIFA IRSD)[11].

The NT includes 41 of the 100 most disadvantaged regions in Australia scored using the SEIFA IRSD. Considering that the NT is home to only 1% of Australia's population, it is significant that the NT includes more than 40% of Australia's 100 most disadvantaged regions. Further, it is indicative that a large proportion of Territorians live in complex and challenging conditions, which impacts their access to equitable heath care.

Psychological Distress

Measures for psychological distress reflect the impact of the social determinants for health.

In 2017-18, adults living in areas of most disadvantage across Australia were more than twice as likely to experience high or very high levels of psychological distress than adults living in areas of least disadvantage (18.3% compared with 9.0% respectively). [12]

Aboriginal and Torres Strait Islander people experience rates of high or very high psychological distress at nearly 3 time the rate of non-Indigenous Australians. In urban areas, Aboriginal and Torres Strait Islander people are more likely to experience high or very high levels of psychological distress (32%), compared with those in remote areas (24%).[13]

In the Northern Territory, an average of one in nine (11.3%) adults aged 18 years and over experienced high or very high levels of psychological distress.[12]

Burden of Disease

Burden of disease is a measure used by the Australian Institute of Health and Welfare to indicate the impact of living with illness and injury and dying prematurely. Information on the health impacts of different diseases, injuries and risk factors is important for monitoring population health and providing an evidence base to inform health policy and service planning.

The burden of disease for mental health and substance use disorders, including suicide related self-inflicted injuries, alcohol use disorders and depressive disorders make up approximately 36% of the total burden of disease in the NT. This is 3 times the Australian average for the same cluster of disorders (12%).[14]

Child and Adult Suicide

Many individuals with mental illness are not affected by suicidal thoughts and not all people who attempt or die by suicide have mental illness. A useful way to think of suicide is as a combination of risk factors and tipping points. Sometimes this involves a history of mental illness and sometimes it does not.

The suicide rate among people with a mental illness is estimated to be at least seven times higher than that amongst the general population.[15] Less than 30 per cent of people who died by suicide in the NT were reported to have seen a mental health professional at least once, and less than 10 per cent were clients of NT Government mental health services.[10]

The risk factors associated with suicide reflect the social determinants of health and include poverty, reduced access to health services and poor health status, low education, lack of transport, unemployment, and inadequate and overcrowded housing. Additional factors that affect Aboriginal and Torres Strait Islander people include cultural dislocation, racism and discrimination, removal from family, unresolved loss and grief and chronic disadvantage.[16]

In 2018, there were 3,046 registered deaths of people who died by suicide in Australia.[17] The standardised death rate by suicide was 12.1 deaths per 100,000 people. The NT had the highest death rate at 19.5 deaths per 100,000 people compared with Victoria that had the lowest standardised death rate at 9.1 deaths per 100,000 people.

The suicide rate was lowest in the Greater Darwin region at 14.2 per 100,000 people compared to the rest of the NT at 27.1 per 100,000 people.[18] Nationally, the Aboriginal and Torres Strait Islander suicide rate is double that of non-Aboriginal people and this is reflected in the NT.[19]

According to the Australian Bureau of Statistics, deaths of children from suicide is an extremely sensitive issue and the number of deaths of children attributed to suicide can be influenced by coronial reporting practices.[17] Child deaths by suicide are defined as those aged between 5 and 17 years of age and the suicide rate among children in 2018 was 2.5 deaths per 100,000 children.

More than three-quarters of child suicides in 2018 were between the ages 15 to 17 (78.0%). When all child suicide deaths are combined for years 2014 to 2018, the Northern Territory reported the highest jurisdictional rate of child deaths due to suicide with 12.5 deaths per 100,000 or 5 times the national average.[17]

NT Mental Health and AOD Treatment Services

Acute Care and Community Mental Health Services

In 2017–18, the NT had the highest rate of mental health-related ED presentations at 280.4 people per 10,000 population compared to the national average of 115.9 per 10,000 population. This constituted 4.4% of presentations to ED in the NT, compared with the national average of 3.6%.[20]

The NT has the lowest number of acute care beds (17.4 per 100,000 population), which is equivalent to half the number of beds available in New South Wales (34.8 per 100,000 population) and significantly below the national rate (27.9 beds per 100,000 population).[20]

The number of acute care beds in Darwin is three times less than cities of comparable size such as Cairns and Hobart.[21] At the time of writing, Healthscope is constructing a $16 million dollar private 18 bed inpatient and outpatient unit at the Darwin Private Hospital. Once complete, it will provide the NT with its first private mental health and AOD facility[22].

Despite having limited availability of acute care options, the NT does not provide proportionally higher access to community mental health services.

When considering the average number of service contacts per patient, the NT had the lowest level of contact at 11.4 contacts per patient, compared with 30.6 contacts per patient in Victoria and 21.8 contacts per patient nationally. The NT also had the lowest number of average treatment days per patient at 9.1 compared with 14.7 nationally.[20]

Alcohol and Other Drug (AOD) Treatment

In 2017, a survey undertaken by the Association of Alcohol and Other Drug Agencies NT indicated the following issues within the AOD sector of the NT:[23]

- Confusion about the referral process, referral pathways, and the delivery of the appropriate intervention based on the person's need can negatively impact the service delivery continuum for treatment service clients and can lead to a denial of service or inefficient use of time and resources upon intake.
- Limited access to evidence-based locally available dedicated specialist dual diagnosis services to support people experiencing substance dependence and mental health diagnosis.
- Clients who are dually diagnosed report being turned away from both mental health and substance abuse services due to their co-occurring needs.
- In response to treatment demand, agencies reported providing unfunded AOD treatment services, ranging from day programs and withdrawal services to telephone support. Half of the surveyed organisations reported providing at least one (and often multiple) unfunded services.

General Practitioner (GP) Care

According to the NTPHN, 2019 Program Needs Assessment, the NT General Practice workforce is often transient, can be heavily reliant on locums and overseas trained doctors, and faces challenges of recruitment and retention.[10] This presents issues, particularly in the NT context where the disease profile is quite different to the rest of Australia and supporting/complementary services for referral are sparse.

Territorians are less likely than the national average to have a usual GP or place of care, and less likely to rate their care highly or report that they felt involved in their care and comfortable with communication.[24]

Consultation Design

The Darwin Lived Experience Consultation organised by the NTLEN on the 23rd of July 2020 was specifically designed to inform the establishment and operation of the new Adult Mental Health Centre, and to position people with lived experience as key stakeholders in local planning and co-design activities.

With relatively short notice, 21 participants attended and actively participated at the Consultation. Additional members of the community responded and expressed an interest to participate in future activities because they were unable to attend due to work commitments.

The Consultation was designed and promoted as a safe space for people with lived experience to share the knowledge and experience they have gained through:

- Access, attempted access, or no knowledge of how to access services for issues related to mental illness, trauma, alcohol or other drug use and suicide.
- Knowledge and experience gained both within the Darwin region and in other areas.

To prevent the Consultation being attended by service providers and observers, the event was promoted for people with lived experience only and warned that professionals seeking to attend for the purpose of observing would be asked to leave. The decision to include such direct messaging was based on observations that previous community consultations were dominated by people working within the sector and this would not provide a safe environment for community members to disclose their experiences. This decision was validated through the feedback process at the end of the Consultation (Attachment 5).

The Consultation was designed and delivered by two lived experience facilitators, and the NTLEN was fortunate to receive sponsorship from a local business to cover the cost of catering and Welcome to Country by Larrakia Nation, Traditional Owners of the Darwin region.

The broad objective of the Consultation was to gather a body of evidence relating to people's "actual experiences" accessing support, and by extension, what they felt would constitute an "ideal experience".

Based on the service model described in the consultation paper for the Centres, a series of questions were posed to participants who were seated at five tables. Each table group captured their responses to the questions on large sheets of butcher paper.

Consultation questions included:

1. FINDING SUPPORTS
    a. What is your experience finding the supports you or a loved one has needed in the past?

a. What could help people to understand what supports are available and how to access them?

2. ACCESSING NEW SERVICES

a. What is your experience of you or a loved one accessing a new service for the first time?

b. What could improve people's experience when accessing a new service for the first time?

3. MENTAL HEALTH SUPPORTS

a. What is your experience of you or your loved one receiving mental health supports in the past?

b. What kind of mental health supports could help in the short-to-medium term?

4. CRISIS CARE

a. What is your experience of you or a loved one receiving support in a crisis?

b. What kind of alternative model for short-term crisis care would help people?

Part way through the Consultation it became clear that most people's first time seeking and accessing support occurred as the result of a mental health or suicidal crisis.

At this point, the facilitators and participants discussed the potential to adjust the remainder of the Consultation program. The group decided it would not add value and may cause unnecessary discomfort for participants to answer Questions 3a and 4a (Attachment 4, 5).

Consultation Outcomes

The following responses were contributed by 21 participants arranged in five table groups. Participant responses are shown verbatim in quotations. Uppercase lettering indicates an emphatic participant response.

