CCQ COUNTRY TO COAST, QLD
Healthy, connected communities

MENTAL HEALTH REFORM PROJECT

Phase 1, Stage 3: Community Consultations

Community Consultation Report

Prepared by: **Country to Coast, QLD**

Date: **5 February 2024**

phn CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government Initiative

Country to Coast QLD is an independent, not-for-profit organisation committed to building healthy, connected and resilient communities across the Central Queensland, Wide Bay and Sunshine Coast regions. We deliver the Australian Government's PHN Program and partner with health providers and the community to design and commission quality primary care services.

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Acknowledgement of Country

Country to Coast, Queensland, acknowledges Traditional Owners of Country throughout Australia. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present, and emerging. We also accept the invitation in the Uluru Statement from the Heart to walk together with Aboriginal and Torres Strait Islander peoples in a movement of the Australian people for a better future.

Disclaimer

This document has been prepared by Country to Coast, Queensland (CCQ), based on a report originally developed by Social Ventures Australia (SVA). SVA was commissioned by CCQ to conduct extensive consultations across the region, with the aim of supporting CCQ's Mental Health, Alcohol and Other Drugs, and Suicide Prevention Reform Project. The insights and findings derived from these consultations have been synthesised by SVA and serve as the foundational basis for the content presented herein.

CCQ acknowledges the contributions of all stakeholders who participated in the consultation process and extends gratitude for their thorough and insightful contributions. This adapted report is a testament to the collaborative efforts aimed at driving positive change in the areas of mental health, alcohol and other drugs, and suicide prevention within our region.

Executive Summary

Mental ill-health remains a significant issue across Australia, with health systems struggling to meet the needs of the community. PHNs play a crucial role in improving this picture, to ensure local community needs and priorities can be best met. In recognition of the challenges faced by the community in its own region, Country to Coast, Queensland (CCQ) is exploring opportunities to reform the types of mental health, alcohol and other drugs, and suicide prevention services it procures as a PHN. This reform process, through CCQ's *Mental Health Reform Project,* aims to better meet the needs of the community and ultimately improve outcomes for people living in the region.

PROJECT & REPORT OVERVIEW

CCQ's *Mental Health Reform Project* is currently in its first phase, with the primary objective of CCQ actioning a step-change or partial improvement in the services it procures, and how it procures them. This phased approach is in recognition of the complexity of the issues involved, and the likelihood of reform needing to be achieved iteratively and over time. The stages involved in this first phase are outlined below.

Mental Health Reform Project Phase 1 (2023/24) – Stages

- **Stage 1: Case for Change** (completed) was an investigation of key data sets and sources to establish the case for change and understand key gaps or shortcomings in current mental health outcomes in CCQ's region. This stage concluded in July 2023 with issuing of the *Improving Mental Health – The Case For Change* report.
- **Stage 2: Research Report** (completed) was a research stage to identify best practice system principles, approaches, and service models / models of care. This culminated in development of the *Mental Health Reform Opportunities Research Report*, finalised in October 2023, and identification of key consultation topics for Stage 3.
- **Stage 3: Initial Community Consultations** (current) has included facilitation of seven in-person workshops throughout CCQ's region, on topics identified in the *Mental Health Reform Opportunities Research Report*. This stage is expected to be finalised in February 2024 with the completion of this report, which summarises the key workshop findings and opportunities to be taken forward.
- **Stage 4: Solution Development & Procurement** (planned) is expected to include validation (with community) and review (within CCQ) of the key findings and opportunities identified in Stage 3, towards developing new RFQs and contracting new services, intended to commence in July 2024.

This report's primary purpose is to summarise the findings of Stage 3 of Phase 1 of the *CCQ Mental Health Reform Project*, for it to be used as a key input and guide for Stage 4, and towards procuring new services and establishing new contracts.

KEY FINDINGS – THEMES AND OPPORTUNITIES

The important findings from this Stage of the project are organised into two classification categories:

- ***Themes*** – which represent topics that are presumed to be of significant importance based on their representation across the workshop feedback received.
- ***Opportunities*** – which represent a mapping of the themes and best-practice (from the previously completed *Research Report*) to identify intersections, and therefore key opportunities for the *Mental Health Reform Project* to consider moving forward.

11 key themes and 16 opportunities have been identified through the workshop synthesis. These are described in detail in the body of the report.

Themes identified from Stage 3 workshops	
1. Improving service navigation, access, and availability	6. Developing and strengthening the workforce

Themes identified from Stage 3 workshops	
2. Enhancing collaboration and integration of services 3. Leveraging lived experience and peer workers 4. Addressing regional and geographical needs 5. Contract structures and particulars	7. Engaging and empowering consumers and communities 8. Reducing stigma and improving health literacy 9. Supporting innovative service delivery 10. Focus on prevention and broader social supports 11. Inclusion of diverse cohorts
Opportunities identified	
Specifying new services or service requirements	**Funding infrastructure and system-level supports**
1. Implement centralised service hubs, with key inclusions to ensure they are efficient, effective, and provide equitable access 2. Strengthen and support intake processes across all services with a 'No Wrong Door' approach 3. Incentivise equity of service access and provision in commissioning processes and contracts 4. Encourage co-design and co-delivery with lived experience, key cohorts, and peer workers 5. Invest in community education and programs	6. Fund key infrastructure and services to facilitate digital access, including 'outside of the home', where digital services are proposed 7. Systems, pathways, and support for service navigation 8. Facilitate and support systems for sharing of consumer information 9. Include scalable wait-list support mechanisms in contracts or other services
Contracting particulars and funding principles	**Workforce development**
10. Facilitate flexibility in service delivery to reduce overall system burden 11. Adjust contract particulars to support sustainable delivery by service providers 12. Adjust tender processes to facilitate and encourage collaboration, not competition	13. Advocate for and support strategic mental health workforce planning in rural and remote areas, through career and financial incentives and targeted university placements. 14. Include specific supports for and engagement of peer workers in practitioner engagement and education activities 15. Implement cross-sector and cross-professional training opportunities to build strong and diverse communities of practice 16. Encouraging representative diversity in the workforce

CONCLUSIONS

Based on the findings from this Community Consultation stage of the reform project, four key takeaways emerged:

1. With a broad distribution over a number of key themes, **establishing centralised service hubs** represents a key opportunity for further exploration as part of procurement processes. Importantly, these would represent significant contracts within which other improvements can be implemented.
2. **Other specific services or inclusions may need to be considered in contracts**, such as community education, navigation support, and digital infrastructure.
3. Other considerations for the procurement process include considering how to **reform processes and contract particulars to make delivery more sustainable, collaborative, and flexible.**
4. Considerations outside the procurement process include **iterating the PHN's approach to practitioner education and engagement** to include meeting the needs of peer workers and encouraging cross-sectional interactions.

These conclusions can be taken forward and tested as part of further community engagement and solution development.

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Introduction and Context

CCQ Mental Health Reform Project

CCQ is exploring opportunities to reform the services it procures through the *Mental Health Reform Project*. The project is currently in its first phase, with the primary objective of CCQ actioning a step-change or partial improvement in the services it procures, and how it procures them. This is in recognition of the complexity of the issues involved, and the likelihood of reform needing to be achieved iteratively and over time.

CCQ plans to achieve this initial step-change through its procurement processes for contracts commencing in July 2024. To that end, this initial phase of the project consists of four planned stages:

Mental Health Reform Project Phase 1 (2023/24) – Stages

- **Stage 1: Case for Change** (completed) was an investigation of key datasets and sources to establish the case for change and understand key gaps or shortcomings in current mental health outcomes in CCQ's region. This stage concluded in July 2023 with issuing of the *Improving Mental Health – The Case For Change* report.
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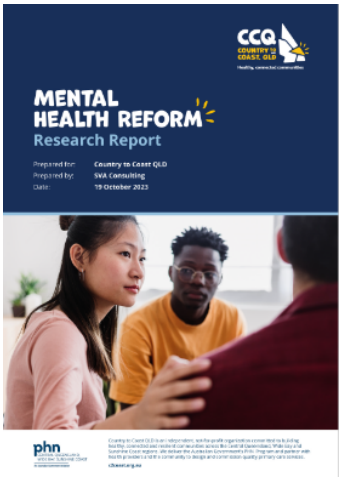


This report

This report's primary purpose is to summarise the findings of Stage 3 of the *CCQ Mental Health Reform Project*, for it to be used as a key input and guide for Stage 4, and towards procuring new services and establishing new contracts. To meet this purpose, the report includes four key sections:

- **Stage 3 Methodology:** This section describes the key steps and processes undertaken to identify the findings included in this report. This includes describing – within sub-sections – how workshop inputs (i.e. topics) were defined, how the workshops were conducted, how the workshop data was processed, and how the processed data was synthesised into recommendations. This section is important as elements of the methodology are inherently subjective, due to their need to aggregate and process significant quantities of qualitative data.
- **Key Workshop Findings:** This section identifies the key findings from the analysis of the workshop data. The key findings are organised into:

    - *Themes*: These represent categories across which feedbsolutionack has been aggregated and documented, and describe important topics that were raised across a large number of locations and conversations.
    - *Opportunities*: Informed by feedback within one or more *Themes*, these represent hypotheses for actions that could be taken in procurement processes to deliver the step change that CCQ is pursuing.
- **Detailed Workshop Feedback:** This section of detailed feedback introduces and discusses each *Theme* (described above), the key feedback within it, its links to the *Mental Health Reform Opportunities Research Report*, and how the feedback is translated to *Opportunities*. The key *Opportunities* linked to each *Theme* are listed against each *Theme*.

Stage 3 Methodology

This section describes the methodology adopted as part of this Stage of the project, including workshop design and delivery, and data aggregation and analysis. The following sub-sections are included:

- **About the workshops:** This sub-section provides key details on the workshops, including dates, locations, participants and timing.
- **Choosing workshop topics:** The workshops focused on five distinct topics. This section describes how they were selected.
- **Workshop methodology:** The workshops followed a consistent format across all locations. This section describes this format, including what was presented to commence the workshop, how the discussions on the key topics were facilitated and how a prioritisation activity was delivered.
- **Synthesis methodology:** A thematic analysis approach was adopted to aggregate, analyse and draw conclusions from the data collected during the workshops. This section describes this process.

