Adelaide PHN Primary Mental Health Care Services Redesign: Stakeholder Consultations Summary Report

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1. Abbreviations and Key Terms

1.1 Abbreviations

CAC	Community Advisory Committee
CALD	Culturally and linguistically diverse
CRM	Customer relationship management
CRU	Central Referral Unit
CSP	Commissioned service provider
ESL	English as a second language
FGD	Focus group discussion
IEC	Information, education and communication
LETSS	Lived Experience Telephone Support Service
LGBTIQA+	Lesbian, gay, bisexual, transgender, intersex, queer, asexual and questioning
LHN	Local Health Network
MHC	Mental health clinician
SES	Socioeconomic status
SIPS	Structured intervention program for people who have attempted suicide
SPS	Suicide prevention services

1.2 Key Terms

Missing Middle	The term ‘missing middle’ is used to describe people whose needs are not met by available mental health services. They are typically too unwell for primary care, but not unwell enough to be eligible for state-based services. They may have recently accessed mental health care services, however, the services accessed could not accommodate their needs (i.e. in terms of care duration, or the level of care appropriate for more complex and severe mental health conditions).
Stepped Care Model	The Stepped Care Model is an evidence-based, staged approach to mental health service delivery, comprising a hierarchy of interventions matched to a person’s needs at any given time. Implementation of the Stepped Care Model is designed to ensure that people can access the most appropriate services for their mental health needs, with the flexibility to ‘step up’ or ‘step down’ to different levels of care intensity as needed.

2. Executive Summary

In 2021 Adelaide PHN undertook stakeholder consultations to inform the redesign of primary mental health care services scheduled for commissioning and implementation from 2022 to 2025. The consultations engaged over 100 stakeholders from diverse groups, including people with lived experience of mental illness, GPs, mental health clinicians, and representatives from Adelaide PHN primary mental health care Commissioned Service Providers (CSPs), mental health peak body organisations, Local Health Networks (LHNs), and the SA Government. Stakeholders provided feedback in relation to existing Adelaide PHN commissioned primary mental health care services, with a focus on identifying key strengths, concerns, and solutions to concerns. Stakeholders had the opportunity to identify the vulnerable populations within the community in the context of mental health. They also had the opportunity to consider and identify the key attributes for the successful implementation of the proposed primary mental health care 'hub' service delivery model.

Strengths of **Low Intensity Services** identified by stakeholders included: minimal wait times; flexibility in terms of delivery and modalities offered; and consumer's sense of ownership and agency brought about by program structure. Strengths of **Psychological Therapies** included: clients' needs being met through the availability of a range of modalities, a pool of clinicians and flexible delivery; the longer duration of support available to consumers; and session structure, content, and consistency. Strengths associated with **Wraparound and Coordinated Services** included: the ability to access a range of programs and services tailored to a consumer's individual needs; clinical care coordination/shared care; and consistency in clinician. A strength of **Psychological Therapies for Children Aged 0-11 years** was the ability to engage parents and caregivers in therapy. Strengths of clinical **Suicide Prevention Services** included: the evidence-based structure, content and intensity of the programs; health care provider collaboration to support continuity of care; and consumers' ability to access assessment and support quickly. A strength of the **Central Referrals Unit** service was the ease of making referrals; and a strength of the **GP Psychiatry Support Line** was the availability of advice to support diagnostic decision-making, treatment planning, and provision of medication support for patients.

To address the challenge of **long wait times** proposed solutions included: communicating transparently with consumers regarding wait time duration; maintaining regular contact with waitlisted consumers and carers; increasing the frequency of GP sessions; recommending alternative modalities during the waiting period; promoting engagement in community-based social activities; and enhancing CSPs' knowledge of the primary mental health care service landscape to support cross-referrals to other CSPs. To address the **lack of services for children aged 0-11 years**, solutions identified included: increasing service availability, distribution, and therapy duration; providing evidence-based parental/caregiver or familial therapies; promoting services and enhancing access; and increasing opportunities for paediatric mental health training for clinicians. To respond to the **poor visibility**

of commissioned services and programs and the lack of clarity regarding eligibility and intake procedures, solutions identified included: providing educational opportunities for GPs, clinicians and CSPs; strengthening the profile of available services and programs in the community through targeted communications; refining search algorithms and digital referral decision support tools embedded within CSPs' and Adelaide PHN's websites; developing non-digital communications to promote services and programs to vulnerable populations; using consistent suicide risk language; and ensuring the availability and visibility of multilingual information. To address **workforce shortages**, stakeholders proposed: promoting and valuing diversity and work-life balance; and providing more opportunities for professional development and staff support and supervision.

The three key attributes for successful hubs proposed by stakeholders included: i) **accessible and convenient** hubs, with considerations including location, support services to remove barriers to access, service size, and flexibility; ii) **safe and welcoming** hubs, encompassing co-designed facilities, flexible, comfortable and welcoming physical layout with inclusive visual cues, and leveraging the peer, lived experience and volunteer workforce; and iii) **collaborative and integrated** hubs, supported by multidisciplinary and diverse teams, cross-sectoral partnerships, and the application of best practice principles to strengthen collaboration.