Experience of Participants

Table 1 includes participant experiences of finding and accessing services organised by themes. Similarly, Table 2 reports participant experiences of using services organised by themes.

The 'Groups' refer to the number of table groups where themes emerged, with the phrase 'Repeated References' used to identify key themes.

Table 1: Thematic analysis of participant experiences finding and accessing services Reference: Questions 1(a) and 2(a)

4 Groups Repeated references	**Needing to self-navigate the service system and having trouble finding supports and services:** *"Google", "Telephone book", "Searched Council Resources", "Research"* *"You don't know what you don't know."* *"Had to find services on your own."* *"NOT GOOD – not easy to go to an informed source."* *"Finding help beforehand, support that was not CRISIS related."* *"Not knowing system and supports and where I fit in."* *"Made a list of needs. What I did need? What I didn't need?"* *"Went to doctor – didn't know what to do."* *"Found out by accident I was unwell."* *"GP relationships can be critical - may be the first point of contact."* *"Accidently found out about non-clinical services while walking through shopping mall and saw information display for mental health week."* *"Psychologist was first service accessed. They were reassuring, but I had to go back to GP to get referral and put steps in place to return to psychologist at a time when I couldn't easily think."* *"Looking for: safe places for young people, short-term unit for 6 mon."*

2 Groups	**Some participants reported searching for support using non mental health pathways:** *"Trusted relationships – therapeutic in nature but not necessarily a mental health professional."* *"Asked around."* *"Went to eye clinic who recommended Psychiatrist with good reputation and to pop in try get an appointment → no availability."*
4 Groups Repeated references	**Accessing a service for the first time during a time of crisis:** *"Ambulance → Triage → Psychiatric Centre."* *"Was transported to hospital."* (2 accounts from the same table) *"Rang the police needing immediate support. Police went and saved the person."* *"Ended up needing to call police weeks later resulting in involuntary admission."* *"Only happens in extreme crisis."*
4 Groups	**Having to wait a long time before receiving support:** *"Journey is TOO LONG", "Needed ASAP", "Deteriorated drastically",* *"No availability", "Lack of timeliness", "Takes a long time",* *"WAIT TIMES: too long, needed asap, hopeless, deteriorated drastically."*
3 Groups Repeated references	**Being found ineligible when seeking support from a service:** *"Too 'high risk'", "Being 'referred out'", "Not meeting criteria",* *"Really difficult to get a service."* *"Got hung up on by triage because disclosed drug use."* **Service denials that resulted in deterioration and hospital admissions:** *"Denied service → Crisis → Hospital → Denied service → Crisis etc."* *"DISMISSED because 'not serious enough' → had to wait until things were BAD."* *"Finding help beforehand, support that was not CRISIS related."* *"Went straight to psychiatric ward, sent back to GP then into psychiatric ward again."* *"Sorry, can't help you, too busy."*

	Being denied access to crisis services: *"Another occasion, when the Psychiatric ward was full was told 'Lucky Mate'."* *"Told to call back in 15 minutes even though I was in crisis… Transported to hospital after attempted suicide."*
2 Groups	**Unable to identify supports or access supports because of a very low level of English:** *"Learned from family members and friends that behaviour was unusual. Came from a different country and culture so was hard to identify new / emergent issues."* *"Background / Learning English causing difficulty with Doctors and Psychiatrists."* *"Communication in a CBT environment was difficult."* *"How to find someone who could speak the language?"* *"Carer became interpreter."*
1 Group	**Consideration to moving interstate to access support:** *"Considered going down south. Transport issues? Living away from home? How do you take that plunge? Fear."*
1 Group	**Unable to access private support due to expense:** *"How does a young person pay to see a psychologist?!?"*

Table 2: Thematic analysis of participant experiences using services
Reference: Questions 3(a) & 4(a)

5 Groups Repeated references	**Experience of stigma by service providers:** *"Told not eligible / person was rude and I was hung up on."* *"Was judged based on historical notes."* *"Response was panicked (by staff)."* *"Told 'time-wasting'."* *"Feeling of disregard."* *"Bias / perceptions from professionals: STIGMA, PREDJUDICE."*

	"Automatic assumptions about symptoms that were incorrect leading to medically based decisions that affected my rights." *"Have felt workers were fearful of my presentation."* *"Needs to be non-punitive and labelling of the person for having symptoms."* *"Was stigmatised by GPs in language, referrals and in Drs notes."* **Stigma experienced by marginalised populations within services:** *"Stigmatising / suppression / incapacity of the system to accommodate sexual assaults related to trauma / issues including sexuality."* *"Poor experience with institutionalised racism, fat phobia, LGBTIQ+ needs and identities."* **Stigma experienced in the community:** *"Stigma", "stigma",* *"Being in Cowdy defined you as mentally ill."* *"Went to hospital for the first time in the 70s. Stigma was like going prison."*
5 Groups Repeated references	**Poor experiences accessing care.** **Not being listened to or having to retell their story:** *"Repetitive", "Didn't gather info sensitively", "Dr was not listening"* *"Difficulty communicating my needs → service was assuming my needs."* *"Communications not with me directly – 'managed by others."* *"'Prodding or Probing' → No → Had to invite people in."* **A lack of support or appropriate care:** *"Feeling of disregard", "Hopeless", "Lacked support", "Frustration/Anger"* *"TRUST & MISTRUST. DIFFICULT. LONELY."* *"Struggle to find a trusted person – in and outside of service."* *"I knew more than they did → they were not experienced enough for my complex situation."* *"What did I need: advice, support and understanding → for emotional needs as well as crisis related."* *"Not a place she needed to be."* *"Mistook a suicide attempt for mental illness."* *"I wasn't ready."* **Poor communication and an absence of person-centred care:** *"Power imbalance between worker and patient."*

	"Settling for what the system has available rather than what I want or need." *"Given what "they" (staff) thought we needed."* *"Lack of consultation / info."* *"I was not asked what was important to me or what I needed."* *"Not the 'right' help."* *"USE OF LANGUAGE – what are we even talking about?"* *"What happens in the 2 weeks leading up to appointment?"* *"Anxious period between services."* *"No outreach service or on call."* **A lack of follow up and referral pathways to other services:** *"Not taking into consideration context and experience."* *"No holistic approach. No one asked. No offer of help re other aspects."* *"No follow up after ED or Tamarind presentation."* *"No follow up / referral."* *"First time in crisis → helpless, no info or support after."* *"Vulnerable people rely on chance and good will of the public."* **A reliance on pharmacotherapy by care providers:** *"Doctor wanted to put on anti-depressants, could only direct to mental health centre."* *"Short term fix, e.g. meds."*
3 Groups	**Poor experiences by family members providing care and support:** "*Was told 'Sorry can't help you, too busy'."* *"Powerless, Overwhelmed, Unacknowledged."* *"No Parental Consent."* *"Head spinning."* **Absence of carer support or referral to carer support services:** *"Carer's fears."* *"Carers put themselves last."* *"Talked a lot at home with the kids."* "*Onus on Carer to ask questions."* *"Other children (of the Carer) 'bit on the back burner'."*

2 Groups	**Positive experiences of care.** **1) Carer Account** *"Good experience: Rang service, asked me to come in, recognised that if the Carer is upset there were negative consequences for the child."* *"Called the Tamarind Centre: People accessing the phone were highly qualified social workers, not admin staff."* *"Asked for feedback: Happy or do you need more help?"* **2) Account of Veteran's Services** *"Dedicated specialisations, e.g. population cohorts (i.e. Veterans) and/or anxiety/depression, PTSD, Bi-polar."* *"Staff requirement to pursue professional development."*

Participant Perspectives on Proposed Service Model

Participant perspectives on the proposed service model were gathered at the Question 1(b) through 4(b)

Responses to each question have been organised by themes in Tables 3 to 6 as follows.

