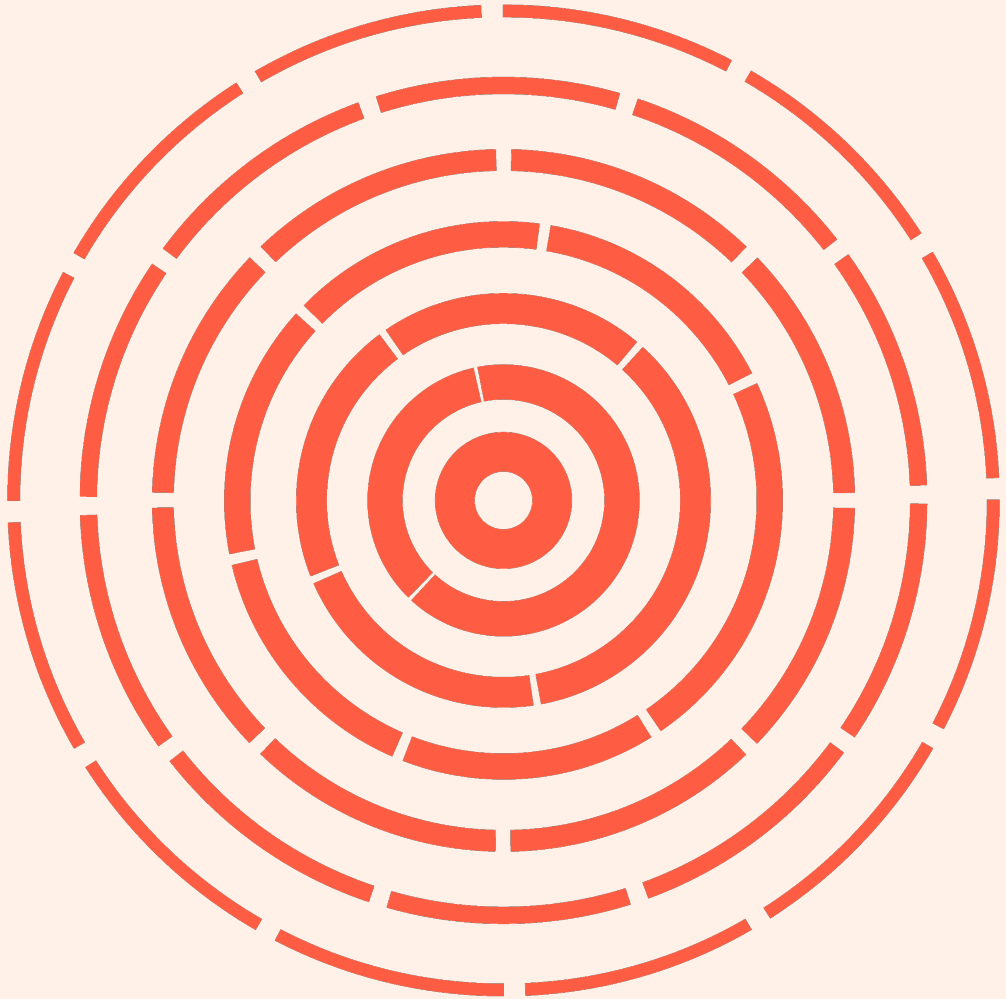
Department of Health Victoria

July 2025

DESIGN OF MENTAL HEALTH AND WELLBEING CRISIS AND EMERGENCY RESPONSES

Engagement Overview: What we heard from participants with lived and living experience



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Acknowledgement of Country

We would like to acknowledge the traditional custodians of the land on which our offices stand, and pay our respects to Elders past, present and emerging. We acknowledge their continuing relationship to this land, its waterways and seas and the ongoing living cultures of Aboriginal and Torres Strait Islander peoples across Australia.

Finally, we would like to acknowledge that sovereignty has never been ceded.

This land always was and always will be the land of Aboriginal and Torres Strait Islander peoples.

Recognition of Lived and Living Experience

We recognise the individual and collective contributions of people with a lived and/or living experience of mental health issues, their families, carers and supporters.

Through listening to and acting on the voices of people with lived experience, those who provide services, those who fund services, and most importantly, those who use services, we will find the information we need to move towards the mental health system that Australia needs.

Every person's story we hear, and every experience shared, helps to develop our understanding of the system that is required to best meet the needs of Australians living with mental health issues, their families, carers and supporters.

Project Background

About this document

This document provides a high-level summary of key themes that emerged from the **lived and living experience (LLE) workshops** during the project. Note: This is not intended to be an exhaustive list of diverse perspectives and insights elicited through engagement activities.

Workshop Overview

During the project, Lively Collective and Impact Co. **facilitated 9 x 3-hour Lived and Living Experience (LLE) Workshops**, focusing on hearing from, and drawing upon the experience and expertise of consumers, families, carers and supporters. We engaged a diverse group of people with LLE to complement our engagement of people in dedicated LLE roles across the sector.