The six recommendations stemming from stakeholder consultations to be considered in the redesign of primary mental health care services were:

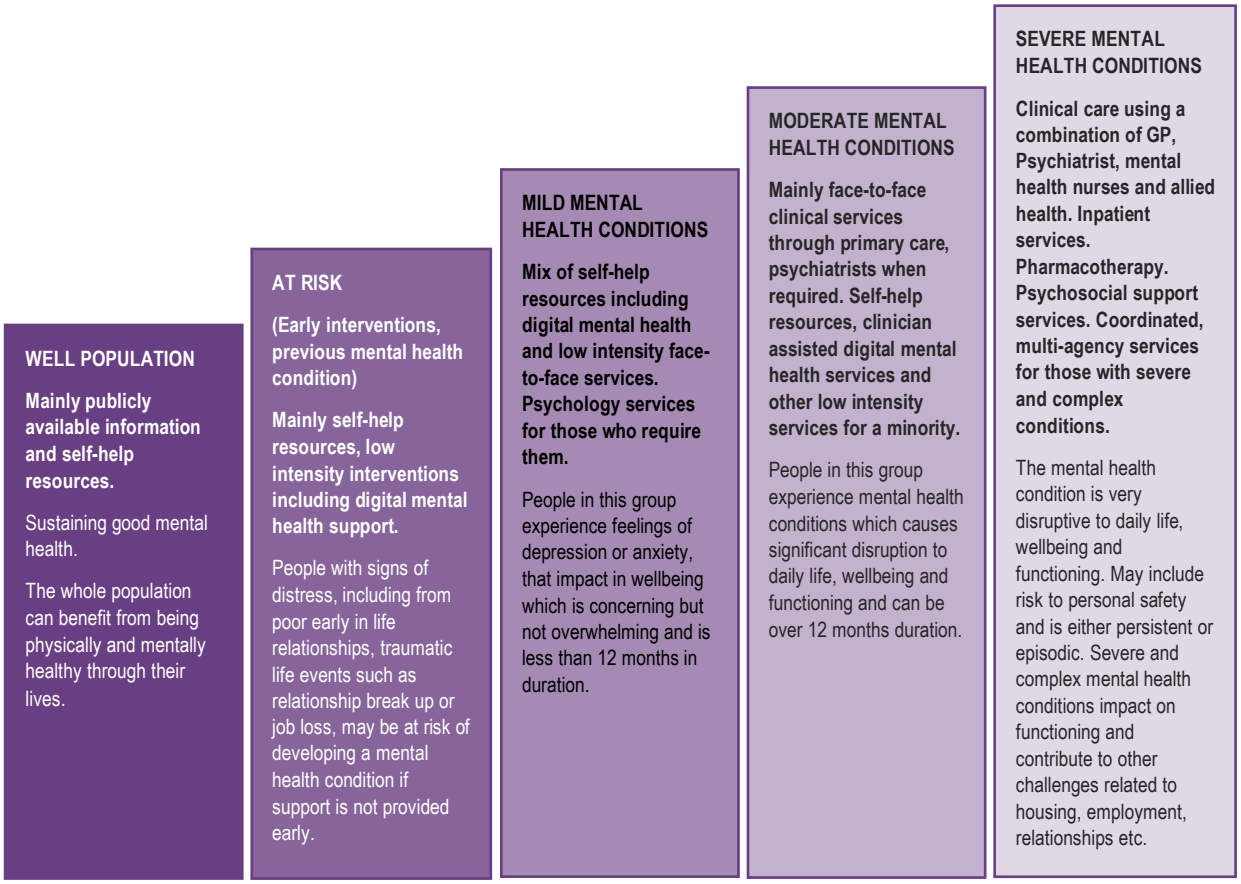
1. Continue to play to our strengths;
2. Devise and implement waitlist strategies;
3. Expand service offerings for children aged 0-11 years;
4. Devise and implement marketing and communication strategies;
5. Devise and implement workforce strategies to address workforce shortages and address consumer needs; and
6. Incorporate the key attributes identified by stakeholders in the design of primary mental health care hubs.

3. Background

During the last quarter of 2021 Adelaide PHN initiated stakeholder consultations to inform the redesign of a selection of its primary mental health care services that are scheduled for commissioning and implementation for the period from July 2022 to June 2025. Due to the breadth of services commissioned by Adelaide PHN, not all commissioned primary mental health care services were included within the scope of this consultation process.[i] The Adelaide PHN commissioned primary mental health care services included within the remit of the stakeholder consultations were:

- Services offered across the Stepped Care Model (Figure 1) for adults aged 25 years and older who are: at-risk of/or experiencing mild mental illness/mental health conditions (Low Intensity Services); experiencing mild to moderate mental illness (Psychological Therapies); or experiencing severe or complex mental illness (Wrap-around and Coordinated Services);
- Psychological therapy services for children aged 0-11 years and their families;
- Clinical suicide prevention services; and
- Services to support integration across primary mental health care services and enhance referral pathways targeted at GPs (Integrated GP Support Services and Referral Pathways)

Figure 1: Stepped Care Model



Services that were excluded from the remit of the stakeholder consultations included: youth mental health services (12-24 years); mental health programs situated within residential aged care facilities; psychosocial programs; Aboriginal and Torres Strait Islander programs; and community-based suicide prevention programs.

The consultations aimed to engage a broad range of primary mental health care service stakeholders, including people with lived experience of accessing or supporting someone who accessed these services, to better understand the gaps and opportunities within the existing service delivery model. Key findings from the consultations will inform the redesign of a person-centred service that best meets the needs of vulnerable populations within Adelaide PHN's region.

4. Consultation Approach

A total of 104 stakeholders were involved in the two phases of consultations: Phase 1 was an online survey; and Phase 2 involved focus group discussions (FGDs).

4.1 Phase 1: Survey

During the first phase in September 2021, an online survey was distributed via email to over 700 contacts from Adelaide PHN's CRM database. The survey was also promoted on Adelaide PHN's Facebook page and Twitter account. The survey was published on Survey Monkey and was open for 3 weeks. Survey respondents were asked to reflect on their experiences with Adelaide PHN commissioned primary mental health services.

A total of 64 respondents completed the survey (Table 1), comprising: 21 stakeholders with lived experience of primary mental health care; 20 mental health clinicians (MHCs)[ii]; 10 Adelaide PHN mental health commissioned service providers (CSPs); 8 general practitioners (GPs); and 5 members of the Adelaide PHN Community Advisory Council (CAC).