About the workshops

Seven workshops were undertaken across different areas of the PHN's region. Workshops were all delivered face to face across November and December 2023. The workshop locations and corresponding dates were:

- **Central Queensland**
  - Emerald: 14th November
  - Rockhampton: 15th November
  - Gladstone: 16th November
- **Wide Bay**
  - Bundaberg: 21st November
  - Hervey Bay: 22nd November
- **Sunshine Coast**
  - Gympie: 28th November
  - Maroochydore: 7th December

Workshop participants were predominantly service providers and other system stakeholders (e.g. HHS personnel), including a significant number of peer workers. A small number of people with lived experience (who were not peer workers) also attended some locations.

Each location-based workshop was run in-person over 3.5 hours. Facilitated table discussions in small groups were used as the key method to gather input from participants, with a focus on ensuring all participants were able to provide feedback across each topic covered in the workshops.

Choosing workshop topics

The key required input for the workshops was the specification of a select number of topics to guide the workshop discussions. These topics formed the basis of table-based discussions during the workshops in seven locations. All topics were discussed in all locations.

Specific topics were adopted in order to:

- Prime and inform the conversations of key opportunity areas that had been identified from a review of best-practice (Stage 2)
- Guide contributions towards solution-oriented comments and feedback
- Provide structure to the conversations and ensure the outputs were useful to inform progression of the *Reform Project*

- Provide consistency between locations and dates to identify any key trends or differentials

The below topics were determined through the following process:

- The *Mental Health Reform Opportunities Research Report* was reviewed by CCQ personnel to identify five key themes, with sub-themes and potential discussion points against each of them.
- The key objectives of the *Mental Health Reform Project* were also considered and reviewed.
- Workshop facilitators (SVA) translated the headline themes, their supporting information, and the objectives of the project into a set of five coupled problem statements and hypotheses.
- These couples were then tested with CCQ personnel prior to being used in the workshops.

Table 1: Workshop table discussion topics

#	**Problem Statement:** We have observed that…	**Hypothesis:** Health outcomes can be improved by…
1	Services lack integration and clear supported transitions across services and across levels of care	Better integration and navigation pathways into (and across) supports and services
2	Access to care is not equitable, with care not meeting the needs of all key cohorts	Delivering targeted services that are tailored and appropriate for key cohorts
3	Rural and remote communities are missing out on care, and it is challenging for services to adequately meet needs	Approaches that include digital health, central hubs supporting rural/remote areas, and others
4	Mental health service delivery is fragmented and contracts are small in scale, which culminates in challenges for delivery and sustainable efficiency	Increasing consortia approaches, collaboration, resource and workforce-sharing, and co-delivery between services, providers and other system stakeholders but retain the "local "connection
5	Approaches focus on treatment rather than prevention, and do not adequately address the social determinants of mental health	Increasing the focus on upstream approaches and exploring integration of non-health services and social supports

Workshop methodology

The workshops followed a consistent format between locations. The format is summarised in the workshop agenda below, with details provided in the following sub-sections for 'Table Discussions' and 'Prioritisation Activity'.

Table 2: Workshop agenda overview

Agenda Item	Description	Approximate Duration
Welcome & Overview of Mental Health Reform Project	• Participants welcomed to the workshop • CCQ and facilitator personnel introduced to participants • Overview of Mental Health Reform Project objectives and activities provided	30 minutes, including settling period for participants
Workshop Methodology Overview	• Remainder of workshop agenda explained to participants • Table discussion framework described • Table discussion topics introduced	15 minutes
Table Discussions *(see below for more details)*	• A series of 5 consecutive table discussions • Table facilitators (CCQ personnel) moved between tables to discuss the same topic with each table	20-30 minutes per topic

Agenda Item	Description	Approximate Duration
	• Conversations were documented through participants adding sticky-notes to a shared canvas for each topic	2-2.5 hours in total
Prioritisation Activity & Wrap-up *(see below for more details)*	• Table facilitators each identified three key ideas they heard within the discussions that they facilitated • These were presented as proposals to workshop participants • Participants were asked to prioritise the proposals by distributing 5 dot stickers between all of the proposals. This was usually requested alongside thanking participants for their attendance, requesting they distribute the stickers on their way out.	30 minutes

Methodology details – Table discussions

This section provides further details on the methodology adopted for the table discussions used in the workshops.

Facilitated table discussions in small groups were used as the key method to gather input from workshop participants, with a focus on ensuring all participants were able to provide feedback across each topic covered in the workshops.

Table discussions were facilitated for five separate topics in each workshop. Each of the five topics was presented in the form of a **problem statement** and **hypothesis** (potential solution) to form the basis of each table discussion. The problem statements and hypotheses are summarised in Table 1 (above).

To explore these problem statements and hypotheses, table discussions on each topic followed a common framework. The framework has three elements:

1. **Situation**: The problem statement and hypothesis was shared with participants on the table. Participants were asked to share any additional inputs, understandings, descriptions of the issue, or important local context.
2. **Challenges**: Participants were then asked to turn their mind to acting on the problem and hypothesis, and identify what they felt will be the major barriers, challenges and obstacles to addressing the problem.
3. **Ideas**: Finally, participants were asked for ideas that could help address the challenges and/or advance the hypothesis.

Workshop participants were asked to document all of their inputs across these three elements by adding sticky-notes to a sheet of large paper. One sheet of paper was used per element of the framework (i.e. Situation, Challenges, Ideas), making it three sheets per discussion.

An example of collected contributions is provided below. This represents the data captured for one topic at one workshop, across each of the three elements.

Figure 1: Sample of workshop table discussion record

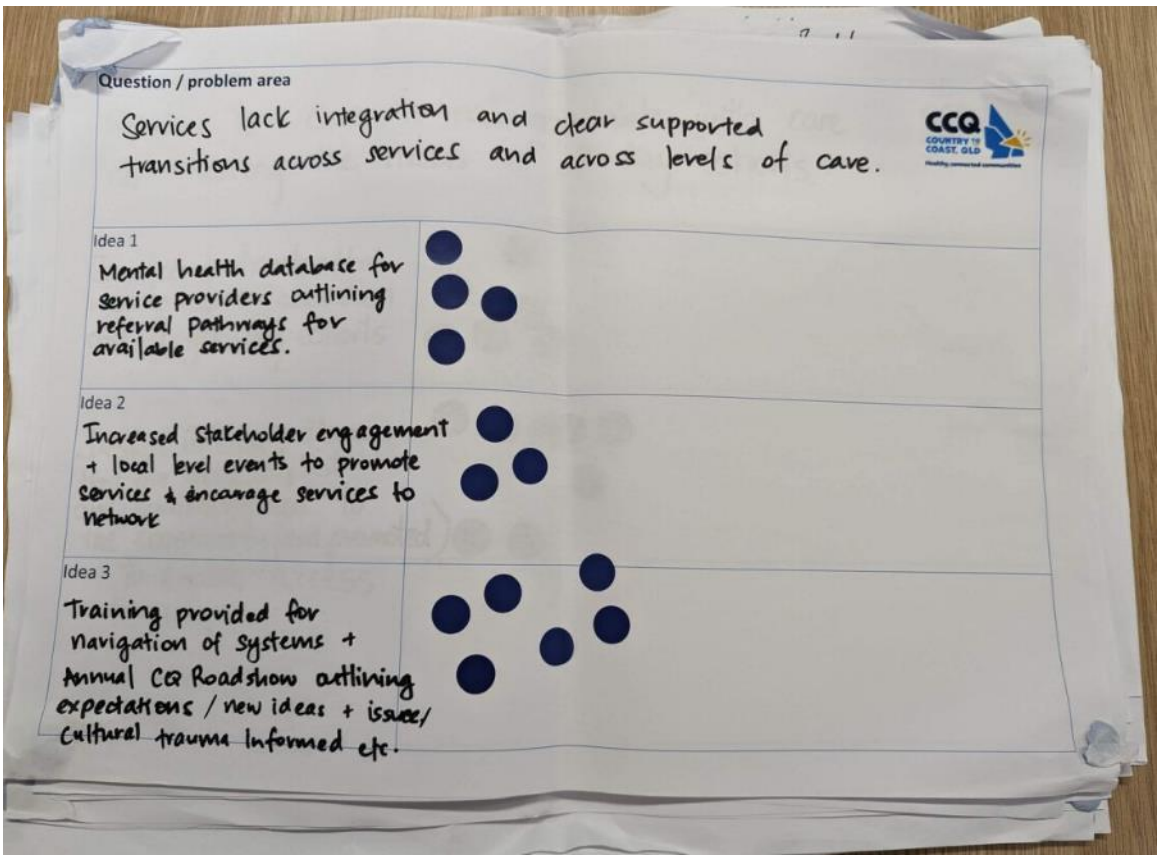
Following conclusion of the table discussion (approximately 20-30 minutes), facilitators would move to the next table, taking the central sheets with them. Subsequent discussions would then build on the previous, with facilitators using their judgement to group contributions as further input was received.

Workshop details – Prioritisation activity methodology

Following conclusion of all the table discussions, table facilitators were asked to identify three key ideas from each topic, based on the conversations they had facilitated. These key ideas were then presented briefly to participants as 'proposals', and workshop participants were asked to prioritise them. Participants were provided with 5 dot stickers each to distribute between all of the proposals.

An example of some proposals presented and prioritised is included below.

Figure 2: Sample of prioritisation activity record



It is important to note that this is not a rigorous, accurate accounting of the key ideas raised during discussions, and is not a substitute for the detailed analysis included in other sections of this report. Rather, this activity is intended to provide a sense-check of key themes as one of several datapoints to be considered moving forward.

Additional consultation

Further consultation was completed in December with CCQ's Community Advisory Council, through an online 2.5 hour workshop. The online workshop utilised the same framework as the face to face workshops, with workshop participants exploring the five problem statements and hypotheses using the following three elements of the framework:

1. Situation
2. Challenges
3. Ideas

The online platform 'Google Jamboard' was used as an online interactive tool to capture input from the group and support facilitation of the group discussion for each of the five problem statements and hypotheses.