Table 3: Participant perspectives – what would help people to understand what supports are available and how to access them
Reference Question 1(b)

5 Groups Repeated references	**A comprehensive navigation resource that is easily accessed and provides direction to holistic supports.** **Face-to-face support:** *"ONE PLACE to find support to get what I need."* *"Walk in service / facility."* *"Someone to find a service for you."* *"Telling me accurately what they CAN and CAN'T do."* *"Physical Centre."* *"Can give you phone number or contact on your behalf."* *"Triage → troubleshooting → where to go. E.g. If feeling anxious → "Follow blue line and someone will help you."* *"Safe space → don't have to engage initially."*

	Online self-navigation: *"INTERNET BASED SERVICE - Portal to all the services available. Direct to a specific service. Not clicking through link after link."* *"Community Services Directory."* *"Creation of a complementary self-navigation tool online and in print to match the services."* *"Don't want to do a PhD in services / websites. "* *"Triage service on-line."* *"Like videos → who you are, what you do, spirit or organisation, simple but powerful, plain and simple."* **Accountability and follow up:** *"Good referral pathways. No buck passing. Follow-up."* *"Improved communication and knowledge."* *"Linked services / flow."* *"Stronger networking."* **Visibility and accessibility:** *"Promotion on the back of busses, TV, Radio, Newspaper, Social Media so it is common knowledge the service exists."* *"Located in a central location and near to bus transit points (so don't need to get connecting buses to get there)."* *"LOCATION: Central → Pinelands."* *"INFORMATION IN LANGUAGE."* *"Need telephone, text, email options to make contact if I am too scared to go to physical location"* *"24 HOURS ACCESS: HOTLINE, REFERRAL."* *"Transport / access 24/7"* **Links / Referrals to holistic services:** *"One Stop Shop (Holistic) → AOD, Psychologist, Psychiatrist, GP, Crisis support, spiritual, nutrition, behavioural specialist, psychosocial, peer support, family/carer support."* *"Holistic counselling: spiritual/spirituality, traditional and alternative healing, massage/touch."* *"Health food available: nutrition/dietician, art therapy."* *"'Whole Person' → holistic supports."*

4 Groups	**Empathetic and non-judgemental staff:** *"Taking the time, attention and really listening."* *"It is really helpful when someone gives me time attention and listens; this often helps to de-escalate and hold me out till I can get the help I need."* *"Compassion, empathy. Receptionist → Front line person. Talk → warm reception."* *"Non-judgemental"* *"Staff who are empathetic, positive, caring and genuine."* **With a preference for lived experience staff:** *"Kiosk staffed by people with lived experience."* *"NON-CLINCAL SUPPORT!!! (Peer Workforce)"* *"Want someone with lived experience → Who has been in that space."* *"Peer advisors"*
5 Groups Repeated references	**Trauma-informed, recovery-oriented, and holistic model of care:** *"Being involved in treatment."* *"Client-centred service: not in a rush, form a relationship."* *"Physical touch – consent may be important."* *"Trauma informed, person-centred."* *"Aboriginal and Torres Strait Islander informed practices."* *"People working in partnership model with people accessing services."* *"Appropriate level of training."* *"Fully qualified people."* *"Well integrated AOD/Mental Health."* *"Person (not disease) centred."* *"Recovery focussed."* *"GP relationship can be critical to building a support plan. May be 1st point of support. Must be person-centred."* *"MALE as well as female staff (noting this sector has more woman than men)."*
3 Groups	**A comfortable space that reflects community:** *"Not a 'boring clinical space'."*

	"ARTWORK, DIVERSITY, COLOUR IN SPACE." *"SPACE that can reflect the person, be creative."* *"Comfortable physical environment, i.e. chairs, NO BIG WHITE LIGHTS & WHITE WALLS!"* *"What constitutes a safe place? Medical model may not be a safe space."* *"Place to express self – safe place."* *"Non-Clinical: green space, no fluro lighting."* *"Hopeful atmosphere / creative vibe / healing environment."* *"Environment that makes you feel safe, is well lit and not out of the way."* *"You need to be visible to the service on arrival."* *"Feel welcome → NOT like Centrelink → I don't want to be directed to do something online."* *"Feels totally UNLIKE places like MVR."* *"Soft surfaces, not noisy, gentle background music, decorated by community so it reflects community."* *"To be able to sit privately while waiting."* *"Created by people who are community people and are representative of the diverse community."*

Table 4: Participant perspectives – what would improve people's experience when accessing a service for the first time
Reference Question 2(b)

5 Groups	**Staff profile:** *"ADVOCATES"* *"PEER WORKERS"* *"NON-CLINICAL SUPPORT"* *"Case managers: build rapport and clients trust, helping to facilitate connection to 'stigma' services."* *"Work alongside a trusted support person: lived experience peer, central coordination."* *"Social works or skilled Cert IV qualified (Community Services, Mental Health, Peer Support)."* *"Highly skilled."*

5 Groups *Repeated references*	**Staff attributes:** *"Respectful and nurturing staff"* *"Anyone welcome."* *"Staff that are accepting of confusion and emotionality."* *"Safe and comfortable to be and express."* *"Staff that are not dominated by the efficiency paradigm."* *"Staff with a compassionate approach who have time to spend with clients."* *"Building rapport."* *"Not to be treated like a patient / pigeonholed → i.e. risky, dangerous."* *"Staff need to be approachable."* *"Excellent interpersonal qualities."* *"Non-judgemental."* *"Patient."*
5 Groups	**Service delivery model includes** **Intake and assessment:** *"Non-clinical triage: only have to tell story once, linked in services / holistic."* *"Share with peer staff with (lived) experience."* *"I need help with …. choice, can give you a phone number or contact on your behalf."* *"Can have a reason for people to go there that is not about the problem (e.g. dieticians, positive services, alternative medicine, massage, GP)."* **In-house services:** *"Relaxed / Non-Clinical / Non-Judgemental."* *"Creating treatment plans."* *"Ability to manage co-occurring issues: mental health, physical, AOD."* *"Ability to choose a different key worker."* *"INDIVIDUAL & GROUP SERVICES."* *"Clinical / therapeutic / peer support → there are a range of options for the different needs of a person."* *"Free or subsidised courses and information: Mental Health First Aid, psychoeducation, self-management, parenting, nutrition/diet."* *"Support after service at the centre"*

	"Options for a feminism informed approach → acknowledgement of systemic oppressions that are in the service approach: racism, LGBTIQ+, class." **Service collaborations for people with multi-agency needs:** *"Consistent person to see."* *"Referral. All the information can be shared with all of the affiliated professionals."* *"Different orgs have offices in the centre. Coordination organisation has responsibility and accountability."* *"Types of services located / integrated within the Centre: mental health, AOD, advocacy, therapeutic programs, Centrelink outreach, legal support."* *"Types of services connected to case management but located offsite: financial aid, domestic violence."* *"Emergency accommodation. Connected and rapport with other people."* *"What services do I want there: other service options links → art therapy, not just linkages, other options to connections, WHOLE PERSON, WE WANT TO CONNECT WITH YOU → not you telling us what we want, financial information and help."*
1 Group	**Transport support:** *"Transport to services."*
4 Groups	**Architectural design and function:** *"CO-CREATED SPACES."* *"Food, drink, comfort and safety."* *"Access to PC, internet space."* *"Positive vibe, breakout space available."* *"Different orgs have offices in the centre."* *"Homely environment: conducive for relations, accounting for sound and technology sensitivity, non-clinical, not every room the same, couches, cushions, colours, art, low stimulus."* *"SPACE"* *"Environment: music, welcoming space, artwork, natural light, relaxing / safe."*

Table 5: Participant perspectives – what kind of mental health supports would help in the short-to-medium term
Reference Question 3(b)

4 Groups	**Operating principals / ethos at the Centre:** *"Cultural sensitivity and responsiveness."* *"LGBTQIA+ & trauma informed."* *"Being able to see the same clinicians (most of the time)."* *"Emphasis on mental health rather than mental illness: de-pathologising."* *"Crisis = Opportunity."* *"Clear / accessible language. Pathways in and out of the service."* *"Normalising emotional distress and release: grief and loss, episodic treatment, traumatic event."* *"CALD"* *"Don't like lots of security in authoritive / obvious uniforms."* *"Follow up / check-ins by service if you haven't been for a while."*
5 Groups *Repeated references*	**Intake and assessment process:** *"Strengths and needs based. Individualised support."* *"Holistic planning for overall wellbeing before official treatment plan."* *"People come in for one reason and find opportunities for other kinds of support."* *"Introduction to options and rights."* *"Exploration of supports available. Diversity of types of support options. Not a one size fits all approach."* *"One stop shop: social workers, peer support worker (provided support as someone to talk to and can direct you to a service that will help if you are OK with that), liaise with GP."*
5 Groups *Repeated references*	**In-house (or in-reaching) formal mental health supports:** *"PEER SUPPORT."* *"ACCESS TO ADVOCACY."* *"ADVOCATES"* *"Individual advocates."* *"GPs that are skilled in mental health and holistic care."*

	"GPs that have access to psychiatrist or perhaps a psychiatrist on site but NOT a bank of psychiatrists located at the centre." *"NECESSARY CLINICAL: psychiatry, psychology, mental health nurse, GP."* *"Multi-disciplinary mental health care and case coordination."* *"Referrals to telehealth specialists interstate and facilities for people to do telehealth appointments (psychiatrist, psychologist interstate)."* *"Acceptance and commitment therapy."* *"Peer support, AOD, case management, counselling, psychologist, social worker, links to community services, online services, GP, psychiatrist, trauma, support groups, family services."* *"Counselling."* *"Group work / therapy."* *"Self-compassion. Learning."* *"EDUCATION: engagement, conditions, coping, general."* *"Understanding my illness & hearing / exploring strategies used by people with lived experience → available to individuals and families."* *"Trauma support."* *"Therapy dogs and birds."* *"Support groups."* *"Healthy lifestyle advice."* *"Resilience and growth and capacity building."* *"Aid people in their self-advocacy abilities."* *"ACCESS TO OTHER SERVICES: impacts on wellbeing, social determinants of health."* *"Refer to affiliated services."*
1 Group	**Informal in-house mental health supports:** *"Drop in and have a chat."* *"Library – mental health books."* *"Computers, newspapers."* *"Printing services."* *"Attracting people in isolation."* *"Fun place to go."*