Table 1: Survey Respondents by Stakeholder Group

Stakeholder Group	Number of Respondents
Lived Experience	21
MHCs	20
CSPs	10
GPs	8
CAC Members	5
TOTAL	**64**

Note: not all survey respondents answered all survey questions; respondents were given the option to skip any questions that did not apply to them or that they did not wish to respond to. The figures in Table 1 represent the highest response rate recorded to a single survey question from each of the stakeholder groups.

4.2 Phase 2: FGDs

The second phase of consultations involved five FGDs with diverse stakeholder groups. Preparation of the FGD question guides was informed by the preliminary analysis of responses to the online survey.

The FGDs were facilitated by Adelaide PHN staff during October 2021. A total of 40 participants attended the FGDs (Table 2). Ten CSP representatives participated in the first FDG; six GPs participated in the second; 10 representatives from Adelaide-based mental health peak-body organisations, LHNs and SA Government participated in the third; eight people with a lived experience of primary mental health care services (as consumers or carers) participated in the fourth; and six MHCs participated in the fifth FGD. The organisations represented in the FGDs are detailed in Appendix 1. All FGDs were audio recorded. FGD participants were also given the opportunity to provide their written feedback via email within the consultation period.

Table 2: FGD Participants by Stakeholder Group

FGD & Stakeholder Group	Number of Participants
FGD 1 – CSPs	10
FGD 2 – GPs	6
FGD 3 – Peaks/LHNs/SA Govt.	10
FGD 4 – Lived Experience	8
FGD 5 – MHCs	6
TOTAL	**40**

5. Data Processing and Analysis

The survey data were extracted from Survey Monkey and imported into a qualitative data analysis program, NVivo 12, for thematic analysis, as the majority of survey questions allowed for open ended responses. The FGDs were transcribed and the transcripts were deidentified to protect participants' privacy. The transcripts were imported into NVivo 12 for thematic analysis.

6. Key Findings

Stakeholders had the opportunity to consider and provide feedback on: i) what we are doing well – specifically the key strengths of the Adelaide PHN commissioned primary mental health care services that they knew of or had engaged with; and ii) areas for improvement – specifically the key concerns related to the Adelaide PHN commissioned primary mental health care services that they knew of or had engaged with. Stakeholders were also invited to identify: iii) solutions to the key concerns they raised; iv) who the most vulnerable populations are in the Adelaide PHN region; and v) the attributes of the proposed hub service delivery model that would contribute to the success of the primary mental health care. The key findings are detailed below.

6.1 Perceptions Towards Services Offered Across the Stepped Care Model

6.1.1 Low Intensity Services

Strengths. A key strength of low intensity services raised by stakeholders was the fact that delivery is flexible, with options including online, telehealth and group-based therapy. Several stakeholders noted that this flexibility contributes to enhanced service coverage and accessibility. Other strengths raised were that the programs bring about a sense of ownership and agency in consumers who participate in them; and that wait times to access services are short or reasonable.
Concerns. Several stakeholders noted that there is a perception among some consumers and GPs that low intensity programs are less effective or less valuable compared with psychological therapies. Stakeholders also emphasised that there is a low awareness among GPs about the available programs. Other concerns raised included: that group-based therapies are often fully booked, leading to protracted wait times; and the lack of clarity concerning eligibility and categorisation for referrals. Several stakeholders noted that certain modalities were not suited to the needs of some consumers (specifically group-based therapies and programs not offered face-to-face).

6.1.2 Psychological Therapies

Strengths. Stakeholders emphasised the ability to offer a range of modalities to consumers, via a range of mediums (i.e. face-to-face, telehealth, online), with access to a pool of clinicians, as strengths that led to consumer needs' being met. Additional strengths raised were the longer duration of support offered to consumers; the structure, content and consistency of sessions; and the stepped service delivery.
Concerns. Protracted wait times to accessing psychological therapies for consumers experiencing moderate mental health conditions was raised across multiple stakeholder groups. Additional concerns raised were lack of psychologists; the additional support needs of consumers seeking to access NDIS; and the increasing complexity and severity of presentations in primary mental health.

6.1.3 Wrap-Around and Coordinated Services

Strengths. A strength of services available for people with severe and complex mental health conditions identified by stakeholders was the ability to offer a range of wrap-around programs and services tailored to a consumer's individual needs. Additional strengths identified included: clinical care coordination/shared care; screening and assessment; and consistency in clinician.
Concerns. Access to psychiatric assessment and advice, long wait times and attracting psychologists to work within services were the top three concerns raised by stakeholders. Additional concerns identified included the cessation of group therapies; barriers to access for consumers with complex needs and/or experiencing crisis; and the lacking collaboration between GPs and hospitals.

In the survey, more than half of the Lived Experience survey respondents (N=13) indicated that they or someone they know who had received a psychological service could also have benefitted from psychiatric assessment, medication or review.

Difficulties in accessing psychiatric care and the very long wait times for appointments with psychiatrists was a source of considerable stress for consumers and their caregivers; this was relayed by several FGD participants:

> It's very difficult to access a psychiatrist. There are plenty of psychologists, but psychiatrists, my experience is that I have to contact 20 before I was able to get one preparing to give me an appointment. And I think that is not acceptable, because if you really need a psychiatrist, it's because your mental health is not there, which means that perhaps cognitive, clarity is not there. So 20 people, 20 clinics, is too much. I don't think a person with that, already that problem should have to go through all those hurdles, to get that. I think that's why a lot of people will never access that.
>
> FGD participant (Lived Experience)

> We've been on the wait list for a psychiatrist, I've called well over 15, closed books… some of them have allowed me to put their name on, but they said it could still be another nine months, [others] where it's nearly over a year. He can't work or study because of…that concentration. So his clinical psychologist has said to him, you have this diagnosis, because he's done the form [screening assessment], but to get medication you need a psychiatrist to actually do the plan for it. So he's like in limbo…we're waiting. His life's on hold and his mental health has deteriorated in this period of time. All of the other parts of you [deteriorate] [when] your life's on hold. And I think the only time we might be able to access help is when he's back in hospital with a suicide attempt. And so why should it get to that stage?
>
> FGD participant (Lived Experience)

6.1.4 Psychological Therapies for Children Aged 0-11 Years

Strengths. Having the ability and flexibility to engage parents and caregivers in therapy was a key strength raised, and several stakeholders remarked that it was critical to offer services to the child-carer dyad for this consumer age group. Another strength raised was the fact that Adelaide PHN commissioned services are free of charge, removing the barrier of cost.