Data collected during this workshop was reviewed, with key findings integrated into the synthesis included in this report.

Limitations of the consultations

This report primarily reflects the findings of input from participants across the conducted community workshops. These workshops were predominantly attended by service providers and other system stakeholders, including peer workers. An additional workshop was undertaken with people with lived experience through the Community Advisory Council. It is important to note that this is not necessarily a representative sample of service providers and/or the community, and it is therefore unlikely that this report comprehensively summarises the views of all relevant stakeholders. In particular, it has been noted that representation of Aboriginal and Torres Strait Islander peoples and service organisations (e.g. ACCHOs, AMSs) was limited in the workshops conducted during this round of consultations.

Synthesis methodology

A thematic analysis approach was adopted to aggregate, analyse and draw conclusions from the data collected during the workshops. This section describes this approach.

The synthesis methodology consisted of four high-level steps:

1. Data collection and transcription
2. Thematic analysis of transcribed data and identification of key feedback
3. Mapping of *Research Report* findings to identified themes and iterative identification of opportunities
4. Hypothesis-driven trend testing by region

It is important to acknowledge that thematic analysis is an inherently subjective process which requires the analyser to employ a degree of discretion in how it is conducted. This section has been developed in response to this fact to provide transparency regarding how this report's findings have been conducted. Nevertheless, it is important that findings are tested with community in subsequent stages of the project to ensure their validity and the community's ongoing buy-in to the *Mental Health Reform Project* (as is recommended in the conclusion of this report).

The following sub-sections detail the processes that were applied within these high-level steps.

Data collection and transcription

Workshop data from each of the seven workshops was transcribed into an Excel spreadsheet.

The following fields were captured:

- *Sticky note text written during the workshop*
- *Workshop location and region*
- *Discussion topic*
- *Framework element (i.e. Situation, Challenges, or Ideas)*

A total of over 2,800 individual sticky notes were recorded across locations, with approximately 140 of this number requiring editing, extrapolation, or removal due to legibility or recording issues.

The below table summarises the number of contributions by topic, framework element, and region.

Table 3: Summary of recorded data

Topic	Data Type	Region			All regions
		Central QLD	*Wide Bay*	*Sunshine Coast*	
1: Service integration and transitions	Situation	47	34	26	107
	Challenges	68	86	90	244
	Ideas	69	74	90	233
	Total	**184**	**194**	**206**	**584**
2: Equitable access to care	Situation	57	69	64	190
	Challenges	60	71	59	190
	Ideas	63	91	57	211
	Total	**180**	**231**	**180**	**591**
3: Rural and remote communities	Situation	63	38	52	153
	Challenges	81	68	73	222
	Ideas	86	70	120	276
	Total	**230**	**176**	**245**	**651**
	Situation	6	67	31	104

Topic	Data Type	Region			All regions
		Central QLD	*Wide Bay*	*Sunshine Coast*	
4: Fragmented, small services	Challenges	60	78	39	177
	Ideas	68	78	71	217
	Total	**134**	**223**	**141**	**498**
5: Social determinants and prevention	Situation	49	63	18	130
	Challenges	50	58	55	163
	Ideas	78	67	78	223
	Total	**177**	**188**	**151**	**516**
	Total all topics	***905***	***1012***	***923***	***2840***

The following sections describe how this data was analysed and ultimately translated into key findings and next steps.

Thematic analysis of transcribed data and identification of key feedback

Thematic analysis of the transcribed data was completed. This involved reading through the recorded data points to iteratively identify key themes. Themes featured in this report represent topics that are presumed to be of significant importance based on their consistent or repeated representation across the workshop feedback received.

It is important to note that this element of the methodology requires a degree of discretion from the analyser, reinforcing the importance of validating the findings of this report in the future Stages of the *Mental Health Reform Project*.

This process consists of four key steps that are iterated:

Thematic analysis steps

1. **Sorting into themes:** Reading a data point and identifying which theme(s) it belongs to.
2. **Identifying new themes:** Where a data point is not fully reflected by existing themes, identify a new theme and/or expand the definition of existing themes, so that it is fully reflected.
3. **Rationalising themes:** Reflecting on themes and data contained within them to evaluate whether segmentation into two or more themes is warranted, and/or if one or more themes can be combined.
4. **Confirming completeness of themes:** Reviewing the original data set to ensure all relevant themes are identified.

These four steps were iterated until each of the themes encapsulates an *approximately* equal amount of data (i.e. there are no outliers with too many or too few datapoints).

With the themes identified, a similar four-step thematic analysis approach was applied to the data within each theme (noting that many data points appear in two or more themes). This process led to the identification of key feedback points within each theme, and in some cases iteration or adjustment of the themes, to ensure key insights were captured.

Mapping of Research Report findings to identified themes and iterative identification of opportunities

Following the identification and iteration of the key themes and feedback within them, they were compared to the high-level findings of the *Mental Health Reform Opportunities Research Report*. This allowed comparison and mapping of the themes to best-practice principles, system approaches, models of care, and enablers of models of care. These links to best-practice were then used as the primary basis to develop a list of opportunities to take forward.

Hypothesis-driven trend testing by region

Data was further analysed based on the three PHN regions (Central Queensland, Wide Bay and Sunshine Coast) to understand whether there were key regional differences in the workshop findings. This process was driven by testing hypotheses involving potential regional differences in priority cohorts, service access, internet and technology access, workforce challenges, and transport. Overall, there were limited differences between regions when findings were analysed through this hypothesis-driven trend testing. Differences that emerged through this process have been highlighted in the Key Findings section outlined below.

Workshop Findings

Overview

The important findings from this Stage of the project are organised by two classification categories:

- ***Themes*** – which represent topics that are presumed to be of significant importance based on their representation across the workshop feedback received.
- ***Opportunities*** – which represent a mapping of the themes and best-practice (from the previously completed *Research Report*) to identify intersections, and therefore key opportunities for the *Mental Health Reform Project* to consider moving forward.

These have been identified through the application of the methodology described in the previous section.

11 key themes and 16 opportunities have been identified through the workshop synthesis. They are listed in the below table, and their intersections demonstrated on the table following. Subsequent sections of the report describe both in further detail.

Table 4: Summary of themes and opportunities

Themes identified from Stage 3 workshops	
1. Improving service navigation, access, and availability 2. Enhancing collaboration and integration of services 3. Leveraging lived experience and peer workers 4. Addressing regional and geographical needs 5. Contract structures and particulars	6. Developing and strengthening the workforce 7. Engaging and empowering consumers and communities 8. Reducing stigma and improving health literacy 9. Supporting innovative service delivery 10. Focus on prevention and broader social supports 11. Inclusion of diverse cohorts
Opportunities identified	
Specifying new services or service requirements	**Funding infrastructure and system-level supports**
1. Implement centralised service hubs, with key inclusions to ensure they are efficient, effective, and provide equitable access 2. Strengthen and support intake processes across all services with a 'No Wrong Door' approach 3. Incentivise equity of service access and provision in commissioning processes and contracts 4. Encourage co-design and co-delivery with lived experience, key cohorts, and peer workers 5. Invest in community education and programs	6. Fund key infrastructure and services to facilitate digital access, including 'outside of the home', where digital services are proposed 7. Systems, pathways, and support for service navigation 8. Facilitate and support systems for sharing of consumer information 9. Include scalable wait-list support mechanisms in contracts or other services
Contracting particulars and funding principles	**Workforce development**
10. Facilitate flexibility in service delivery to reduce overall system burden 11. Adjust contract particulars to support sustainable delivery by service providers 12. Adjust tender processes to facilitate and encourage collaboration, not competition	13. Advocate for and support strategic mental health workforce planning in rural and remote areas, through career and financial incentives and targeted university placements. 14. Include specific supports for and engagement of peer workers in practitioner engagement and education activities 15. Implement cross-sector and cross-professional training opportunities to build strong and diverse communities of practice 16. Encouraging representative diversity in the workforce

Table 5: Mapping of themes and opportunities

		Themes										
		1	2	3	4	5	6	7	8	9	10	11
Opportunities		Improving navigation, access, availability	Service collaboration and integration	Lived experience and peer workers	Regional and geographical needs	Contract structures and particulars	Developing and strengthening workforce	Engaging consumers and communities	Reducing stigma and improving health literacy	Innovative service delivery	Focusing on prevention and broader social supports	Inclusion of diverse cohorts
New services or requirements												
1	Centralised service hubs	✓	✓		✓			✓	✓	✓	✓	
2	Strengthening intake processes	✓										
3	Incentivising equity of access	✓			✓							✓
4	Co-design and co-delivery			✓			✓	✓				✓
5	Community education				✓			✓	✓		✓	
Infrastructure and supports												
6	Digital access		✓		✓			✓		✓		
7	Navigation support	✓		✓								
8	Information sharing		✓									
9	Wait-list supports	✓									✓	
Contracting processes												
10	Delivery flexibility	✓			✓	✓				✓	✓	
11	Contract particulars				✓	✓				✓	✓	
12	Collaborative processes		✓			✓		✓				
Workforce development												
13	Strategic planning						✓					
14	Peer worker engagement			✓			✓					

		Themes										
		1	2	3	4	5	6	7	8	9	10	11
Opportunities		Improving navigation, access, availability	Service collaboration and integration	Lived experience and peer workers	Regional and geographical needs	Contract structures and particulars	Developing and strengthening workforce	Engaging consumers and communities	Reducing stigma and improving health literacy	Innovative service delivery	Focusing on prevention and broader social supports	Inclusion of diverse cohorts
15	Cross-sectional engagement			✓			✓					
16	Workforce diversity						✓					✓

The below section describes each identified opportunity in more detail. Following the opportunity descriptions, the themes are discussed.

Detailed descriptions of identified opportunities

Specifying new services or service requirements in contracts

Five opportunities have been identified within this category. They focus on opportunities that represent contracts being expanded to include new services, or new requirements being added into these contracts (relative to previous iterations).