	"Mindset of a café → how do I get people to come." *"Doesn't put a label on people."*
1 Group	**Alternate forms of healing offered in-house:** *"Body work: trauma informed movement therapy / dance / energetic healers."* *"Naturopathy."*
2 Groups	**Transport support:** *"Travel support."* *"Outreach."*
3 Groups	**Architectural design and function:** *"PLACES PRIVATE for support person to be with person."* *"Lounge rooms."* *"Kiosk rooms."* *"Mental health training rooms."* *"Community feel."* *"Ambience."* *"Not sterile environment."* *"Big spaces to have places to do individual and group work, even in the garden."* *"Nice for staff as well as clients (nurses, drs, social workers)"* *"A hospital down south has a glass house with greenery that is used on special occasions and by visitors and staff. It's a wonderful place."*

Table 6: Participant perspectives – what kind of alternative model for short-term crisis care would help people
Reference Question 4(b)

5 Groups	**Accessibility and community awareness:** *"ACCESSIBLE, 24 HRS"*

	"24-hour peer crisis team, hotline and text service." *"All hours is very important."* *"COMMUNITY AWARENESS."* *"Marketing to reflect the diversity of people with lived experience."* *"CLEAR guidance to ambulance and police about the centres function. Requires a framework and training for emergency services with regard to ED transfers, Centre admissions and Spin Dry."*
5 Groups *Repeated references*	**Operating model:** *"Solution focussed, problem solving."* *"AUTHENTIC ENGAGEMENT."* *"Quickly engaged upon entry (not left to wait)."* *"Walm welcome (not having to queue at the desk)."* *"Triage is very important: minimise distress, skilled experience worker - passionate, empathetic, non-judgemental, calming staff who look 'non-clinical'."* *"Understanding and supportive atmosphere."* *"Acceptance for difference."* *"Know that you could go to the one place and be told 'we can help you'."* *"Be listened to."* *"Availability for people to be there long enough to have a sleep and then a proper conversation (risk assessment, agreed follow up, care planning) after you wake up."* *"Good support, food is important, having a place to smoke is important (and availability of Nicotine therapy for patients who are trying to quit."* *"Food options in a pantry store."* **Staffing:** *"CLINICAL + SUPPORT + PEER"* *"Collaborative care teams: minimum of 2 people – clinical and non-clinical recognising the persons strengths and strategies the individual has to keep themselves alive."* *"Therapy dog."* *"APPROPRIATE PERSONNEL → i.e. mental health person instead of police."* *"Security trained in mental health and AOD → De-escalation, not physical."* *"Staff trained in de-escalation."*

	"Staffing demographic reflects community demographic." *"Availability of staff who are specific gender / culture."* **Responsive to carers and families:** *"CARER SUPPORT OFFERED AT TIME: communication, plan, how to help."* *"Mindful of all age groups."* *"Carers can go and take someone without feeling uncomfortable."* *"Therapeutic to Carers as well as individuals."*
5 Groups	**Follow up and out-reach:** *"PLANNING after crisis → medium term."* *"Doctors and services sharing and actually reading notes → through GP or designated."* *"Transport to meet the person in their own space."* *"Peer workers does checks → referral possible at day end."* *"Follow up next day via call / text, then ongoing per agreement."* *"Follow up is very important → needs to be outreach."*
5 Groups *Repeated references*	**Architectural design and function:** *"ALTERNATIVE TO EMERGENCY DEPARTMENT WAITING ROOM → HAVE ACTUAL BEDS!"* *"DE-ESCALATE: CALMING & SUPPORTIVE ENVIRONMENT."* *"Positive space, break out spaces, not crowded, space, privacy, relationships with persons, sitting down, comfy chair."* *"Furniture, lights, walls."* *"Books, fidgets, puzzles."* *"Weighted blankets."* *"Outside space."* *"Architecture to remove stigma."* *"Mentally and physically safe."* *"Design that accommodates different client groups."* *"Encourages respectful behaviour. Discourages anti-social behaviour."* *"Safe space – break out room."*

	"Lots of nature, sea views with lots of gardens → sunlight and water." *"Knowing that I am not going to get locked up."* *"First time through the door is the most important impression."* *"Reception, vibe is very important."* *"Don't want to alienate based on stigma."* *"Ideal environment: safe, an area to understand your issues, pleasant view, greenery, no physical barriers."* *"NOT LIKE COWDY → Far more therapeutic environment."* *"Instead of steel fences, use bullet proof glass."* *"Break out spaces."* *"Nice for staff as well as clients."* *"Being in a space that is private and not able to be seen by others."* *"TV with headphones."* *"No people who can look in or walk by."* *"No thoroughfare for staff."*

This part of the Consultation also generated several questions from participants, which are captured in Table 7.

Table 7: Participant questions relating to short term crisis care operation

3 Groups	**Questions from Participants:** *"How do you make a community space that is safe for everyone without being discriminating?"* *"Can it be safe there to be under the influence but not completely intoxicated?"* *"WHAT WILL THE DEMAND BE?"* *"WHAT ARE THE STATS OF ED PRESENTATIONS WHO ARE SENT HOME?"* *"HOW MANY PEOPLE ARE BEING TAKEN TO SOBER UP SHELTERS INSTEAD OF ED BECAUSE POLICE AND LARRAKIA NATION KNOW THEY WOULD NOT BE ADMITTED?"*

Participant Perspectives of Centre Operation

Although participants were asked specific questions related to the proposed service model, there were universal themes that emerged in relation to the overall operation and design of the Centre. These are captured in Table 8, with a selection of participant perspectives to illustrate each theme.

Table 8: Participant perspectives – themes that emerged in relation to the overall operation and design of the Centre

5 Groups Repeated references	**The Centre should operate using a comprehensive navigation resource that is publicly accessible and provides direction to holistic supports.** **Face-to-face, telephone and text support:** *"ONE PLACE to find support to get what I need."* *"Can give you phone number or contact on your behalf."* *"Need telephone, text, email options to make contact if I am too scared to go to physical location"* **Online self-navigation:** *"INTERNET BASED SERVICE - Portal to all the services available. Direct to a specific service. Not clicking through link after link."* *"Creation of a complementary self-navigation tool online and in print to match the services."* **Links / Referrals to holistic services:** *"One Stop Shop (Holistic)"* *"'Whole Person' → holistic supports."*
5 Groups Referenced repeatedly	**It is important that the Centre is well known, is easily accessible and has transport options for vulnerable clients.** **Promotion:** *"Promotion on the back of busses, TV, Radio, Newspaper, Social Media so it is common knowledge the service exists."* **Location and accessibility:** *"Located in a central location and near to bus transit points (so don't need to get connecting buses to get there)."* *"LOCATION: Central → Pinelands."* **Transport for vulnerable clients***:* *"Access and transport availability", "Transport"*

	Hours of operation: *"ACCESSIBLE, 24 HRS", "All hours is very important."* *"24-hour peer crisis team, hotline and text service."*
5 Groups Referenced repeatedly	**The Centre should have staff that are empathetic, non-judgemental and reflect community:** *"Compassion, empathy", "Warm reception", "Non-judgmental",* *"Respectful and nurturing staff."* *"Staff who are empathetic, positive, caring and genuine."* *"MALE as well as female staff (noting this sector has more woman than men)."* *"Staffing demographic reflects community demographic."* *"Availability of staff who are specific gender/culture."*
5 Groups Referenced repeatedly	**The physical design of the Centre is important.** **Offer a welcoming and non-stigmatising introduction to Centre:** *"Feel welcome → NOT like Centrelink. Feels totally UNLIKE places like MVR."* *"Not a 'boring clinical space'."* *"Call it a "Wellness Centre" NOT a "Mental Health Centre", e.g. "Mind & Body Wellness Centre".* **Provide a comfortable, safe and therapeutic environment:** *"Soft surfaces, not noisy, gentle background music."* *"Comfortable physical environment, i.e. chairs, NO BIG WHITE LIGHTS & WHITE WALLS!"* ***"**Music. Welcoming space. Artwork. Natural light. Relaxing. Safe."* *"To be able to sit privately while waiting"* *"Food, drink, comfort and safety"* **Reflect the Darwin community and the people in it:** *"ARTWORK, DIVERSITY, COLOUR IN SPACE."* *"CO-CREATED SPACES"* *"Created by people who are community people and are representative of the diverse community."*