Concerns. Stakeholder concerns included the lack of services available for children. Additionally, the fact that children aged 3-4 years are not eligible for services funded by Adelaide PHN was identified as a service gap. Other key challenges raised related to managing high levels of demand and wait lists, and the limited pool of clinicians with paediatric specialisation (especially male clinicians), the lack of service visibility; and the fact that too few sessions are offered, resulting in recurrent waitlisting and disjointed/interrupted therapy.

6.1.5 Suicide Prevention Services

Strengths. Stakeholders emphasised the evidence-based structure, content and intensity of suicide prevention services commissioned by the Adelaide PHN as key strengths. Other strengths raised were: the way service providers worked

collaboratively to support continuity of care for consumers; and consumers' ability to access assessment and support quickly. Several stakeholders provided positive feedback on specific Adelaide PHN commissioned clinical suicide prevention services:

> The Suicide Intervention Program…works well as it is a brief, client client-centred and targeted intervention for people who have a suicidal crisis. It helps clients understand why their crisis occurred, gain information about their triggers, and collaboratively create their own individual safety plan.
>
> Survey Respondent (MHC)

> The SPS Program is effective at stabilising situational crises/emotional distress, which helps to promote therapy readiness by the time clients access moderate-intensity programs.
>
> Survey Respondent (CSP)

> The SIPS program saves lives it keeps people out of hospital beds and enables emergency doctors to effectively do their jobs.
>
> Survey Respondent (MHC)

> Adelaide PHN specialised services Anglicare and SIPS are excellent, we have amazing support from these organisations.
>
> Survey Respondent (GP)

> Provision of care between GP, Anglicare and Psychmed worked well.
>
> Survey Respondent (CSP)

Concerns. The lack of communications from CSPs after referring a patient to a suicide prevention service was a key concern raised by several stakeholders. Additional concerns raised included misdirected referrals; post-program support for consumers who lack strong social support; strict eligibility criteria for at-risk clients; and wait times for psychological support and tertiary care. Among Lived Experience survey respondents who answered the question: *'do you feel that the psychological services you or someone you know received helped you or them cope better with suicidal behaviour and/or ideation?'*, one-third (N=6) disagreed. An FGD participant elaborated on the challenges for ESL consumers when they do not receive support in their first language:

> Someone that I know ended up being in hospital because attempting suicide, and after I called and say, "How you going...do you have a safety plan?". "Oh, yeah, but it's only in English, and I have no idea what it says."
>
> FGD participant (Lived Experience)

6.2 Perceptions Towards Integrated Referral Pathways and GP Support Services

6.2.1 Central Referral Unit (CRU)

Strengths. Several GP survey respondents reported that the key strengths of the CRU are that it is easy to refer patients and that the service works well once you understand referral eligibility criteria. A CSP stakeholder advised that the flow of communications between CRU and providers is a strength.

Concerns. In both the online survey and FGD, GP stakeholders asserted that they were better placed to assess the needs of their patients, particularly those with whom they have a long-standing clinical relationship. Another concern raised by GPs in both the survey and FGD was that there was a lack of clarity and transparency regarding the CRU's triaging procedures and processes, and for some this had led to the CRU refusing to take referrals for some patients. Due to this lack of transparency, some GPs remarked that they did not trust the CRU and would prefer to 'hold onto' a patient rather than refer them to CRU. The concerns of several GP FGD participants are elaborated below:

> But also I tried to refer something to that and, again, it's not for something acute. So it's also knowing – because I was like, "Oh, this must be" – because we used to have…a central referrals unit for mental health [in another country] and all the referrals went there and then they would be triaged into their rightful places. So I assumed that was what it was.
>
> FGD participant (GP)

> The other thing that's problematic is when you do refer to the CRU, you don't necessarily know what the wait is going to be and the communication on that can be lacking. So that means that you've got a patient that you're basically responsible for, because we do hold onto responsibility even when we've referred to that mental health provider, and you're left in a vacuum because you're not sure when they're going to get seen, who's going to see them, what they're going to do with them… I like a bit more control in that…
>
> FGD participant (GP)

6.2.2 GP Psychiatry Support Line

Strengths. GP stakeholders praised the GP Psychiatry Support Line for assisting them and their colleagues in making diagnostic decisions, formulating medication treatment plans, and providing medication advice and support to patients. A GP FGD participant described their colleagues' use of the service:

> She got some great advice about what to do with medication, and I think that's the real strength of that line… brilliant resource, because you can ring up, present your case, get some advice around medication, and then you've got somewhere to go and I think there is actually a way to go back to that as well, but she was very impressed… it's good for having your hand held.

FGD participant (GP)

Concerns. A GP survey respondent noted that the delay in response time is not helpful when a patient is too unwell. Another was concerned that when they had used the service a briefing note request for a psychiatrist with specific experience in paediatrics was not met or acknowledged.