Opportunity 1: Implement centralised service hubs, with key inclusions to ensure they are efficient, effective, and provide equitable access

Centralised service hubs were generally well supported as a mechanism to efficiently provide services, increase collaboration and integration between services, and provide foundations to reach all locations within regions. However, feedback emphasised that they are not a panacea, particularly if not scoped and organised appropriately. The following inclusions or adjustments have been developed based on the feedback received in the workshops, with a focus on ensuring more rural and remote locations do not miss out:

- Bring together mental health and AOD services, along with broader support services where possible.
- Include non-clinical, inclusive spaces and services
- Region-specific policies and procedures for the hubs should be developed, in partnership with regional service providers
- Hubs should be adequately resourced and equipped with technology to support both digital access and in-person support
- Hubs providing outreach services should recognise the cost and time of practical aspects such as travel, and appropriate supervision and experience of staff travelling to rural and remote areas
- Leverage existing rural and remote community infrastructure and relationships as 'spokes' wherever possible, through partnerships with existing services and community organisations, rather than providing detached outreach services
- Outreach services should be coordinated to maximise accessibility / efficiency of access for individuals in locations reached by the hubs

This opportunity is broadly compatible with all other opportunities and may represent a key commissioning vehicle upon which additional improvements can be made.

Opportunity 2: Strengthen and support intake processes across all services with a 'No Wrong Door' approach

There is an opportunity to strengthen and support intake processes across all services, with feedback identifying this is a key source of friction, inefficiency, and resulting in limited access to services for consumers. The key opportunity is to adopt a 'No Wrong Door' approach across services that the PHN procures, with specific options including:

- Simplifying intake processes
- Making intake processes and assessments more holistic, focusing on all needs of the individual presenting
- Encouraging and facilitating self-referrals

Opportunity 3: Incentivise equity of service access and provision in commissioning processes and contracts

There is an opportunity for contracts to measure, incentivise, and support service providers to provide equitable access to their services across their region of provision and to all cohorts within their region. One potential application of this opportunity is to 'ring-fence' funding for specific populations, however there are also less rigid mechanisms available. These may include:

- Measuring and reporting relevant client demographics (potentially including geographic location, cultural identity, socioeconomic status) for comparison to population statistics
- Processes to understand and respond to trends/differentials in demographics, where necessary
- Extending service hours
- Increasing outreach services
- Offering transportation or transfer services (or the subsidisation of them) to facilitate access

Opportunity 4: Encourage co-design and co-delivery with lived experience, key cohorts, and peer workers

An opportunity identified across a range of themes and topics was to increase the degree of co-design and co-delivery by service providers. There is an emphasis on engaging both lived experience and key cohorts that may be missing out on services. Further, peer workers represent a cost-effective, effective model of care that is applicable to all levels of mental health severity. Options identified include:

- Including co-design and co-delivery as requirements of contracts
- Including co-design in commissioning processes
- Direct facilitation of engagement with community, lived experience, and key cohorts by the PHN

Opportunity 5: Invest in community education and programs

A specific expansion of the scope of services funded by the PHN was identified, into supporting community education and programs. Suggestions included funding programs for community that:

- Address social isolation
- Promote social inclusion
- Reduce stigma (particularly in rural and remote areas)
- Increase trust in local services

Suggestions for how to deliver these programs included:

- Leveraging existing community groups and community spaces
- Offering them in targeted settings such as schools and workplaces

- Empowering local champions and advocates (particularly in rural and remote areas and diverse communities)

Funding infrastructure and system-level supports, either within contracts or as additional procurement activities

There are four opportunities identified within this category. These opportunities represent options to fund specific infrastructure or supports with the potential to improve the efficiency or effectiveness of other services.

Opportunity 6: Fund key infrastructure and services to facilitate digital access, including 'outside of the home', where digital services are proposed

Suggestions for how to achieve this included:

- Establishing technology hubs in rural and remote locations, leveraging existing locations/facilities (e.g. libraries, councils) where possible
- Providing technical support services to facilitate the use of technology
- Enabling service providers to take internet to consumers, particularly those in very remote locations
- Exploring subsidies for technology access

Opportunity 7: Systems, pathways, and support for service navigation

There is an opportunity to invest in documenting and formalising navigation pathways to improve service provider knowledge and awareness, maintain up-to-date and reliable resources, ensure consistency across regions. There was significant interest in the value of specific personnel with roles as community or service navigators, and the potential for these to be filled by non-clinical personnel and peer workers, as well as in the opportunity for centrally coordinated systems and documentation.

Opportunity 8: Facilitate and support systems for sharing of consumer information

A specific opportunity was identified for the development and implementation of shared and common information sharing systems, that would allow communication and coordination between services to offer more efficient and more person-centred care.

Opportunity 9: Include scalable wait-list support mechanisms in contracts or other services

There is an opportunity for contracts to acknowledge the likelihood of significant ongoing wait times to access services, and both specify and fund the provision of interim support. Options for this may include:

- Requiring PHN-funded referring services to maintain connection with wait-listed clients
- Expanding the scope of PHN-funded services (e.g. Head to Health) to directly provide this support
- Funding standalone or integrated diversionary care models, such as non-clinical, peer-staffed drop-in centres

Contracting particulars and funding principles

This section describes three opportunities that broadly represent introducing flexibility into contracting particulars and funding principles that have the potential to improve service delivery outcomes.

Opportunity 10: Facilitate flexibility in service delivery to reduce overall system burden

There is an opportunity for service contracts to provide a degree of flexibility in service provision. This is consistent with a 'No Wrong Door' approach and person-centred care. Examples of this flexibility may include:

- Allowing services to go outside their defined scope of practice to minimise potentially unnecessary referrals, when efficient to do so

- Accepting self-referrals on a broader scope than would be accepted from other providers, particularly when there are minimal other services available
- Specifying KPIs that are outcomes-focused, as opposed to output-/activity-focused
- Permitting 'innovation' budgets to trial potentially more efficient service delivery, with appropriate restrictions

Opportunity 11: Adjust contract particulars to support sustainable delivery by service providers

With contracts themselves being seen by providers as a barrier to high-quality, sustainable service delivery, this opportunity summarises potential adjustments to contract particulars that may address some of these concerns.

Suggestions provided include:

- Maximising contract durations, with easier processes to extend periodically
- Matching contract durations to other key cost timelines e.g. facility lease durations
- Adopting more flexible funding models e.g. fee-for-service or outcomes-based contracting
- Prioritising 'meaningful' KPIs that are outcomes-focused, not activity-/output-focused
- Providing flexible and realistic KPIs, particularly in rural and remote locations
- Valuing non-clinical as well as clinical work and services
- Indexing payments over the life of contracts, relative to the real economic situation (i.e. wage, other expense increases)
- Providing emergency/crisis funding buckets with contracts

Opportunity 12: Adjust tender processes to facilitate and encourage collaboration, not competition

The challenge of service providers being required to both compete for contracts, and then be expected to collaborate and integrate in service provision, led to identification of the opportunity to incentivise, facilitate, and/or encourage collaboration over competition in tender processes.

Examples of this may include:

- Providing forums and processes for consortia / collaborations to be established during tender development
- Co-design processes for RFQs and contracts
- Explicitly valuing collaborative / coordinated responses to tenders when making commissioning decisions
- Directly engaging head contractors (e.g. to establish central service hubs), with an expectation that supporting, diverse contracts will be established through collaborative design shortly after

Workforce development

Four key opportunities were identified that are related to workforce development.

Opportunity 13: Advocate for and support strategic mental health workforce planning in rural and remote areas, through career and financial incentives and targeted university placements.

As workforce shortage issues persist, there is an opportunity to explore strategic workforce planning activities, with potential for the PHN to facilitate, contribute to, or resource such initiatives.

Opportunity 14: Include specific supports for and engagement of peer workers in practitioner engagement and education activities

Given the PHN's role in practitioner engagement and education, this represents an opportunity to expand the scope of supports to directly respond to the needs of peer workers. Best-practice in peer-worker models emphasises the value of appropriate mentoring and support for peer workers and flexible working models.

Opportunity 15: Implement cross-sector and cross-professional training opportunities to build strong and diverse communities of practice

There is an opportunity to emphasise diverse interactions in education and engagement activities. This was suggested to include cross-sector (e.g. mental health and alcohol and other drugs), cross-professional, clinical/non-clinical, and peer/non-peer interaction opportunities. Key emphases of this opportunity should include facilitating communities of practice with a target cohort lens (rather than profession lens) and breaking down stigma in health professionals towards non-clinical supports, lived experience, and peer workers.

Opportunity 16: Encouraging representative diversity in the workforce

Feedback noted the value and opportunity of improving diversity in the mental health workforce, and particularly improving representation of key cohorts, including those that may access these services more than others. There is a limited scope of specific suggestions for how this can be actioned, and some may be impractical:

- Specifying requirements in contracts, including the use of identified positions
- Advocating for specific recruitment strategies
- Providing recruitment support to increase diversity

Discussion of key themes and related opportunities

This section discusses each of the key themes. These discussions are organised by the following sub-headings:

- **Overview of theme and key feedback:** This provides a brief description of what is meant by the theme, and what responses / inputs it captures. The most common inputs or issues raised across workshop responses are then summarised, with an emphasis on surfacing ideas that were recommended or supported.
- **Discussion and opportunities:** This summarises a brief review of the key feedback against the context of the reform objectives, and the findings of the *Mental Health Reform Opportunities Research Report*. The section concludes with identifying the opportunities (listed in the previous section), to which feedback received in a theme contributed to.

Theme 1: Improving service navigation, access, and availability

Overview of theme and key feedback

The 'Improving service navigation, access and availability' theme encompasses feedback from the workshops that despite services nominally being present, or being delivered in an area, navigating and accessing them remained challenging in many instances.

Feedback within this theme focuses on addressing practical challenges to awareness and navigation of services, accessibility (such as transport and opening hours), the overall approach of services, and the experience of waiting to access services in the context of capacity constraints. Key ideas relating to this theme that were prioritised highly within workshops included "designing referral pathways that are made explicit and communicated to the community (and promoted) to enable access locally" (in Rockhampton) and "community navigators to support individuals to link to and access a holistic range of services" (in Bundaberg).