Workshop Objectives

These sessions sought to:

- Develop a shared understanding of the current state of the crisis service system, highlighting key strengths and existing challenges;
- Define the ideal future state where anyone can easily access the right crisis support, at the right time, delivered by a well-supported workforce; and
- Explore the below five new/redesigned service models in detail, to understand how they can best meet the needs of consumers, families, carers and supporters.


Crisis Telehealth


Peer led Drop in Safe Spaces


Clinical Assistance


Crisis Stabilisation


Crisis Outreach

Workshop Attendance Summary

Dates	Workshop Focus	Participant Numbers
Service Design		**50**
Wed 21st May	Clinical Assistance	10
Wed 28th May	Telehealth & Outreach (Session 1)	7
Wed 28th May	Telehealth & Outreach (Session 2)	5
Fri 30th May	Stabilisation (Session 1)	6
Fri 30th May	Stabilisation (Session 2)	9
Wed 4th June	Safe Spaces (Session 1)	7
Wed 4th June	Safe Spaces (Session 2)	6
System Design		**32***
Fri 6th June	High-Level System Design (Session 1)	18
Fri 6th June	High-Level System Design (Session 2)	14

** Most attendees at the System Design session also participated in a Service Design session*

CURRENT STATE LLE INSIGHTS: CURRENT & IDEAL FUTURE EXPERIENCES

Engagement participants identified the need for a more responsive an integrated crisis system that streamlines access points to make it easier to seek help, invests in community promotion to raise awareness of available supports, and embeds LLE roles across all levels.

Experiences of the Current System	Opportunities for the Future System
• People often do not get the right care at the right time because of unclear entry pathways, fragmented services, and low community awareness. • Community stigma and/or low trust in services can contribute to low uptake.	• Creating streamlined/centralised entry pathways for crisis services. • Expanding community promotion, especially within broader settings (e.g., General Practitioners, schools) to support awareness and uptake of the new crisis services.
• Expansion of community services (e.g., Locals, Connect Centres) has improved experiences and increased access to early intervention support. • People who use community mental health services have usually experienced a mental health "crisis" before, so more work is required to support people before reaching crisis.	• Expanding the integration between local non-government organisations and tertiary services to support smoother step-up/step-down care pathways. • Exploring how Stabilisation and Safe Spaces may integrate with existing services.
• Historically, there has been a shortage of Alcohol and Other Drug (AOD) expertise in crisis services despite high prevalence of co-occurring needs. • Expansion of Mental Health, AOD Emergency Department Hubs has significantly improved care for many.	• Embedding AOD clinical and peer worker expertise in all crisis services for consumers with dual diagnosis. • Expansion of harm reduction team training and LLE harm reduction roles.
• Access to LLE supports and LLE staff promotes holistic care during crisis. • Currently there are LLE roles in Area Service community and bed-based teams but limited presence of these roles in Triage and Crisis Outreach.	• Embedding LLE roles in all new crisis services. • Creating clear service guidelines, position descriptions and team training that supports the effective integration of LLE roles into new/redesigned services.
• People experiencing crisis for the first time often default to 000 or Emergency Departments because they are not aware of what services are available. • Referrals support continuity of care but are more effective when done with consumers and followed up to confirm they were seen by the next service.	• Integrating Telehealth with 000 to support Emergency Departments and first responder diversion, including diversion to Crisis Outreach and/or Stabilisation. • Embedding policies in new crisis services that require warm and confirmed transitions of care when transitioning between services.

KEY THEMES: LIVED EXPERIENCE INSIGHTS

Five key themes emerged through engagement with lived experience stakeholders. These insights reflect critical priorities and opportunities for system design improvements, particularly for future crisis services.
The summary below synthesises key lived experience contributions.

Connection and continuity of care builds trust and better outcomes

There is a need to build trust in the system.
Participants described long-standing mistrust of services due to fragmented care, long wait times, incorrect referrals, misinformation, and unnecessary escalation.

Existing services must be connected.
Consumer and carer supports (e.g., GPs, community services) should be able to interact directly with crisis services for improved referrals and support.

Follow-up care is key to preventing re-occurring crisis. Participants highlighted that often, after crisis or intense experiences (e.g., leaving prison), there is a lack of follow-up care. This causes further distrust in the system and reduces likelihood of help seeking in the future.

"Transparency and trust in the service – they are accurately listening and not making judgements on their own."

Workforces must be holistic and inclusive of LLE and AOD expertise

Peer involvement is needed in all levels of service delivery. Participants described peer workers as essential to trust-building and service relevance**.** Peer workers must be well versed in understanding the service system to ensure appropriate linkages are made.

AOD expertise is a major system gap.
Participants identified that embedding AOD clinicians and peer workers in all crisis services would significantly boost integrated care responses and address a key system gap.