6.3 Perceptions Towards Vulnerable Populations

CSP, GP and MHC stakeholders were explicitly asked to reflect on which populations are the most vulnerable in the context of mental health in the communities in which they work. Table 3 shows the vulnerable populations that they identified. Additionally, CSP, GP and MHC stakeholders were asked to reflect on the vulnerability of children and 93% of respondents (N=29) answered 'yes' to the survey question: *'Would you include children 0-11 years with mental health issues and their parents or carers as a vulnerable group?'*.

In the FGD with Lived Experience stakeholders, participants were not explicitly asked who they perceived vulnerable populations to be, but through the discussion and their experiences of the primary mental health care system it became evident that there was overlap with those identified by the other stakeholder groups, namely:

- Children and their families;
- People with complex needs;
- People from low socioeconomic backgrounds;
- LGBTIQA+ communities;
- People from CALD, refugee or migrant backgrounds, particularly those with ESL;
- Adults with ADHD or seeking an ADHD diagnosis;
- Survivors of torture and trauma; and
- People who do not have a regular GP.

It was also evident through the discussion in the FGDs that vulnerabilities are often intersecting (i.e. meaning that one person could be experiencing multiple vulnerabilities simultaneously). It was noted by stakeholders that for these individuals, the challenges in terms of accessing primary mental health care are compounded as a consequence of these intersecting vulnerabilities:

> Everything about being trans is expensive. So if you're broke, then forget about it.
>
> FGD participant (Lived Experience)

> Oh, there's always social determinants… if you've got a mother with severe postnatal depression but she's also got two disabled children at home, she's going to be higher needs than another mother whose same level of depression but who has a supportive partner and family around her…but we've still got nowhere to send them.
>
> FGD participant (GP)

He has paranoid schizophrenia from the trauma he experienced. And being from Afghanistan…we found it very hard to access support that is appropriate, that he could understand. It was an incredibly terrifying system to try and navigate.

FGD participant (Lived Experience)

I'm sort of hearing lots of discussions about homelessness and their issues and complexities of everyday social determinants of living. And those health issues need to be addressed as well as the mental health ones.

FGD participant (CSP)

Table 3: Vulnerable Populations Identified by Stakeholders

	CSPs	MHCs	GPs	LIVED EXPERIENCE
VULNERABLE POPULATIONS	***CALD, migrant and refugee communities (especially ESL)***	***People with comorbidities***	***People with comorbidities***	***Children and families***
	Parents during the perinatal period	***CALD, migrant and refugee communities (especially ESL)***	***People with complex needs***	***People with complex needs***
	Children and families (incl. CALD and those engaged in child protection system)	***LGBTQIA+ communities***	***CALD, migrant and refugee communities (especially ESL)***	***People from low SES backgrounds***
	LGBTQIA+ communities	***People without a regular GP***	***LGBTQIA+ communities***	***LGBTIQA+ communities***
	Survivors of domestic violence	*People from low socioeconomic status (SES) backgrounds*	***Children and families***	***CALD, migrant and refugee communities (especially ESL)***
	People with comorbidities	*People with complex needs*	**Adults with ADHD**	***Adults with ADHD***
	People who have recently been released from the prison system	War veterans	*Survivors of domestic violence*	***Survivors of torture and trauma***
	Survivors of trauma or torture	People experiencing problem gambling or gaming	*People from low SES backgrounds*	*People without a regular GP*
	People with complex needs	People experiencing active suicidal ideation (no prior attempt/crisis)	*Survivors of trauma or torture*	
	Neurodivergent children and adolescents	People experiencing chronic suicidality	*Parents during the perinatal period*	
	People experiencing homelessness or living in transient accommodation	Mothers/parents with mental illness	Men	
			Perpetrators of domestic violence	
			People experiencing family dysfunction	
			People without access to transport	
			Elderly people with mental illness	
			The Missing Middle	

Notes: text in bold and italics denotes vulnerable groups mentioned by more than one stakeholder (from within a stakeholder group) and more than one stakeholder group; bold text denotes vulnerable populations identified by more than one stakeholder (from within a stakeholder group); and italics text denotes vulnerable populations identified by more than one stakeholder group

6.4 Identification of Solutions to Key Concerns

In both the online survey and the FGDs, stakeholders were given the opportunity to put forward solutions to address the concerns that they had raised. Table 4 shows the recurrent key concerns – specifically the concerns that were raised repeatedly across stakeholder groups during the consultations – and the service context/s in which these concerns were raised. The solutions that stakeholders identified to address these key concerns are detailed below.

Table 4: Key Concerns and Service Context

KEY CONCERN	SERVICE CONTEXT/S	SOLUTIONS
Long Wait Times	Low Intensity Services Psychological Therapies Psychological Therapies for Children 0-11 Referring from SPS to Primary or Tertiary Care GP Psychiatry Support Line	Constructively Manage Wait Times
Lack of Services for Children Aged 0-11 Years	Psychological Therapies for Children 0-11	Address Service Gaps for Children Aged 0-11 Years
Poor Visibility and Lack of Clarity / Transparency	Low Intensity Services Psychological Therapies Psychological Therapies for Children 0-11 CRU SPS	Enhance Service Visibility, Transparency and Integration
Workforce Shortages	Psychological Therapies Wrap-around and Coordinated Services Psychological Therapies for Children 0-11	Address Workforce Shortages

6.4.1 Constructively Manage Wait Times

Long wait lists was consistently raised by stakeholders as a key concern in relation to the range of services offered across the Stepped Care Model (except for suicide prevention services). In FGDs with MHCs, GPs and Lived Experience participants, the challenges concerning wait lists were was explored further, with a focus on the optimal ways to reduce consumer anxiety or disengagement due to uncertain or prolonged wait times, and the potential for solutions to make wait times a more productive and positive experience for consumers and their carers. The solutions that were raised are listed below and illustrated in Figure 2 below.