The below points summarise the key findings related to this theme:

- **Lack of service awareness amongst community and service providers:** Workshop participants commonly raised the issue of limited awareness of services across the community, presenting a key barrier to initial access and referrals. Building awareness, understanding and trust between services was seen as an important initial step. Service awareness also included improving awareness of the offerings and services of NGOs and encouraging health professionals to leverage the supports of NGOs. A focus on ensuring service providers and health professionals are aware of services available in the region, and their relative capacity, to facilitate referrals. 'Project ECHO' was highlighted as a best practice example of developing a community of practice to increase awareness of referral pathways.
- **Navigation and intake processes:** The need to improve service navigation and have positive, effective and empathetic intake and assessment processes was commonly raised. The need for navigator roles to facilitate in this space, such as community navigators and peer navigators, was seen as a focus area. Navigators should have knowledge that spans beyond clinical services to connect consumers with local community and social supports. Peer navigators in particular were highlighted as a useful 'soft entry' point to services, to build rapport with consumers. Additionally, ensuring intake and referral processes were person-centred and simple: "simplifying intake: no wrong door", and include psycho-social assessments to capture the full picture of an individual's situation, with a trauma informed approach.

  "No wrong door"
- **Transport and practical challenges to access:** Practical challenges to access services, mostly related to their location and (a lack of) transport options, were emphasised during the workshops. Feedback emphasised that these challenges were most acute for people experiencing financial hardship and potentially without transport, and for rural and remote communities. This point was consistently raised across all workshop locations.

- **After-hours access:** Across several locations, the importance of providing support during evenings, nights, and weekends was raised. This was explained as being able to cater for different schedules and reflect workshop participants' experiences that mental health crises are more prevalent in the evenings and overnight. Participants highlighted that the impact of not having after hours availability resulted in increasing presentations to emergency departments and poorer outcomes for individuals. Ideas included extending hours of operation of services, the availability of specific professionals after hours (e.g. "mental health nurse on call outside hours") and having a group of staff rostered on after hours from different organisations or services. The 'Lighthouse' service was highlighted as a specific service example for consideration of increasing service hours.

  "After hours access is hard to find – but people work".

- **Experiential challenges to access:** An additional impediment to access was the 'clinical' focus of services, with a need to move towards welcoming and friendly spaces. Comments of this type were raised in several contexts, including related to stigma and past negative experiences with the health system. This was seen as particularly important for people in crisis – emergency departments were commonly highlighted as a setting that was not conducive to the environment that should be provided for someone in crisis.
- **Outreach as a useful but underused model:** There was strong support for expanding the reach of current services. Ideas included the deployment of mobile clinics, extending or increasing outreach and community outreach programs, and targeted initiatives in underserved areas. Extending outreach of current services was common across all regions, particularly in reaching underserviced cohorts, and was emphasised more when participants were discussing ideas for rural and remote contexts.
- **Timeliness of services and improving the experience of waiting:** Workshop participants emphasised the importance of reducing wait times and improving response times across the system. Acknowledging that wait times would likely continue to be an issue, additional suggestions to reduce the burden of this challenge on consumers included building in mechanisms for referrers to follow up with clients before the commencement of the next service, e.g. through a phone follow-up. Incentivising service providers to take responsibility for consumers was raised as an idea, where service providers take responsibility for consumer outcomes rather than simply passing on to the next service.

Discussion and opportunities

The key points identified within this theme highlight that the current system is not achieving the universal access that it sets out to provide. In particular, it is falling short in delivering equitable access to services, and there are key opportunities to provide more accessible and efficient services (i.e. with outreach and after-hours), and offer more person-centred care (i.e. through support while on wait lists, or more flexible services).

In addition to being relevant to the pursuit of whole-of-system best practice, ensuring service access and availability is important to delivering outcomes for consumers across the spectrum of services. This includes the importance of navigation pathways and 'efficiency of access' to the success of low intensity, self-led, and integrated care models for mild to moderate mental illness. Further, many key models of care emphasise the importance of self-referral options, including models in alcohol and other drugs, preventative/upstream approaches, and low intensity models.

Theme 2: Enhancing collaboration and integration of services

Overview of theme and key feedback

'Enhancing collaboration and integration of services' was highlighted as a theme to enhance coordination across service providers and other stakeholders, with many workshop participants providing ideas for the role that the PHN could play in facilitating and incentivising this activity. Participants acknowledged the importance of creating a more unified approach to service delivery, consistent with a key enabler of applying a Stepped Care approach to the delivery of mental health, alcohol and other drugs, and suicide prevention services. In the prioritisation activity, examples of key ideas that were highly voted included "co-location of services to support collaboration and relationship building between services" (in Maroochydore) and "incentivising collaboration not competition" (in Bundaberg).

Key points related to this theme are summarised below:

- **Resource constraints:** Feedback from the workshops, consistent across most locations, was that collaboration and integration require effort, which is challenging for service providers to absorb in a resource-constrained environment.
- **Low levels of inter-service communication and knowledge:** Workshop participants felt there was a role for supporting regular communication between providers and supporting service providers to understand the relative capacity across other service providers in the region.
- **Better systems for sharing consumer information:** Feedback raised the issue of sharing consumer information and working towards a shared plan. Ideas included the facilitation of shared care plans, and improving the way data is shared across services to improve communication and ultimately care. Improving data collection and data sharing capabilities of service providers was suggested as an area to support the PHN to identify gaps and enable a collective response. Incentivising 'warm handovers' across service providers was also raised, to ensure service providers do not simply refer on without supporting the transition.
- **Alignment of policies and procedures across service providers and sectors:** ensuring there is consistency in approaches, including through collaborative development of policies and procedures within each region.
- **Fostering partnerships and coalitions across service providers and the community:** This was highlighted as being of particular importance across the mental health and AOD sectors where the need for partnerships was highlighted across community groups, NGOs and other service providers to facilitate community-level integration, trust and rapport. Creating formal processes to facilitate partnerships such as a memorandum of understanding between organisations was raised as an idea.

"Can providers collaborate/ form coalitions to close gaps?"

- **Co-location or 'hubs' as a key opportunity to drive collaboration and integration:** Co-location of services and development or strengthening of hubs was commonly highlighted. Workshop participants identified key advantages of co-location and hubs as providing a 'one-stop shop' of community members, facilitating collaboration across providers, and providing a space for telehealth access alongside face to face service delivery, e.g. "community hub – one stop shop". Implementation considerations were highlighted, including "central hubs need to be adequately funded", and "integrated hubs – rooms with tech and in-person support". Challenges were also raised with hubs e.g. "central hubs decrease options". It was recognised that hubs are not always helpful or practical, and there is therefore a role for outreach. Collaborative approaches to outreach were suggested, including consortium outreach e.g. "big bus, 3 or 4 organisations".

Discussion and opportunities

The points within this theme have stressed the importance of collaboration and integration to the effective and high-quality delivery of mental health services to the community. This is consistent with definitions of best practice for whole-of-system approaches and is a critical enabler of a Stepped Care approach. Further, these elements are important enablers for key models of care across the mental health spectrum, including:

- **In mild and moderate mental illness:** Integrated and collaborative care models have a strong evidence base, and require care coordination, service knowledge, and communication between teams to be delivered effectively.
- **In crisis care and suicide prevention:** Linking and connecting existing services has been identified as a key element of successful community suicide prevention models.
- **In severe and complex mental illness:** Intensive case management models have a strong evidence base and several successful implementation examples by PHNs, and require provision of a broad range of services, often from disparate providers.

Despite acknowledging the importance of these activities to providing quality care and best-practice models, it is evident from the workshop feedback that collaboration and integration remain challenging for services to adequately deliver. The feedback indicates this is due to a combination of resource constraints, a lack of appropriate 'organising infrastructure', and systemic complexity that is challenging even for providers to understand.

Theme 3: Leveraging lived experience and peer workers

Overview of theme and key feedback

This theme emphasises the importance of inclusion of lived experience across mental health and AOD, and increasing representation of lived experience in the mental health workforce. Inclusion of lived experience across all aspects of service design and service delivery was recognised as being integral to ensure services reflect the needs of the communities they are serving. This is consistent with current trends in service provision across the mental health spectrum increasingly valuing the role of peer workers. An example of a key idea related to this theme that was highly voted in the prioritisation activity was "building local capacity in workforce development, including lived experience and peer workers" in the Rockhampton workshop.

The below points encompass the key points that were raised in the workshop relating to this theme:

- **Increasing peer workers and embedding lived experience across services:** the importance of a peer workforce was consistently highlighted across all workshops and topics, with the need to ensure peer workers are employed and valued across services. Ensuring adequate funding for peer worker roles to build and sustain a peer workforce within the mental health sector was raised. "More peer input and collaboration".
- **Acknowledging the value that lived experience brings:** workshop participants felt that the value of lived experience could be elevated across services, including health professionals e.g. GPs placing greater value on the benefits that a peer workforce can bring. Stigma was raised as an issue in how peer workers are sometimes viewed by 'professionals', with a call to support greater acknowledgement of lived experience contributions: "stigma for peer workers with lived experience – are 'broken'".
- **Integration within clinical services:** workshop participants mentioned the need for advocacy for better integration of peer workers in clinical settings, promoting a holistic approach to mental health care. This includes ensuring peer workers are optimally utilised within services, and clinical staff have a good understanding about the role of peer workers. Greater inclusion of peer workers in particular service settings that tend to be more 'clinical', such as in emergency departments, was raised as an idea to improve experiences for people experiencing mental health issues, particularly in a crisis. Another key service area for peer workers was in the intake and service navigation space, which is discussed further in the *Improving service navigation, access, and availability* theme.
- **Recognising the unique needs of a peer workforce:** challenges were raised regarding peer workers in particular, including the need to recognise trauma that peer workers might be exposed in supporting peers, the risk of burnout, and boundaries/scope of practice. Workshop participants acknowledged the toll of exposure to mental health challenges and suicide, particularly in view of the risk of re-exposing them to trauma. Existing support and training options for peer workers were suggested e.g. Roses in the Ocean (a national lived experience of suicide organisation), and participants mentioned the need for ongoing support, supervision and networks for peer worker roles, with contributions such as "Structures (or lack of) for peer support workers" and "How do we protect peer workers?"