	Provide access to outside spaces: *"Big spaces to have places to do individual and group work even in the garden."* *"Ideal environment: safe, an area to understand your issues, pleasant view, greenery, no physical barriers."* **Has co-located services or they are nearby:** *"Connections to community → other activities in community AWARENESS."* *"Access to PC, internet space"* *"Other service options links → i.e. art therapy, not just linkages"* *"Can have a reason for people to go there that is not about the problem (e.g. dieticians, positive services, alternative medicine, massage, GP)."*
5 Groups Referenced repeatedly	**The principals underpinning the service model are important.** **Holistic and well-integrated services:** *"Whole Person→ holistic supports."* *"Clinical / therapeutic / peer support → there are a range of options for the different needs of a person."* *"Ability to manage co-occurring issues: mental health, physical, AOD."* *"Emphasis on mental health rather than mental illness."* **Person-centred and recovery focussed:** *"Client-centred service. Not in a rush. Form a relationship."* *"People working in partnership model with people accessing services."* *"Person (not disease) centred", "Recovery focussed"* *"Being involved in treatment", "Not you telling us what we want"* **Safe and responsive:** "*Aboriginal and Torres Strait Islander informed practices."* *"Trauma informed, person-centred."* *"Acknowledgement of systemic oppressions that are in the service approach: Racism, LGBTIQ+, Class."* **Responsive to carers and families:** *"Mindful of age groups."* *"CARER SUPPORT OFFERED AT TIME: communication, planning, how to help."* *"Carers can go and take someone without feeling uncomfortable."*

	Continuity of care / single point of contact: *"Working alongside a trusted support person (lived experience peer). Central coordination."* ***"**Advocate for each person."* ***"**Non-clinical triage. Only have to tell story once."* *"Share with peer staff with (lived) experience."* **Diligence and follow up:** *"No buck passing", "Follow-up", "Support after service at the centre"*
5 Groups Referenced repeatedly	**Well integrated non-clinical and clinical mental health services are required.** **Single point of contact to ensure continuity of care:** *"Case managers: build rapport and clients trust, helping to facilitate connection to 'stigma' services."* *"Social workers or skilled Cert IV qualified in Peer Work, Mental Health/AOD."* *"Strength and needs based individual support."* **Support for co-occurring issues using multi-disciplinary teams:** *"Well integrated AOD/Mental Health", "AOD", "Mental Health and AOD",* *"trauma support"* **Availability of clinical support:** *"GP relationship can be critical to building a support plan. May be 1st point of support."* *"NECESSARY CLINICAL: psychiatry, psychology, mental health nurse, general practitioner."* *"Nutrition/dietician."* **AND non-clinical support:** *"PEER WORKERS", "NON-CLINCAL SUPPORT!!! (Peer Workforce)"* *"INDIVIDUAL & GROUP SERVICES", "Therapeutic programs"* *"Family/Carer support", "ACCESS TO ADVOCACY"* *"Learning and education: self-compassion, engagement, conditions, coping, general."*

5 Groups Referenced repeatedly	**Formal service collaborations are required to support people with multi-agency needs:** *"Coordination organisation has responsibility and accountability."* *"Referral with all the information can be shared to all of the affiliated professionals."* *"Different orgs have offices in the centre."* *"Clients are deidentified for case conversations (use initials for case planning)."* *"Stronger networking. Improved communication and knowledge."* "ACCESS TO OTHER SERVICES: impacts on wellbeing, social determinants of health."

Discussion of Consultation Outcomes

Participant Experiences

The following high-level summary captures participant experiences from the Consultation.

Locating a Service:

- Needed to self-navigate the service system and had difficulty finding a service (4 of 5 groups).
- First accessed a service during a time of crisis (4 of 5 groups).
- Denied access to service (3 of 5 groups). Reasons included 'too high risk', 'not meeting criteria' and 'disclosing drug use'.

Accessing Service:

- Reported deterioration after being denied service (3 of 5 groups). Subsequent outcomes included crisis hospital admissions and suicide attempt.
- Had to wait a long time before receiving support (4 of 5 groups).
- Were unable to identify and access support because of low English (2 of 5 groups).

Receiving Support:

- Being stigmatised by care providers (5 of 5 groups).
- Poor experiences accessing care (5 of 5 groups) including:
    - Having to retell their story,
    - Not being listened too,
    - Lacking support,
    - Absence of person-centred care,
    - No follow up or referral pathways to other services,
    - Reliance on pharmacotherapy.

- Poor experiences by carers and no referral pathways to carer supports (2 of 5 groups).
- Positive experiences of care (2 of 5 groups).

Participant Perspectives

A high-level summary of what the participants felt the new Centre should provide is included below.

Find support when you need it:

- SERVICE NAVIGATION: comprehensive, accurate, self-navigate online, access support from the Centre.
- ONSITE INTEGRATED SUPPORT: holistic, multi-disciplinary care, non-clinical and clinical supports, shared care planning, person directed, carer friendly.

Access support when you need it most:

- SUPPORT PEOPLE WITH COMPLEX NEEDS: single point of contact, person directed, service collaboration, shared records, address social determinants.
- SHORT TERM CRISIS CARE: non-pathologizing, solution focussed, carer friendly, post crisis care, safe alternative to ED.

Location, design and function are important:

- ACCESS: 24 hours, telephone, text/email, face-to-face, well promoted, easy referral pathways.
- FUNCTION: in house integrated supports, group activities, learning spaces, breakout spaces, connected to community, co-located and visiting services.
- LOCATION: centrally located, minimal travel, public transport access, transport for vulnerable people.
- ENVIRONMENT: therapeutic, comfortable, spacious, offer privacy, outside green spaces, reflect community diversity, be integrated with community.

High quality and person-centred care are essential:

- Non-judgemental, non-pathologizing, solution focussed and SAFE support.
- Multi-disciplinary teams including non-clinical and clinical staff. Lived experience workforce. Mental Health GPs with psychiatrist support (not psychiatric dominated). Staff that reflect community.
- Individual and group-based recovery focussed supports. Capacity building.
- Responsive and safe for First Nations people, culturally and linguistically diverse people, LGBTIQ+ community and vulnerable members of the community

Operating using evidence-based principals:

- Provide continuous care and individual advocacy for clients who will be supported by a key worker.

- Provide non-clinical triage service that has clinical supervision and support. Offer integrated and holistic care planning and supports that address mental health, AOD and physical health needs.
- Coordinated by a lead organisation working to shared principals with collaborating services.
- Include co-located services and facilitates for in-reach visiting services.

NTLEN Recommendations

Meaningful engagement of people with Lived Experience in the NT

The NTLEN was instigated in recognition that the NT was the only state or territory without a lived experience network. This has impacted the ability for people with lived experience to be meaningfully engaged in co-design processes such as the Darwin Adult Mental Health Centre.

In response to the national consultation for the Adult Mental Health Centres, the NTLEN advocated for the inclusion of measurable Key Performance Indicators for the meaningful engagement of people with lived experience within the national Evaluation Framework.

In the same vein, the NTLEN has made the following recommendations:

- The NTPHN should establish a Steering Group to oversee the design and establishment of the Centre and the development of an evaluation framework. Membership should include representatives from local key stakeholders, including members representing the clinical and non-clinical sectors. The NT Lived Experience Network should form part of the Steering Group. Importantly, the Steering Group should have a composition that includes at least 30% representation by independent people with lived experience recruited through a skills and experienced based Expression of Interest process. **(Recommendation 1)**
- The NTPHN should engage an external evaluator and with the support of the Steering Group, apply program logic to co-design an evaluation framework for the Darwin Centre that aligns with the desired impacts and outcomes. The evaluation framework should capture: meaningful engagement of people with lived experience during the co-design, establishment and operation of the Centre; outcomes and experiences for both consumers and carers accessing the Centre; population health outcomes and the experience of staff working at the centre. **(Recommendation 10)**

Use of existing evidence

There is a large body of enquiries and reports framing evidence and recommendations to address systemic issues nationally and locally. The NTLEN recommends that the NTPHN undertakes a broad and comprehensive review of the literature and presents recommendations to the Steering Group for consideration. **(Recommendation 2)**

Similarly, to harness models of best practice already in existence, NTLEN recommends the Steering Group is presented with an overview of: **(Recommendation 7)**

- Peer models and trends across Australia, and
- Service collaboration models / collective impact approaches to support people with mental health conditions and multi-agency needs relating to the social determinants of health.

Broader community feedback

Considering the themes raised at the Consultation, the NTLEN recommends that people in the Greater Darwin region are surveyed more broadly to solicit consensus for the community's preference in relation to the establishment and operation of the Centre. **(Recommendation 3).**

The location of the Centre will be a key issue for the community, and it was raised by two table groups at the Consultation.

The population in the Greater Darwin region is spread across a region that is 3,164 square kilometres. Most of the population in the region is concentrated in roughly 3 areas: Darwin CBD, Darwin northern suburbs and Palmerston CBD, noting that the population is growing fastest in the Palmerston local government area.

There are two regional hospitals, Royal Darwin Hospital in the Darwin northern suburbs and Palmerston regional hospital in Palmerston.

The NTLEN believes that it is of critical importance to engage the broader community in the Greater Darwin area to determine the preferred location of the Centre. Influencing factors will include the distribution of the population, growth areas, proximity to either of the regional hospitals and community spaces, public transport routes and arterial roads (refer to Figure 2).