Lived Experience Participants' Solutions:

- Increasing the frequency of GP sessions while waitlisted.
- Participating in community-based social activities, such as men's groups, or carer support groups.
- Having the ability to attend a child friendly retreat for single mothers 'to clear your head'.
- Having the ability to chat / check in with other carers via multiple modalities, i.e. face-to-face; phone; email; chatbot; moderated online groups, with support in your first/preferred language.
- Having access to peer support.

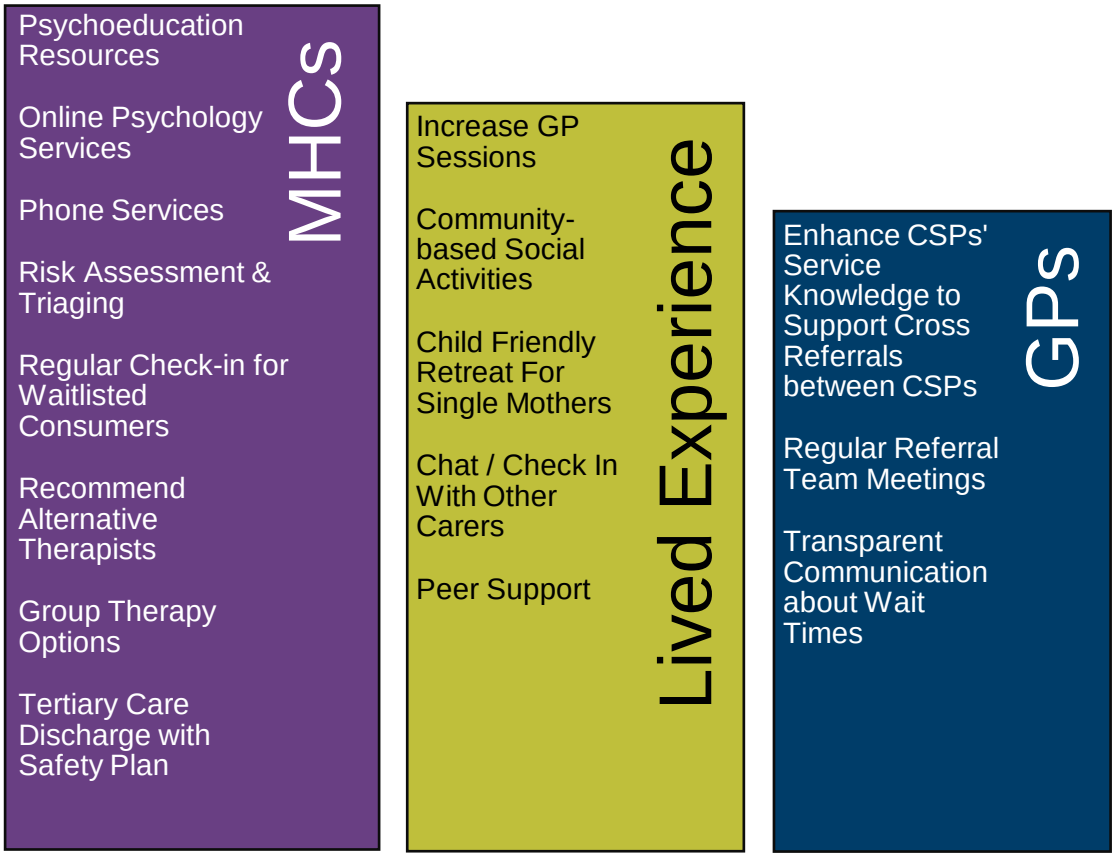
MHC Participants' Solutions:

- Recommending online psychoeducation resources, such as Head to Health or This Way Up.
- Suggesting online psychology services.
- Recommending phone services (for acute mental health), including lived experience phone services (for crisis).
- Triaging clients based on risk assessment; with weekly check-in call for waitlisted clients.
- Searching for and recommending alternative therapists, using the Australian Psychological Society's Find a Psychologist service/database.
- Providing group therapy options and accommodating groups with low numbers (i.e. up to 5 clients, with leniency in relation to minimum attendance requirements).
- Discharging from tertiary care with a safety plan in place incorporating multiple modalities/settings to avert long wait times (recommending drop-in centres; making patients aware of the Urgent Mental Health Care Centre; providing advice about when to call an ambulance or present to ED; suggesting online resources; and recommending psychosocial programs).
- Promoting ongoing shared care between the GP and psychologist and/or psychiatrist, provided the consumer has a regular GP and a trusting GP relationship).

GP Participants' Solutions:

- Ensuring CSPs have sufficient knowledge of the services offered by other CSPs in the Adelaide PHN region, to facilitate cross-referrals between CSPs.
- Having weekly referral team meetings to ensure that patient referrals and wait lists are managed in a proactive and timely manner.
- Receiving clear communication from CSPs regarding wait times, in order to inform client decision making.

Figure 2: How to Constructively Manage Wait Times – Stakeholders' Solutions



6.4.2 Address Service Gaps for Children 0-11 Years

Stakeholders determined children aged 0-11 to be a vulnerable population. They also highlighted the shortfalls in addressing children's mental health needs within the current primary mental health care service landscape, due to services offered in the private health system being unaffordable for many families and the limited offerings in the public system.

Stakeholders offered a range of solutions to address the service gaps for children aged 0-11 years, specifically:

- Increasing service availability, distribution and duration of therapy by allocating more resources to support this population.
- Providing evidence-based parental/caregiver or familial therapies, including group-based therapies, family peer support workers and psychosocial support (i.e. parenting education), to support parent/caregiver mental health, to recognise and address the association between child mental health with parent/caregiver mental health.
- Undertaking information, education, and communication (IEC) campaigns to promote and enhance awareness of and access to services in the community.