Discussion and opportunities

Points raised within this theme highlight the importance of building trust and rapport in delivery of mental health services, which can be enhanced through inclusion of lived experience in service design and delivery. This approach values the lived experience that peer workers can bring to mental health service delivery, to break down barriers to access and reduce stigma associated with mental health issues.

The Mental Health Reform Opportunities Research Report features peer workers and similar models throughout, with these elements being incorporated in most emerging, evidence-based mental health programs. This includes:

- Peer workers and ‘connectors’ being identified across summary literature as beneficial across a variety of models for mild to moderate mental illness
- Peer-led models, with appropriate training and mentoring, have been highlighted as an important emerging model by the mental health Royal Commissions

Theme 4: Addressing regional and geographical needs

Overview of theme and key feedback

This theme centres on the importance of ensuring that services are tailored to meet the unique regional and geographical needs across the PHN area. Discussion within this theme centres on acknowledging the distinct challenges that are faced, in particular in rural and remote regions, and therefore the need to take different approaches to service design and delivery compared with metropolitan regions.

Feedback within theme covers the unique needs of people and communities in rural and remote areas, the challenges related to transport, and workforce issues that impact the ability to embed a trusted, sustainable mental health workforce within communities. The key findings related to this theme are summarised in the points below:

- **Leveraging existing strengths of communities:** Leveraging the infrastructure, trust and networks of existing organisations, services and community groups through local partnerships was commonly mentioned, to ensure services are more accessible, resources are maximised, and services better meet the needs of local communities. The positives of offering local, place-based services were highlighted, to build relationships and trust locally, or leveraging existing place-based spaces to allow outreach services to network and be better supported. "Don't re-create, optimise existing", and "look to optimise and strengthen existing services, not reinvent." Suggestions included identifying existing collaborations and services that are already working well together, highlighting the need to understand the local context and strengths of the community and build from there.
- **Expansion of telehealth:** many participants acknowledged the role of telehealth in regional, rural and remote areas to address likely ongoing workforce challenges, and access to specialist care. However challenges experienced in these areas were commonly raised, such as the issues with reliability of internet, the current reliance on consumers having their own internet, digital literacy and consumer preferences, and the difficulty in building rapport for effective treatment and support across a digital medium. Specific ideas to support digital access in rural and remote areas were offered, including enabling service providers to take internet to consumers, particularly those in very remote locations, e.g. taking satellite internet. Digital challenges and solutions are discussed in greater detail in the *Supporting innovative service delivery* theme.
- **The hub and spoke model and outreach:** was specifically mentioned in a number of responses e.g. "Hub and spoke Rocky and out", as well as outreach models. However challenges were raised with these models that need to be considered in solution design: "hub and spokes – outreach misses out", "outreach only for existing clients", "risk that services and health professionals bear in outreach" (referring to limited support, supervision and potential safety issues when working in rural and remote areas, particularly in people's homes with limited phone reception), and "cost of outreach is not included in funding". It was highlighted that funding did not match the unique needs of outreach work, in terms of time, cost and pressure on staffing schedules. Ideas were offered to improve the delivery of outreach e.g. having fixed service dates / days for community outreach and mobile health clinics that travel to rural and remote locations.

  "Stoicism and stigma around help-seeking in rural areas".
- **Recognising the impact of stigma in rural and remote communities:** workshop participants frequently mentioned the barrier of stigma and the impact of 'stoicism' in rural and remote communities. There were also concerns around privacy in small communities where 'everyone is known', particularly in relation to visibly accessing services. These points should be considered in community education and service design.
- **Consideration of hubs:** participants felt there were advantages of hubs that could provide a range of resources in a single, accessible location. In the design of hubs, many workshop participants felt it was important to consider how stigma in rural and remote communities affects access to mental health and AOD services and privacy concerns in these communities. Therefore, participants suggested hubs should consider the 'outward facing' look and feel that did not preclude people from visiting the hubs.

- **Transport:** Transport was frequently highlighted across all regions as a key challenge that affected individuals' ability to access mental health services in rural and remote areas. The impact was seen in terms of time taken to access services, and cost of transport, particularly in view of rising cost of living. Ideas were offered to reduce these barriers such as integrating with existing community services to reduce the need for transport and providing funding support for transport costs. Costs of transport were also highlighted for service providers (for example when providing outreach services), with suggestions provided such as fleet cars and corporate partnerships with car dealers to supply vehicles in rural areas.

Discussion and opportunities

The above feedback is consistent with findings from the *Mental Health Reform Opportunities Research Report* that identified the need for system approaches that were 'complementary' to the widely recognised Stepped Care approach to providing services. Responses from the workshops seem to indicate that the tools available (i.e. outreach, virtual, hub and spoke models) are applicable, however challenges in their implementation or their limited availability curtail their usefulness.

A factor identified in this theme and in the *Mental Health Reform Opportunities Research Report* – the utilisation of local resources and facilities – is also a success factor of place-based approaches, a key approach for upstream prevention.

Recognising that the centralisation of services is likely to continue to some degree, the feedback received on this theme has informed a broad range of particulars within several of the identified opportunities, as well as led to the identification of specific opportunities, as listed below.

Theme 5: Contract structures and particulars

Overview of theme and key feedback

This theme encompasses workshop data relating to contract processes and contract structure in the context of service provision in the mental health space. Contracts were frequently mentioned across all workshops, with over

150 mentions of contracts specifically across the data. Further, key ideas directly relating to contract structures received a high proportion of votes in the prioritisation exercise in the majority of workshops, for example: "longer contracts that are targeted and meet geographical domains, up to 5 years" was an idea generated in the Rockhampton workshop that received 21% of the votes from participants. Discussion surfaced across all workshops in relation to how contracts are designed, their duration, contract conditions, and how these factors impact on service delivery.

Key findings from the workshop data related to this theme are captured in the points below:

- **Contract length**: contract length was seen to be a significant area that could facilitate improvements in service delivery. Participants highlighted the need for longer contracts, for example up to 5 years, with the ability to extend contracts periodically, to support continuity of care, provide more certainty for service providers and their workforce and improve the ability to build trust and relationships in the communities that service providers were serving. Example responses included: "showing commitment to community = longer contracts to establish relationships" and "funding contracts are shorter than lease periods on facilities. Very expensive to relocate and fit out unnecessarily".
- **Staffing challenges:** The impact of contracts was highlighted specifically around staffing challenges, in terms of contract challenges affecting the ability to provide job security, attract quality staff to regional, rural and remote areas, and administrative challenges associated with staff management within contract terms. "Funding contracts are short. New HR legislation says you can't extend temporary contracts more than twice. Staff must be permanent but funding isn't!" and "small contracts impact on flexibility of service delivery such as counselling if services are struggling to fill position".

"Staff must be permanent but funding isn't!"

- **Amount and flexibility of funding:** amount and flexibility of funding within contracts was highlighted, with ideas ranging from advocating for preventative services to transitioning from block funding to a fee for service model: "no more block funding – fee for service", "limited capacity and time for providers to scale up, establish, recruit, train and deliver services within block funding constraints". Introducing greater flexibility was seen to be key to enable service providers to better meet local needs and ensure their services are responsive to changing needs. Amount of funding was highlighted in relation to rising costs to ensure contracts recognise rising costs and appropriately cover infrastructure and equipment: "indexation of cost over the life of the contract, relative to the real economic situation".
- **Incentivising collaboration and collective impact across service providers**: the tender and contract process was identified as a key area that could be changed to facilitate greater collaboration across service providers. Workshop participants felt that the process currently limited collaboration in favour of competition for contracts. Ideas were presented, for example incentivising joint tender submissions and considering contract particulars: "build in collaboration and report writing into contract and fees" and "clearly prescribe expectations in service contracts. How do services integrate? What do the pathways look like? How do you track it and measure impact?"
- **KPIs, streamlining processes and administration:** KPIs within were commonly highlighted as an issue, in terms of whether they are realistic, and recognise the complexity of service delivery. Including flexibility in KPIs, valuing non-clinical work, and introducing meaningful KPIs that reflect meaningful outcomes for consumers were raised as suggestions. Realistic KPIs were raised in particular in a rural and remote context: "realistic KPIs – can't see 6 clients if travelling 2 hours each way". Other areas to consider included simplifying administrative processes around contracts and reporting.
- **Sourcing alternative funding for services and programs:** several workshop participants felt that there was opportunity to look at alternative ways to boost funding, particularly taking a regional lens. Ideas included cultivating partnerships to source alternative funds that are relevant to local communities, for example partnerships with private organisations such as mining organisations to support local initiatives.

Discussion and opportunities

Feedback from the workshops within this theme reveal several key issues and opportunities for the approach to contracts for service providers. Contract length can have significant implications for service providers, particularly on staffing, continuity of care, and the building of relationships within communities – there was a clear preference for longer contracts. Introducing greater flexibility in contracts was highlighted, and workshop participants also recognised opportunities in contract processes to improve collaboration across the mental health sector.

Theme 6: Developing and strengthening the workforce

Overview of theme and key feedback

This theme covers workshop data regarding challenges and ideas to build a stronger mental health workforce. Broadly, data covered areas across upskilling a new workforce, leveraging a community workforce, better training, collaboration and shared knowledge across existing workforce, supporting unique needs of peer workforce. A key area was capacity-building of the current workforce, through shared professional development and networking opportunities, and building capacity in particular of the peer workforce. An example of a key idea that was highly voted in the Gympie workshop was "invest in workforce conditions, opportunities and education/development".