Demand on Services

Several questions and concerns were expressed at the Consultation about the demand that would be placed on the Centre and whether the allocated funding by the Commonwealth Government[25] to establish ($5 million) and operate the facility ($3 million per annum) will be sufficient to meet demand.

Participants noticed the lack of clarity within the Commonwealth consultation paper about the use of the ED alternative for people who may be affected by alcohol and other drugs. The NTLEN recommends exclusion criteria be explored by the NTPHN in conjunction with key stakeholders (including people with lived experience) and clarified. Noting that one table group at the Consultation recorded the need for:

> *"CLEAR guidance to ambulance and police about the Centre's function. Requires a framework and training for emergency services with regard to ED transfers, Centre admissions and Spin Dry* (Sobering Up Shelter)*."*

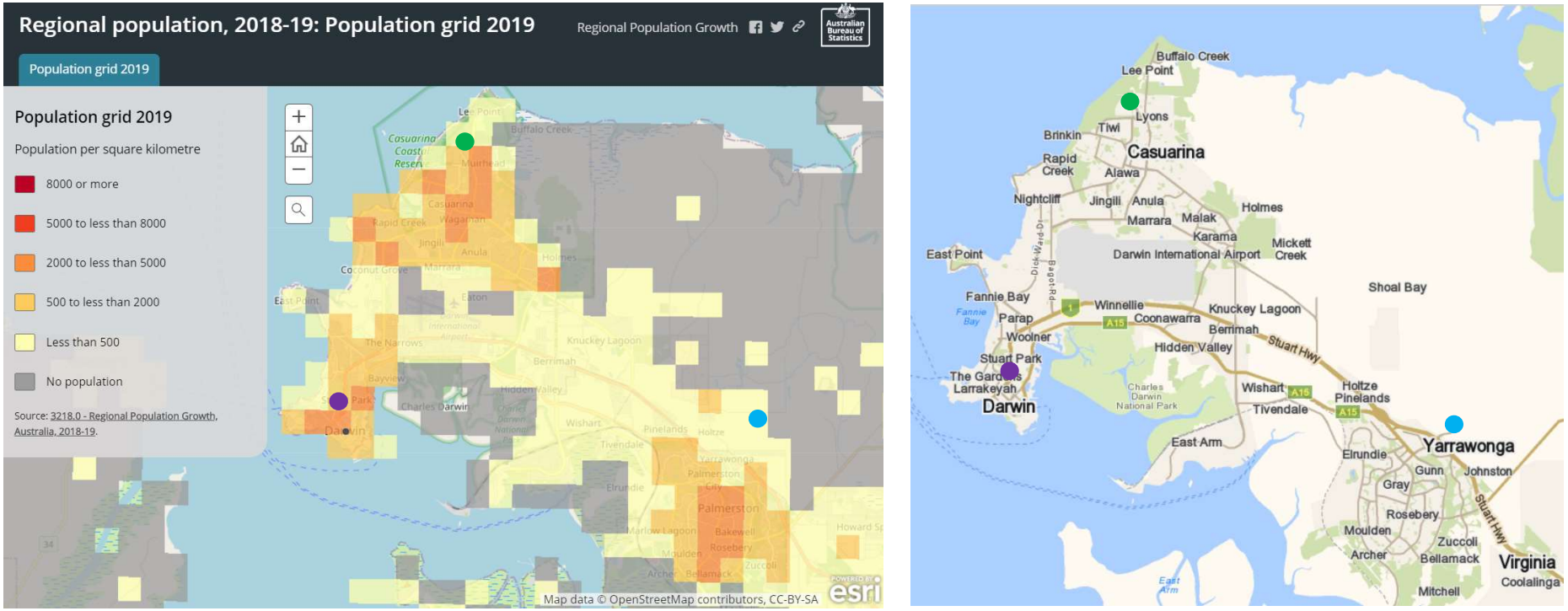


Figure 2: Population density in the Greater Darwin region, location of Darwin and Palmerston hospitals and major arterial roads

In response to the concerns related to demand, the NTLEN recommends:

- The NTPHN should perform a comprehensive review of mental health, suicide and related data to estimate the projected demand on the four core service elements proposed for the Centre. This should include consultation with people with lived experience to review the underpinning assumptions when calculating demand. **(Recommendation 4)**
- To mitigate the risk of budget overruns and schedule delay, the NTPHN should commission an appropriately skilled organisation to develop an accurate estimate of the capital funding required to establish and fit out the Darwin Adult Mental Health Centre. The cost to maintain the facility and pay for services each year should also be calculated. **(Recommendation 5)**
- Similarly, the NTPHN should commission an appropriately skilled organisation to develop an accurate estimate of the cost to deliver services within the Centre. **(Recommendation 6)**
- The NT Government should be approached to co-contribute the balance of capital funding and service delivery funding required to establish and operate the Centre. This should be done without impacting existing services. **(Recommendation 7)**

Service Navigation and Referral Pathways

The Centres are supposed to act as a central point to connect people to other services in the region and undertake in-house assessment, including information and support to access services

This function will be highly valued within the Northern Territory, noting that Consultation participants expressed significant difficulty locating services outside of crisis times and poor experiences accessing care due to service denials and having to retell their story.

This experience is collaborated by the Northern Territory Mental Health Coalition which has worked in partnership with people with lived experience to previously advocate to the NT Government and the NTPHN that one of the most significant system level issues in the NT is the absence of a comprehensive, online service navigation tool to locate the right service at the right time.

The absence of a comprehensive online service navigation tool has meant that the public and people working within mental health and related sectors have been unable to identify clinical and community based mental health and suicide prevention services without relying on their own knowledge and personal or professional networks.

Without a service navigation tool, there is no visibility into the NT mental health system to understand service eligibility criteria, cost, or referral pathways. Without visibility to service eligibility criteria, referrals are frequently made incorrectly. As evidenced by the Consultation this leads to people losing valuable time (contributing to worse mental health outcomes) and having to retell their story (which is frustrating, causes disengagement and is potentially re-traumatising).

The absence of an appropriate service navigation tool has inhibited:

- Families and individuals from being able to self-navigate the system.
- First responders (e.g. schools, sporting groups, religious associations, accountants, employment services etc) from being able to connect someone to appropriate support.
- Community based services (e.g. NT Government Families and Children Enquiries Support service (FACES), Aboriginal Community Controlled Health Services and other community services) from making timely and appropriate referrals (without relying on the knowledge and professional networks of individual staff members).
- Clinical mental health services (e.g. GPs, Top End Mental Health Service case managers, social workers, psychologists, psychiatrists) from referring patients to non-clinical services (e.g. free counselling, youth programs, psychosocial support, NDIS Access support, Carer services).

Not having a comprehensive, online service navigation tool will also inhibit the Centre from acting as a central point to connect people with other services in the region and undertake in-house assessment, including information and support to access services. To address this issue the NTLEN has made the following recommendation.

- The NTPHN should co-design and implement a comprehensive resource to navigate the NT mental health system. This should be done with the support of the Steering Group and people with lived experience more broadly. **(Recommendation 9)**

The resource should align with the stepped care model (per Commonwealth Guidelines for Initial Assessment and Referral)[26] and be publicly accessible online to reduce demand on the Centre by facilitating self-referral and referral by other agencies.

The navigation resource should incorporate eligibility and exclusion criteria where relevant, and be able to direct people to:

- Commonwealth and NT Government funded mental health, suicide prevention, AOD and related services that support people to address the social determinants of health,
- Medicare funded mental health services including support to locate a local or telehealth mental health practitioner,
- Digital self-help options, online mental health resources, national telephone and web-based support services, and
- Consumer and carer resources relating to rights, responsibilities, and complaints processes (e.g. Hospital Charters, NT Health Consumer and Carer Guides, Community Visitor Program, Health Complaints Commission).

Peer workforce development

The NT has a small peer workforce that's growth has been inhibited by the absence of a local accredited pathway to study the Certificate IV in Peer Support. Several projects funded by

the NTPHN and NDIS Information Linkages and Capacity Building grants are presently underway, each with a focus on growing and professionalising the NT peer workforce.

Consultation participants expressed a clear desire to be supported by the lived experience workforce, particularly as their first point of contact with whom to share their story, as an advocate on their mental health recovery journey and as a provider of capacity building mental health supports.