- Increasing opportunities for paediatric mental health training for clinicians, to address workforce shortages, specifically the shortages of: i) clinicians with specialisation in paediatric mental health; and ii) male clinicians with paediatric mental health specialisation.
- Offering both child-only sessions and parent/caregiver-only sessions, recognises the fundamental reliance on the parent/caregiver role in the child's journey to improved wellbeing, and allows the child a space for therapy without parent/caregiver interference, and vice-versa.
- Enhancing collaborations across other key sectors to enhance service integration with schools and community services.

6.4.3 Enhance Service Visibility, Transparency and Integration

An overarching concern raised by GP, MHC and CSP stakeholders was that the Stepped Care Model is complex and difficult to navigate when seeking to identify primary mental health care services and program options that are best suited to a consumer's needs. Stakeholders noted that it was challenging to access and filter information about the available services, referral pathways, integrated pathways and eligibility criteria, and expressed a desire for clearer information. As a GP FGD participant remarked:

> I think GPs are aware of the [Stepped Care Model], but our issue is getting people in the right door. So it's not so much knowing how the model works, it's knowing where this person belongs because there's always that, "Oh, I tried at this level, but they were too sick, and then I tried at this level and they weren't sick enough." It's almost like we need a little road map of which service is what.
>
> FGD participant (GP)

Similarly, in the survey an MHC stakeholder noted that there is 'poor awareness of Adelaide PHN-funded services' among clinicians working in services funded by the state government, resulting in them 'not making appropriate referrals'. A GP stakeholder remarked that one of the challenges is that the landscape of primary mental health care services was 'ever changing', making it difficult keep updated.

The experience of an FGD participant who supports her elderly parent highlights the difficulties from carer's perspective:

> I find it really frustrating. You go to the GP for the support... And they're…restricted because of referrals, there's nothing available. They don't know where to go, yeah.
>
> FGD participant (Lived Experience)

During the consultation stakeholders provided the following solutions to promote visibility and transparency of Adelaide PHN commissioned primary mental health care services and programs for diverse stakeholders:

- Providing educational opportunities for GPs, MHCs, student clinicians and CSPs that showcase the suite of Adelaide PHN's commissioned primary mental health care services and programs and clearly explain the Stepped Care Model, referral pathways, integrated pathways and eligibility criteria. Specific suggestions included:
  - Establishing a primary mental health community of practice (CoP);
  - Upskilling a number of 'GP Mental Health Champions', whose role would include peer training; and
  - Adelaide PHN practice facilitators or CSPs delivering presentations to interdisciplinary meetings in hospitals to provide advice and updates on service and program offerings for discharge from tertiary care.
- Promoting the use of consistent suicide risk language, across services and programs offered by CSPs and educating stakeholders in the nuances of this risk language to prevent misdirected referrals and avoid delays in suicide prevention interventions.
- Building a stronger profile in the community through targeted communications, including enhanced digital marketing and social media engagement, and media exposure that promotes Adelaide PHN's commissioned primary mental health care services and programs to stakeholders.
- Refining search algorithms and other referral decision support tools embedded within Adelaide PHN and CSP websites, to enhance search functionality and information accessibility.
- Developing offline, non-digital communications to promote Adelaide PHN's commissioned primary mental health care services and programs to vulnerable populations, such as peer service navigators for vulnerable groups and grassroots 'street crews' for people experiencing homelessness.
- Ensuring the availability and visibility of multilingual information.
- Ensuring that language used in promotional communications is non-stigmatising.

The feedback and experiences shared by CSP, MHC and GP stakeholders highlighted that integration is critical to effectively navigating the primary mental health care service landscape, but that it also time and resource intensive, involving effective communication and coordination at the interface between Adelaide PHN's

commissioned primary mental health care services and LHNs via community mental health services and hospitals. Additionally, stakeholders highlighted that integration is reliant on the maintenance of professional relationships and networks. A CSP stakeholder emphasised the need for more integration to be better resourced and reflected in project schedules:

> [The] service landscape for external referrals is always shifting, meaning it can be difficult to keep up with formalised MOUs for referral pathways out and there is no dedicated funding to support service integration or mental health prevention/promotion. Integration is supported, facilitated and maintained through relationships, relationships take time [and] service models need to factor in the cost of identifying, fostering and maintaining relationships. Through solid relationships clear understanding of service models points of integration, gaps and opportunities can be identified, solutions can be found, implemented and then maintained. Project Schedules that have a pure focus on client facing service activity don't allow for and support the development of relationships. The absence of integration should not be seen through the lens of apathy but resourcing.
>
> Survey Respondent (CSP)

The reflections of an MHC stakeholder similarly highlighted the resource intensive nature of integration, in the context of identifying suitable psychosocial support services for clients:

> [It] sounds really cold – but I'm almost not engaging at that level. A lot of the time it's the admin [staff] who are doing those calls.
>
> FGD participant (MHC)

6.4.4 Address Workforce Shortages

Solutions to address workforce attraction and retention provided by CSP and MHC stakeholders included:

- Promoting and valuing diversity (specifically engaging workforce from diverse backgrounds with respect to age, culture, ability, gender, multidisciplinary/skills mix, and lived experience/peer workforce).
- Promoting work-life balance.
- Providing professional development opportunities to upskill staff.
- Providing more opportunities for support and supervision of staff including:
  - Internship programs for provisional psychologists; and
  - Placement opportunities for nursing, counselling, social work, psychology, medical students and registrars.
- Supporting psychiatrists working within CSPs with a registrar.