Key points related to the workshop data within this theme are covered below:

- **Diverse cohort representation in staffing:** data highlighted the need to reflect the diversity of the communities that services are embedded in, through more diverse recruitment: "workforce that includes more than just mental health professionals. A space for lived experience and community members who are the experts in their area." There were a small number of suggestions to include staffing profile in contracts, including stipulating the need for people from diverse cohorts or peer workers within contracts.
- **Training and development:** It was recognised that opportunities for cross-sector and cross-professional training could be better leveraged e.g. training across mental health and AOD professionals, and training across clinical and non-clinical staff, to improve exposure and build a diverse community of practice. Lack of funding for services to deliver training and development for their staff was seen as a consideration in the current environment, including funding to support upskilling of staff to broaden their scope of practice.
- **Supporting longer-term workforce development in the region:** workshop participants recognised the need to look ahead into the future to develop the mental health workforce throughout the PHN region. Ideas included building relationships with education institutions and supporting local university pipelines within the mental health and AOD sector: "support TAFE university students to conduct supervised placements at services". There was a specific focus on increasing undergraduate placements in rural settings to attract mental health workers in the longer term to these areas: "more undergraduate placements in rural".
- **Targeted recruitment, removing barriers and incentivising the workforce:** Workshop data commonly identified key barriers to a sustainable mental health workforce, particularly in regional, rural and remote areas, including affordability Issues. Suggestions included career incentives and providing rental subsidies to attract mental health workers to regional and rural areas. The importance of not just attracting staff but also keeping them, particularly in regional and rural communities, was highlighted for stability within mental health services.
- **Housing**: housing was raised as a specific barrier to growing a sustainable mental health workforce, with mental health professionals facing challenges in finding suitable housing, particularly in regional and rural areas, and lack of housing for university and TAFE students to support regional and rural placements.
- **Building capacity in the peer and non-clinical workforce:** The peer workforce was commonly highlighted as a key focus for improving the mental health workforce in the future. Findings related to supporting and building capacity in a lived experience workforce is captured in greater detail in the *Leveraging lived experience and peer workers* theme. Support and training for other non-clinical staff was also raised, "support workers in mental health", recognising the value that a non-clinical workforce can bring, and the need to reduce the reliance on a clinical workforce.
- **Targeted training for the workforce in digital and telehealth:** Workshop participants highlighted the need for targeted training around technology for the mental health workforce, to better leverage digital technologies so they could better support consumers in digital health access.

Discussion and opportunities

Input from workshops across all regions highlighted the key consideration of workforce development, emphasising the importance of a sustainable and well-supported workforce. The challenges and importance of workforce was elevated in regional, rural and remote contexts.

This workshop data aligns with findings from the *Mental Health Reform Opportunities Research Report,* where building capacity and diversifying the existing workforce beyond a clinical focus was highlighted as a key enabler.

Theme 7: Engaging and empowering consumers and communities

Overview of theme and key feedback

This theme elevated the importance of consumer and community engagement across mental health and AOD. Building in more opportunities for the PHN and commissioned service providers to engage with the communities they serve was seen as key to facilitate community-driven, more effective service delivery. Several ideas were offered to support improved community and consumer engagement, including incentivising or stipulating the need for community engagement in contracts, and PHN-led activities that bring regional community and service providers together. In the prioritisation activity, highly voted ideas included "upskilling community to compliment existing services – help with filling the gaps" (in the Emerald workshop) and "using community development to direct existing assets and community champions" (in the Maroochydore workshop).

It was frequently highlighted that community engagement was needed to overcome many of the challenges related to mental health service accessibility and acceptability, to overcome stigma, build trust in service providers, increase awareness of availability of services across community and other service providers, and build services that reflect the needs of the community.

Key findings relating to this theme that emerged from the workshops are captured below:

- **Leveraging what exists within communities:** Working in partnership with local community groups, and leveraging existing spaces or existing events where the community comes together e.g. Mens Sheds, was suggested as a way to utilise community strengths and build a strong foundation of rapport across the community and service providers.
- **Upskilling and empowering the local community:** There was a strong emphasis placed on 'upskilling the local community' to provide a protective layer that reduces the reliance on clinical supports, and empowers communities, for example "making mental health first aid and suicide prevention more widely available in the community." Ideas often promoted a more holistic focus on empowering communities through connections, events and social supports, to move away from a clinical focus: "community supporting community", and support social connection and social cohesion.
- **Co-design of services with consumers and communities:** Embedding consumers and community in co-design of locally tailored services to enable community-led solutions. Suggestions were provided for how community could be better engaged in co-design processes: "informing the community about upcoming collaboration and consultation events to accurately identify funding models. Marketing and medical that is mainstream, not among the practice networks." Participants pointed out the risk of commissioning services where co-design is lacking: "misuse of funding if co-design is lacking or not facilitated for each region."
- **Building relationships and pre-engagement with community:** Building in time and incentives to develop relationships with the community was seen as important. Ensure there is a focus on 'pre-engagement' through community events and engagement with local organisations, acknowledging that this is particularly important to build trust with diverse communities: "need to do events in the community – pre-engagement, warm referrals: especially for CALD".

Discussion and opportunities

Findings from the workshop emphasise the integral role of community and consumer engagement in enhancing mental health services and outcomes. This acknowledges that effective mental health care extends beyond clinical interventions to encompass holistic, inclusive approaches that are designed and developed with and for the communities they serve. The focus on building capacity in communities themselves reflects the recognition that strong communities are a key foundation for good mental health. These findings are in line with findings from the *Mental Health Reform Opportunities Research Report,* where the evidence base emphasises the importance of leveraging strengths and building capacity in communities, particularly in rural areas and in suicide prevention.

Theme 8: Reducing stigma and improving health literacy

Overview of theme and key feedback

This theme emphasises the importance of initiatives that consider the role of addressing stigma and health literacy in mental health and AOD. Stigma was specifically mentioned in approximately 50 sticky notes, in reference to stigma in both the community and health professionals around mental health and AOD issues. 'Early education and interventions' was proposed as a key idea in the Emerald workshop, receiving nearly 25% of votes across participants in the prioritisation exercise.

Key findings from the workshops are covered in the points below:

- **Community-wide initiatives for stigma reduction:** reducing stigma was seen to be important as a community-wide initiative, e.g. campaigns to reduce stigmatising mental health and AOD in schools, workplaces and housing solutions. The benefits of a community approach to stigma reduction were seen to both improve access to services for people with existing mental health issues before reaching a crisis, and act as protective for future challenges. Reducing stigma across the community around mental health and AOD, for example through campaigns and local education – "stigma of reaching out for help (I'm not that bad, that's not for me)".
- **Addressing stigma across health professionals and first responder services**: workshop participants felt stigma should be addressed across these professionals, including police and GPs. Ideas included education for GPs and other service providers around reducing stigma of mental health and AOD issues, so they can better support their clients and provide a safe, trauma informed and empathetic response. GPs were highlighted as a particularly important cohort of health professionals given they are often the first contact point for consumers experiencing mental health challenges. Stigma was also raised within a health professional context around valuing the role of non-clinical supports and lived experience in mental health supports.
- **Role of local champions**: particularly in rural and remote areas and diverse communities, were viewed as useful to reduce stigma at a 'grassroots level' and embed local trust and knowledge in services. Stigma was seen to be a particular challenge in rural and remote communities – there is "stoicism and stigma around help-seeking in rural areas".

Discussion and opportunities

Findings focus on the barriers that stigma and poor mental health literacy can create that are critical to overcome to enable improved mental health service delivery. Importantly, stigma was raised as an issue to address both for community and for health professionals and service providers, who could provide 'less clinical' and more inclusive spaces. The advantages of approaching stigma and mental health literacy through local, community level initiatives were highlighted.

Theme 9: Supporting innovative service delivery

Overview of theme and key feedback

This theme incorporates innovative service delivery, including digital solutions and flexible service models. Innovative solutions in mental health, including pilots and digital / telehealth solutions, were seen to be important however responses highlighted challenges that need to be considered in implementation of innovative solutions.

Key findings from workshop data are included in the points below:

- **Challenges in digital and tech solutions:** A number of challenges were raised in particular for digital and telehealth solutions, highlighting the complexities involved in implementing technology-based solutions in mental health and AOD service delivery. Challenges commonly raised included: accessibility to reliable internet, particularly in rural and remote areas and for people on low incomes who had limited access to data; and digital literacy and acceptance by consumers (and health professionals), particularly navigating a digital landscape in times of mental health challenge.
- **Impersonal nature of telehealth for mental health service delivery:** Workshop participants spoke of the importance of building rapport, trust and relationships to facilitate effective mental health treatment and improve outcomes. This was at odds with the challenges raised about telehealth that service providers had experienced, for example anxiety that may worsen for consumers when accessing telehealth, and greater difficulty for staff to connect meaningfully with consumers and convey empathy. Improving telehealth training for the mental health workforce was mentioned (as discussed in the *Developing and strengthening the workforce* theme) as a way to mitigate these challenges.
- **Combining telehealth and face to face services:** hybrid models were raised by workshop participants, who acknowledged the role of telehealth but felt that option or face to face service delivery, at least in part, was important to build rapport and improve service delivery. It was suggested that local connection or local support could also facilitate the success of telehealth: "If digital health is used, a local connection that attends with, or is contactable and consistent, will encourage participation and retention of the client." It was also recognised that telehealth would not suit everyone, and therefore there would always be a role for solely face to face service delivery: "people with mental health often lose their phones, don't have money for data, and can be paranoid about online digital – doesn't work for everyone." Responses suggested there is a role for peer workers to support individuals in telehealth, but there needs to be appropriate upskilling: "increase skill and training for peer workers to prepare and support clients to feel comfortable/confident using telehealth services."
- **Supporting access to internet and technology through alternative methods of access** e.g. creating digital or tech hubs that people on low incomes or in rural and remote areas could access: "more digital hubs for them to access (at no cost)", and finding ways to bring internet to consumers rather than having to rely on consumers' own internet connection.
- **Scaling innovative models and pilots:** Several innovative approaches and pilots were put forth as examples to note, with workshop participants seeing significant merit in scaling pilots that are working well such as the Mental Health First Responder pilot in Rockhampton. Challenges were however raised in the way funding is approached for 'innovative' models: "innovative, diverse programs tend to be funded through pilots, variations/inconsistent/piecemeal service delivery as a result, and loss of community trust. Needs permanent funding."