Clinical & LLE disciplines remain fractured and non-collaborative.
Teams are still operating in siloes due to traditional models and practices. Blending mental health clinician and peer roles will offer the potential to bridge clinical and experiential knowledge, fostering more holistic, empathetic, and less segmented care.

"Peer support can provide insight to clinicians; they can offer empathy as well."

Clearer service navigation and promotion is critical

Centralised entry points are preferred. Participants consistently identified the need for easy-to-access entry points, wherever possible.

Community awareness of available services is lacking. The new crisis services will need strong community promotion, so people know they exist. LLE participants identified that GPs, schools, libraries and other local spaces will be critical for promotion & early intervention. Having a centralised website for finding services was identified as a solution.

Stigma and discrimination are ongoing barriers to uptake. Stigma about mental health and experiences of judgment, fear, and discrimination from services often discourage people from seeking timely help or receiving equitable, compassionate, and person-centered care.

"People don't call these services unless they are genuinely asking for help."

Accessibility gaps must be addressed in new crisis design

Crisis services need to be accessible. People with disabilities, those who are neurodivergent, and non-English speakers (including Auslan users) struggle to access support.

Inclusive design of physical services.
Wherever possible physical services need to have accessible and welcoming designs. This includes using technology that supports people to non-verbally share their personal background, sensory safe design, and spaces dedicated to families, carers and supporters.

Technology must support care meaningfully. Video, text, and telehealth options need to be more than phone calls. These should facilitate genuine connection and consider accessibility limitations and preferences especially for people in rural and regional areas.

"The service needs to reflect the community NOT adapt to the community."

Crisis services must offer immediate, responsive care

Delays and automated systems risk failing people in crisis. Telehealth must be staffed and responsive — no voicemail, long waits or extended holds. It should connect people quickly and seamlessly.

Transfers between services must be real and immediate. If a transfer to a more appropriate service is needed, immediate transfers and confirmation that care has been received should be sought.

Risk is still a contentious issue that needs further exploration. In crisis mental health services, upholding the dignity of risk means respecting individuals' autonomy and decision-making, while thoughtfully balancing this with traditional risk assessment models to ensure safety without undermining personal agency.

"All services need to be intrinsically linked as you can't have one without the other - work seamlessly and harmoniously."

FUTURE STATE LLE INSIGHTS: SERVICE & SYSTEM INTEGRATION

Key considerations relating to the integration of new or redesigned services are outlined below. LLE participants highlighted the need for connected and supported service pathways.

Service Integration Considerations

Clinical Assistance

Peer workers can play a particularly valuable role in the onsite clinical assistance model, providing support to consumers, families and carers, and complementing clinical functions. Whilst the benefits of real-time peer-based supports are recognised, it is noted that a significant shift in culture and practice would be required to enable meaningful contributions, along with investment in structures and processes to further build capacity and capability, provide role clarity, and ensure access to discipline-specific supervision, support and safe working environments for peer workers.

Crisis Outreach

Continuity of care was noted as an important consideration. It was suggested that consumers could be supported by the same staff members if Area Services Crisis Outreach and Continuing Care teams are combined or the workforce are rotated across the services. Crisis Outreach teams could also co-respond with local, culturally specific services to support holistic community responses (e.g., linking with local Aboriginal Community Controlled Health Organisations who could support with primary or secondary Social and Emotional Wellbeing expertise when supporting First Nations people).

Crisis Telehealth

Community members noted that existing telehealth services can be difficult to find, with limited awareness of options like Area Service Triage services. There was strong support for a centralised statewide service, and a recommendation for access to Telehealth services (call, video, text) for people in regional and rural areas who are waiting for Crisis Outreach or emergency service teams to arrive.

Crisis Stabilisation

While the preferred location for Stabilisation services is in community settings, many participants recognised the practical benefits of locating them on hospital campuses to support rapid diversion from the Emergency Department (ED), as many people may still attend when unsure where else to go and support the ability to quickly escalate care if required. As identified by the Royal Commission, a location away from the potentially stressful and confronting environment of the ED is intended to provide a better environment for recovery-oriented mental health care treatment, care and support.

Drop-In Safe Spaces

While there was agreement Safe Spaces should be LLE-led, there was broad support for optional clinician involvement (in-person or virtual), particularly in regional and rural areas where access to support may be limited. Participants advocated for consumer-led decision making including when to call for clinician involvement and for any engagement with clinicians to take place in separate, designated areas (e.g., private rooms or virtual spaces) to preserve the peer-led ethos of the space.

System Integration Considerations

Community promotion of crisis services in non-mental health spaces

Expanding community promotion and awareness of crisis services through local community spaces (e.g., schools, libraries) with consistent and plain messaging about how people can get support. Emphasis was placed on the need for simple, non-clinical language around service access and offerings.

Streamlined entry points to crisis support and navigation

People in crisis, and their families, carers, supporters and other service providers, to have centralised and clear pathways for activating crisis responses and/or seeking advice on the most appropriate crisis service.

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