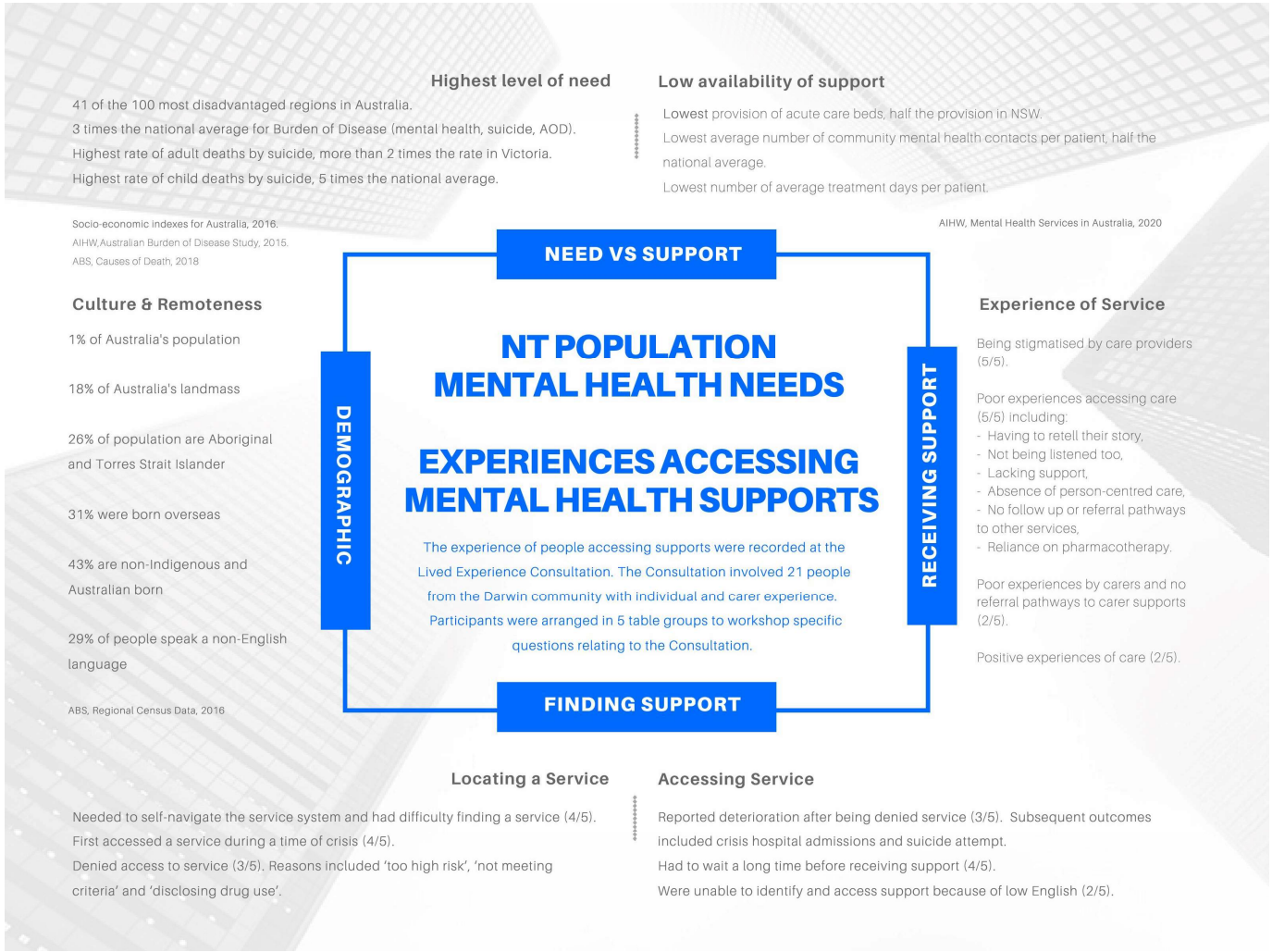
Participants at the Consultation recognised the need for clinical supports; however, they were wary of the Adult Mental Health Centre being dominated by clinical or psychiatric dominated models of care.

The NT has the lowest use of peer workers within Government funded clinical services of all states and territories.[27] Commitment and support is required from commissioning agencies for peers to be accepted and valued as part of multi-disciplinary teams in the Northern Territory.

To address issues related to the availability and sustainability of the peer workforce in time for the Centre commencing operation, the NTLEN recommends that the NTPHN and NT Government support and participate in a NT Peer Workforce Advisory Group. The Advisory Group should include stakeholders from the mental health and Vocation Education and Training sectors and provide guidance to the NTPHN and NT Government to co-commission the following items. **(Recommendation 11)**

- Activities that support the establishment of accredited vocational pathways for people with lived experience to enter the peer workforce.
- Capacity building activities and shared resources for clinical and non-clinical organisations to use to embed peer workers safely and effectively within recovery-oriented practice and multi-disciplinary care teams.
- A review of national best practice guidelines and recommendations by the National Mental Health Commission to develop commissioning guidelines for the NTPHN and NT Government. Commissioning processes should encourage the implementation of peer models, yet ensure organisational structures and processes are in place for the safe and effective employment of peers.
- The development of a comprehensive Northern Territory Peer Workforce Strategy.

Attachment 1 – Overview of Consultation




Design and function are Important
ACCESS: 24 hours, telephone, text/email, face-to-face, well promoted, easy referral pathways.
FUNCTION: in house integrated supports, group activities, learning spaces, breakout spaces, connected to community, co-located and visiting services.
Is $5 million sufficient capital?
LOCATION: centrally located, minimal travel, public transport access, transport for vulnerable people.
ENVIRONMENT: therapeutic, comfortable, spacious, offer privacy, outside green spaces, reflect community diversity, be integrated with community.
WHAT SHOULD IT LOOK LIKE?
High quality and person-centred care are essential
Non-judgemental, non-pathologizing, solution focussed and SAFE support.
WHO SHOULD BE IN IT?
Multi-disciplinary teams including non-clinical and clinical staff.
Lived experience workforce.
Mental Health GPs with psychiatrist support (not psychiatric dominated).
Staff that reflect community.
Individual and group-based recovery focussed supports. Capacity building
Responsive and safe for First Nations people, culturally and linguistically diverse people, LGBTIQ+ community and vulnerable members of the community.
LIVED EXPERIENCE CONSULTATION
NEW DARWIN ADULT MENTAL HEALTH CENTRE
On the 23rd of July 2020, the NT Lived Experience Network hosted a Lived Experience Consultation to gather the experience and perspectives of people in the Greater Darwin region for the New Darwin Adult Mental Health Centre.
HOW WILL IT OPERATE?
Employ evidence based principals
Provide continuous care and individual advocacy for clients who will be supported by a key worker.
Provide non-clinical triage service that has clinical supervision and support. Offer integrated and holistic care planning and supports that address mental health, AOD and physical health needs.
Coordinated by a lead organisation working to shared principals with collaborating services.
Include co-located services and facilitates for in-reach visiting services.
WHAT SHOULD IT DO?
Find support when you need it
SERVICE NAVIGATION: single point of truth, self-navigate online, access support to navigate, find accurate information.
ONSITE INTEGRATED SUPPORT: holistic, multi-disciplinary care, non-clinical and clinical supports, shared care planning, person directed, carer friendly.
Support when you need it most
SUPPORT PEOPLE WITH COMPLEX NEEDS: single point of contact, person directed, service collaboration, shared records, address social determinants.
SHORT TERM CRISIS CARE: non-pathologizing, solution focussed, carer friendly, post crisis care, safe alternative to ED.

Attachment 2 – Peak Bodies

At least one peak body represents the interests of mental health carers in every state and territory. Except for the Northern Territory, all states and territories are supporting and/or have an extensive history of supporting the interests of mental health consumers through peak bodies including:

- Victorian Mental Illness Awareness Council (VMIAC) in Victoria,[28]
- "Being" in New South Wales[29],
- Lived Experience Leadership and Advocacy Network (LELAN) in South Australia,[30]
- "Flourish" in Tasmania[31],
- Australian Capital Territory Mental Health Consumer Network (ACTMHCN),[32]
- Consumers of Mental Health Western Australia (CoMHWA),[33] and
- A new peak body in Queensland given the dissolution of "Voice" 2019.[34]

This leaves the Northern Territory as the only state or territory that has no jurisdictional peak body representing the interests of mental health consumers, or history of there ever being a network.

The Northern Territory does have related networks and peak bodies, and it is important to understand their function and how they differ from the NTLEN.

The existing peak bodies and networks in the NT include:

- The NT Mental Health Coalition (NTMHC) as the peak body for community managed mental health organisations in the NT.[35]
- National Disability Services NT (NDS NT) as the peak body for disability service providers in the NT.[36]
- The Association of Alcohol and Other Drug Agencies NT (AADNT) as the peak body for alcohol and other drug service providers in the NT.[37]
- The Aboriginal Medical Services Alliance Northern Territory (AMSANT) as the peak body for Aboriginal Community Controlled Health Services (ACCHS) in the NT.[38]
- Carers NT, an organisation funded to provide carer respite and support to people providing unpaid care and support to family members (or friends) affected by disability, chronic illness, mental illness or who are frail aged. Carers NT are part of the National Network of Carers Associations and therefore represent the voice of NT carers.[39]

- Integrated Disability Action Inc (IdA) which is a support network providing individual and systems level advocacy for people living with disabilities. IdA is the peak consumer organisation for people with disabilities in the NT.[40]
- Top End Mental Health Consumer Organisation (TEMHCO), which is the only consumer run organisation in the NT providing a drop-in centre for people living with a mental illness in the Palmerston region.[41]
- Local community-based suicide prevention networks across the NT that have been established by people bereaved and affected by suicide.