Discussion and opportunities

Findings recognise the need to explore innovative models of mental health service delivery, including digital and tech solutions. It is critical however that innovative ways of delivering services are not seen as a panacea, and implementation of innovative or alternative models should carefully consider barriers and challenges that might impede outcomes for consumers. In considering the broader evidence base, innovative models were highlighted in

the *Mental Health Reform Opportunities Research Report,* including the role for telehealth across multiple areas of mental health service delivery. Furthermore, innovative responses such as Mental Health First Responder models have been widely highlighted, for example through the work of the National Mental Health Commission.

Theme 10: Focusing on prevention and broader social supports

Overview of theme and key feedback

This theme considers responses in the data regarding prevention and the broader social determinants of mental health. Workshop participants recognised the importance of addressing the foundations for mentally healthy communities, through a focus on social determinants of mental health such as housing, education, employment and social supports. An example of a key idea that workshop participants voted highly in the prioritisation activity included "health promotion and early intervention in non-clinical settings, supporting housing, education, transport, employment and connectedness" (in the Maroochydore workshop).

The following points highlight the key findings from workshops related to this theme:

- **Funding diversion to prevention and early intervention;** recognising the need to break the cycle of mental health challenges in the community, responses recognised the need to have a focus on funding in prevention and early intervention, e.g. "$ spent in prevention equal to $ spent in treatment". It was however still recognised that there also needs to be a continuation of funding in treatment.
- **Schools and workplaces:** Schools (and parenting/early years) as well as workplaces were highlighted as key areas for involvement in prevention and early intervention, with a focus on 'meeting the community where they are' with place-based approaches and integrating services in non-clinical settings. Several approaches and specific examples of programs were offered that focus on increasing resilience and building capacity in individuals and organisations. These could include mental health and resilience programs in schools, building awareness of services for students and parents through school communication, and building capacity in workplaces to support colleagues and reduce the likelihood of "toxic workplaces".
- **Social determinants focus in prevention:** Workshop participants highlighted that mental health challenges cannot be properly addressed without shifting the focus the broader social determinants with suggestions offered e.g. PHN networks/links with housing, education, etc. Housing was commonly highlighted as a key issue when considering a broader social determinants lens, particularly in the current national housing context. "$ to focus on social determinants needs on top of mental health funding"
- **Holistic, social supports focus:** A focus on non-clinical, holistic supports was frequently raised, for example through social prescribing models to reduce reliance on clinical services and leverage existing community services.
- **Key cohort lens for holistic supports:** Particular cohorts were highlighted for targeted holistic and social supports, for example men – "need help with navigating social situational factors that are fundamental to suicide ideation."

Discussion and opportunities

Findings from the workshop underscore the recognition that mental wellbeing is influenced by broad social determinants, and focus needs to be shifted to these determinants in prevention and early intervention. Place-based settings such as schools and workplaces reflect the need to meet people where they are at and embed initiatives in the community.

These findings are strongly supported by the broader evidence base, as captured in the *Mental Health Reform Opportunities Research Report,* with research demonstrating 'upstream' prevention approaches are evidence-based, effective, and cost-effective. Several approaches that have an existing evidence-base are currently being implemented in a PHN context across Australia, for example models to address loneliness and isolation, social prescribing models, and school-based approaches.

Theme 11: Inclusion of diverse cohorts

This theme highlights workshop data regarding mental health and services for diverse cohorts, including First Nations peoples and people from culturally and linguistically diverse backgrounds. This theme covers key insights relating to diverse cohorts, noting that other themes cover data relating to diverse cohorts as well. Workshop participants highlighted in particular the need to understand the unique needs of cohorts and design services with these communities to reflect needs and be culturally responsive. Addressing the needs of diverse cohorts was discussed across all workshop regions, however a greater focus on First Nations peoples surfaced in the data from Wide Bay and Central Queensland regions compared with the Sunshine Coast region.

Key findings from the workshops within this theme include:

- **Forming collaborations and partnerships with community groups**: connecting with groups 'on the ground' that represent diverse cohorts was commonly highlighted, to better understand the needs of specific cohorts and develop more inclusive and responsive services. It was commonly highlighted in the workshops that meeting the needs of diverse cohorts required building of trust, and should be established *before* formal service provision begins, so service providers are truly seen as a part of diverse communities.
- **Representation of diverse cohorts in the workforce:** Ensuring the mental health workforce reflected the community was highlighted. Recruitment suggestions also extended to ensuring peer workers were from culturally diverse backgrounds.
- **Cultural competency of services**: developing cultural competency of services was highlighted, including through training, education and developing relationships with communities: "Access to culturally responsive and culturally safe services including referral pathways". Training for service providers was discussed and it was also suggested that communities of practice could be structured around key diverse cohorts to foster improved education, relationships and cultural competency of services. "There is a lack of appropriate / relevant training in relation to culturally appropriate practice."
- **Co-design of services with diverse communities:** Ensuring culturally diverse organisations are represented in any engagement and service design was raised as important: "culturally diverse organisations represented → inclusivity", to move towards 'true' co-design of services that better meet the needs of communities.

Discussion and opportunities

Input from the workshops emphasise the importance of culturally inclusive services in mental health service delivery to improve access and outcomes. Building cultural competence in services was highlighted, with representation of diverse cohorts in the mental health workforce, and local community engagement and co-design.

Specific programs and models presented as exemplars

Throughout the workshop data, a number of specific programs and models were suggested as examples. The below is a list of all programs and models mentioned:

- Roses in the Ocean: capacity-building programs for people with lived experience of suicide within the peer workforce
- Mental Health First Responders/Co-responders Pilot: mental health clinicians working with paramedics to co-respond to people experiencing a mental health crisis
- Denmark extension of services to 24/7: acute psychiatric emergency outreach available 24/7
- Project ECHO community of practice: Extension for Community Healthcare Outcomes (ECHO) is a guided practice model to extend capacity in rural and regional areas

- PHaMs and PIR: Personal Helpers and Mentors (PHaMs) and Partners in Recovery (PIR) *(noting these programs are no longer funded at a federal level)*
- Anglicare Dialectical Behaviour Training (DBT): capacity building program
- BUSHkids: free healthcare for children and families living in remote QLD communities
- Grab Life by the Balls: men's mental health charity, focused on solutions for male suicide
- Lighthouse Crisis Support Space: crisis care service for people experiencing mental health distress with peer workers and mental health clinicians
- Community Based Crime Action Committees (CBCAC) working groups: supporting locally-based initiatives for crime prevention
- Brisbane South PHN – Southern Moreton Bay Islands (SMBI) initiative: community-driven, cross-sector place-based approach to health and development of children
- Ask Izzy: mobile website that connects people who are in crisis with services they need nearby
- Mental Health First Aid: courses that teach participants how to identify and appropriately support someone experiencing a mental health concern or crisis
- QUIHN: specialist social and medical services relating to alcohol, other drug use and mental health
- MindCare: clinical psychology
- Gladstone Region Awareness and Suicide Prevention (GRASP): network aiming to promote suicide prevention initiatives throughout the Gladstone region

Conclusions

The analysis included in the preceding sections leads to four key takeaways:

1. With a broad distribution over a number of key themes, establishing **centralised service hubs** represents a key opportunity for further exploration as part of procurement processes. Importantly, these would represent significant contracts within which other improvements can be implemented.
2. **Other specific services or inclusions may need to be considered in contracts**, such as community education, navigation support and digital infrastructure.
3. Other considerations for the procurement process include considering how to **reform processes and contract particulars to make delivery more sustainable, collaborative, and flexible.**
4. Considerations outside the procurement process include **iterating the PHN's approach to practitioner education and engagement** to include meeting the needs of peer workers and encouraging cross-sectional interactions.

These conclusions, as well as all the identified themes and opportunities (repeated below), can be taken forward and tested as part of further community engagement and solution development.

<table>
<tr><th colspan="2">Themes identified from Stage 3 workshops</th></tr>
<tr><td colspan="2">1. Improving service navigation, access, and availability
2. Enhancing collaboration and integration of services
3. Leveraging lived experience and peer workers
4. Addressing regional and geographical needs
5. Contract structures and particulars
6. Developing and strengthening the workforce
7. Engaging and empowering consumers and communities
8. Reducing stigma and improving health literacy
9. Supporting innovative service delivery
10. Focus on prevention and broader social supports
11. Inclusion of diverse cohorts</td></tr>
<tr><th colspan="2">Opportunities identified</th></tr>
<tr><td>Specifying new services or service requirements</td><td>Funding infrastructure and system-level supports</td></tr>
<tr><td>1. Implement centralised service hubs, with key inclusions to ensure they are efficient, effective, and provide equitable access
2. Strengthen and support intake processes across all services with a 'No Wrong Door' approach
3. Incentivise equity of service access and provision in commissioning processes and contracts
4. Encourage co-design and co-delivery with lived experience, key cohorts, and peer workers
5. Invest in community education and programs</td><td>6. Fund key infrastructure and services to facilitate digital access, including 'outside of the home', where digital services are proposed
7. Systems, pathways, and support for service navigation
8. Facilitate and support systems for sharing of consumer information
9. Include scalable wait-list support mechanisms in contracts or other services</td></tr>
<tr><td>Contracting particulars and funding principles</td><td>Workforce development</td></tr>
<tr><td>10. Facilitate flexibility in service delivery to reduce overall system burden
11. Adjust contract particulars to support sustainable delivery by service providers
12. Adjust tender processes to facilitate and encourage collaboration, not competition</td><td>13. Advocate for and support strategic mental health workforce planning in rural and remote areas, through career and financial incentives and targeted university placements.
14. Include specific supports for and engagement of peer workers in practitioner engagement and education activities
15. Implement cross-sector and cross-professional training opportunities to build strong and diverse communities of practice
16. Encouraging representative diversity in the workforce</td></tr>
</table>

CCQ COUNTRY TO COAST, QLD
Healthy, connected communities

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