Attachment 3 – At Risk Populations

Aboriginal and Torres Strait Islander People

Aboriginal and Torres Strait Islander people experience rates of high or very high psychological distress at nearly three times the rate of non-Indigenous people (11%). In urban areas, Aboriginal and Torres Strait Islander people are more likely to experience high or very high levels of psychological distress (32%), compared with those in remote areas (24%)[42].

Inter-generational trauma associated with the impacts of colonisation, cultural dislocation and child protection practices contributes to social isolation and increases vulnerability of Aboriginal and Torres Strait Islander people[10].

For the period between 2014-15, the age standardised hospitalisation rate for NT Aboriginal and Torres Strait Islander people for mental health-related conditions was more than 3 times that for non-Indigenous Territorians (24 per 1,000 compared with 7.4 per 1,000).[43]

For the same period, the age standardised contact rate for community based mental health services for NT Aboriginal and Torres Strait Islander people was 1.6 times the rate for non-Indigenous Territorians (408 per 1,000 compared with 262 per 1,000).[43]

LGBTIQ+ Community

There is evidence that people with diverse sexuality and gender identity experience disparities in their mental health, sexual health and rates of substance use.[44] Almost 1 in 3 (32%) homosexual/bisexual people aged over 16 in Australia meet the criteria for an anxiety disorder in the previous 12 months, compared with 1 in 7 (14%) heterosexual people.

The NTPHN undertook a two-part Needs Assessment for the Diverse Sexuality and Gender Identities Community[45] and Transgender Community[46] which identified the following:

- A broad range of mental health and wellbeing problems are experienced by participants including depression, sleeping problems, anxiety disorder, suicidal thoughts and suicide attempts, eating disorders, self-medicating, addiction, bi-polar disorder and 'exhaustion'.
- Severe chronic depression with suicidal thinking is a common presentation for Transgender people.
- Some Transgender people have been through mainstream psychiatric services which did not address their gender, medicated them but didn't address the underlying main issue.
- The mental health care needs of people with diverse sexualities and gender identities are at times complicated by the tendency of some health care providers to over pathologize issues or engage in 'diagnostic overshadowing', a process whereby physical symptoms are wrongly attributed to mental illness or thought to be caused

by gender dysphoria, resulting in the provider overlooking the presence of co-morbid conditions.

- Participants reiterated the point that being transgender is not a mental illness, nonetheless transgender people are disproportionately at risk of mental ill-health because people are at times having to cope with challenging issues in isolation.
- Better coordination of care through better service linkages and secure referral pathways could contribute to improving support levels for people with diverse gender identity. It was suggested that health and mental health care providers could work in partnership to provide support and direction to people who are needing to navigate a complicated multi-faceted system of care.
- Some of these issues were complicated further for Aboriginal people who identify as having diverse sexuality and gender identity. They need timely access to appropriate multi-disciplinary clinical and non-clinical mental health services that are culturally safe and secure for themselves as well as for their friends and family.
- There are a limited range of options for skilled primary and specialist care in Darwin. There is a need for greater training for mainstream general practitioners and service providers to be more diverse sexuality and gender identity friendly.
- There is a need for additional services and support, including social and psychological support, an online directory and advertising of diverse sexuality and gender identity friendly places, and the option of a telephone service. In the NT, there is currently only one known diverse sexuality and gender identity friendly psychologist with expertise with transgender patients. Access to psychiatrists is limited even for the general population, and it is understood that there is no local access to specialised transgender psychiatry services.
- The cost of care is a burden for many respondents as there is limited access to bulk billing GPs, and limited referral services available at low or no cost to consumers. For people with diverse gender and sexual identities, locating safe or specialised services that also bulk-bill or offer free counselling and support is particularly difficult. Long appointments for complex gender and sexuality-based health issues, add an additional cost burden/barrier.

Culturally and Linguistically Diverse Communities

Within the Greater Darwin region, 31% of the population was born overseas and 20% of the population speaks a language other than English at home.

The NTPHN, 2019 Program Needs Assessment identified the following risk factors for refugees and migrants from non-English speaking backgrounds:[10]

- Likely to experience poorer mental and physical health than the general population and face more barriers in accessing health services.
- Have higher levels of anxiety and depression than the general population, notably among refugees.

- Refugees are also more likely to experience poorer health status, have higher rates of long-term medical and psychological conditions and visit health services more frequently.
- For recent arrivals, poor initial health status, low health (and English) literacy and cultural challenges in adaptation, particularly to the health system, can contribute to poor health outcomes.
- Are less likely to receive treatment for several reasons, including stigma and shame, and language barriers including health literacy, poor knowledge and lack of trust, among others.

Defence Force Personnel and Veterans

There is a significant defence presence in the NT, with many active service people stationed in the Darwin and Katherine regions and a significant veteran population who continue to reside here. The Greater Darwin region is home to 3,672 Veterans[47] who reportedly experience high prevalence of anxiety, depression, post-traumatic stress disorder (PTSD) and suicide risk.

People in contact with the Criminal Justice System

The NT has the highest imprisonment rate of all states and territories, with the highest rate of Aboriginal adult (80%) and youth detainees (94%).[48] The NT Correctional Services Annual Statistics for 2016-17 estimate that 903 people per 100,000 population in the NT are in prison, over four times higher than the national average.[49]

Mental health, drug and alcohol misuse, poor physical health, lack of social support and resources, including support services and housing, are all issues for people in contact with the justice system, particularly on discharge from custody.[10]

People entering prison are likely to have mental and physical health problems and behave in ways that are risky to their health.[50] Half (50%) of all prison entrants had a history of mental health conditions, one-third (31%) had a current chronic condition and three-quarters (74%) were current smokers in 2015.

People who have contact with the criminal justice system experience higher rates of homelessness and unemployment and often come from socially disadvantaged backgrounds, with thousands of people cycling through the system annually at a national level.[10]

Attachment 4- Consultation Schedule

0900 - Arrival (15 min)

0915 - Welcome to Country by Larrakia Nation (15 min)

0930 - Acknowledgement and Introductions (15 min)

0945 - Introduction to the NT Lived Experience Network (15 min)

1000 - Overview to the Commonwealth funded New Darwin Adult Mental Health Centre and the Consultation process (15 min)

1015 - Group Agreement (15 min)

1030 - Ice-breaker Activity to meet people on your table (15 min)

1045 - Short Break (15 min)

1100 – 1a What is your experience finding the supports you or a loved one has needed in the past? (15 min)

1115 – 1b What could help people to understand what supports are available and how to access them? (15 min)

1130 – 2a What is your experience of you or a loved one accessing a new service for the first time? (15 min)

1145 – 2b What could improve people's experience when accessing a new service for the first time? (15 min)

1200 – 3a What is your experience of you or your loved one receiving mental health supports in the past? (15 min)

1215 – 3b What kind of mental health supports could help in the short-to-medium term? (15 min)

1230 - Lunch (30 min)

1300 – 4a What is your experience of you or a loved one receiving support in a crisis? (15 min)

1315 – 4b What kind of alternative model for short-term crisis care would help people? (15 min)

1330 - Reflection and Self Care (15 min)

1345 - How information from the Consultation will be used and the next steps by the NTLEN (10 min)

1355 - Feedback & Close (5 min)

Attachment 5- Consultation Feedback

The following information represents the consolidated feedback and comments by participants.

Participants were asked to provide a score between 0 (very poor) → 10 (very good), with space provided for comments.

1. **How would you rate the organisation of this event?**

Score	Comments:
9.1	• sensitive, inclusive, captured the information • found out about this a couple of days ago • the event was quite well organized • well organized - perhaps could have had more participants but appreciate the circumstances

2. **How would you rate the Facilitators of this event?**

Score	Comments:
9.5	• integrity, openness, authenticity • the facilitators were good, they were engaging and spoke well • clear, concise and person with lived experience

3. **How would you rate your understanding of the how information from the Consultation will be used by the NT Lived Experience Network?**

Score	Comments:
8.4	• to create a safe, non-judgmental space, peak body

4. **How would you rate this opportunity (and future opportunities) to use your lived experience in this way?**

Score	Comments:
9.2	• being a weekday may limit attendance • a way to better ensure changes, it would also be good to ensure another space to further talk • as support for others

5. **How safe did you feel to share your lived experience at today's event?**

Score	Comments:
9.6	• I only needed to disclose generalised experiences and summary of events, not a detailed level of disclosure • I felt quite safe to talk • this was very well explained to participants • everyone has had lived experience, safe, non-judgmental

6. **Is there anything we can do to improve our facilitation of this type of event in the future or do you have any other feedback for us?**

Comments:

- great
- movement breaks, activities
- very informative, knowledgeable, helpful for those who have no idea about mental health
- hope there is video clips about mental health and how to help it, maybe possible, just a suggestion
- it was well managed and illustrated the key notes
- introduction with pronouns, slightly more clarity to help focus group discussions on point for each question
- the questions were a bit repetitive, overlapping
- this is a good project
- presentation was from grass roots experiences
- having more people in the employment of mental health come to these meetings, representation of multiple organisations to support these ideas
- do what you are doing, it was good

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