A Lived Experience FGD participant reflected on the value of having access to a diverse team that includes lived experience peer workers, as well as access to diverse modalities to support recovery:

> Sometimes psychologists don't help. I've had a lot of people who've gone for that support and it hasn't been useful, and they've done their full sessions, and they haven't actually recovered from it. Healing and recovery with mental health can come from lots of different areas. So, like peer workers. There's an emergence of the lived experience peer workforce, and talking to somebody who gets it, and have been through recovery, then it helps with stigma, it helps with normalisation. It helps talking about things that work for other people, but you've got to find what works for you. So I think we do need to think about maybe alternatives. So there is art therapy that's very therapeutic and has evidence base. I know [a local MHC], they also do emotional CPR, this is for anybody in the community, to be able to talk to somebody heart to heart. Like I think that social emotional wellbeing, focusing on that. So I think it's also about the sort of therapies and clinical support you can get. It can be different things that work for certain people.
>
> FGD participant (Lived Experience)

6.5 Exploration of Primary Mental Health Care Hubs: Key Attributes for Success

In both the survey and FGDs stakeholders were asked to: i) provide their views in relation to a hub or 'one-stop-shop' primary mental health care service delivery model; and ii) suggest the key attributes that would make this service delivery model successful.

In the survey, CSP, GP and MHC respondents were asked the question: *'Do you think the public, state and community based mental health services would have improved knowledge and better access to Adelaide PHN commissioned services if they were centralised and located together in one place where consumers could access a range of biopsychosocial services?'*. Most MHC and GP respondents agreed – 82% (N=14) and 71% (N=5) respectively. In contrast, two-thirds of CSPs respondents (N=4) disagreed with this question. Lived Experience and CAC survey respondents were asked the question: *'Do you think you would receive a better service if a range of mental, physical and social health services were available in one easy to get to place?'*. The majority agreed with this question: 95% of Lived Experience respondents (N=19), and all CAC respondents (N=5). Survey respondents were also given the opportunity to elaborate on their responses to these two questions in open ended response format.

In the FDGs, participants were invited to share their perceptions on the key attributes that should be considered in relation to a hub / one-stop-shop / co-located primary mental health service delivery model. In addition, given that this service delivery model will require collaboration and commitment from the various stakeholder

groups, CSP and Peaks/LHNs/SA Government FGD participants were asked to reflect on what had worked well in their experiences of being involved in consortia.

6.5.1 Key Attributes #1: Accessible and Convenient

Stakeholders regarded service convenience and accessibility as key attributes that would contribute to the success of a primary mental health care service hub. Several stakeholders described the benefits of co-located services:

> Definitely, the moment you reach out to one service, they should support you to connect to other relevant services, and being in the same place is very convenient, especially for those who don't drive or who are full time carers for a loved one / single parents. You arrange for support one morning and get everything done, rather than having to go to multiple appointments in different places and different dates, it simply makes things harder for a person who is already having a difficult time.
>
> Survey Respondent (CAC)

> Being able to access mental, physical and social health services in one place would allow for consistency and continuity of service. Having services in one location would avoid difficulties in travelling to multiple locations and having to re-tell your story to a variety of services and navigating confusing referrals and systems to access services. Having services in one location will make it easier to organise support, avoid consumers disengaging due to long wait lists and allow for multi-disciplinary approach and collaboration between mental, physical and social services to promote holistic health.
>
> Survey Respondent (Lived Experience)

> That would be much easier to navigate and find a suitable service. this would hopefully minimise confusion and get clients the help they need right away.
>
> Survey Respondent (MHC)

Key components and considerations identified by stakeholders that underpin convenient and accessible services are summarised below in Table 5.

Table 5: Accessible and Convenient Hubs – Components and Considerations

COMPONENT	CONSIDERATIONS
Location	▪ Centrally located. ▪ Adelaide CBD location may suit people who rely on public transport. ▪ Need to consider access for people living in the outer suburbs of metropolitan Adelaide. ▪ Should be located away from a shopping centre.
Services to Remove Barriers to Access	▪ Transport support, i.e. having a driver to collect people. ▪ Childcare support on site. ▪ Personal care support, i.e. having showers and lockers on site, access to washing machines.
Size	▪ Not too large, as larger services can be overwhelming for some consumers.
Flexibility	▪ Provide a range of service access options, i.e. mobile hub; outreach; telephone service; hybrid service. ▪ Care and support for walk-ins.
Convenience	▪ Service co-location and coordinated partnerships. ▪ Should not be too far away (i.e ~1.5 hours travel time each way 'too far').

6.5.2 Key Attributes #2: Safe and Welcoming

Feeling welcome and safe while attending a primary mental health care service hub was another salient attribute raised by stakeholders, particularly Lived Experience stakeholders. The following remark from a survey respondent highlights the relationship between the attributes of convenience and safety, which could be achieved via service coordination and co-location:

> It would be easier and feel safer for the patient to know their health care is being looked after by one service who understands their needs rather than attending several different services
>
> Survey Respondent (Lived Experience)

An FGD participant elaborated on the need for service locations to be discrete for safety, but that this would need to be balanced with visibility in the community to ensure that accessing the service becomes normalised rather than a source of shame or stigma:

> I'm sort of working through this thing at the moment where I'm scared, like I'm just terrified that someone's going to attack me out of nowhere, or I'm going to get abused, or something like that just because, you know. So it [a hub] needs to be…Discrete, but doesn't feel like you're walking into the back of a sex shop…So maybe then going with the idea of having a place for coffee is that maybe the purpose of it being there is a mental health/wellbeing hub, but it's surrounded by a whole heap of other stuff that the stigma gets completely erased about going there because people are going there for other reasons.
>
> FGD Participant (Lived Experience)

Another FGD participant described a safe hub as a service that supports and empowers consumers to take the lead in their journey towards better mental health:

> [T]hat people can actually the services that they actually need in a more normalised way, and where the front face is actually those with lived experience, so they are, I suppose, putting that supportive arm around people and people are able to engage or not engage at the level that they're comfortable with.
>
> FGD Participant (Peaks/LHNs/SA Govt.)

Key components and considerations identified by stakeholders that underpin safe and welcoming services are summarised below in Table 6.

Table 6: Safe and Welcoming Hubs – Components and Considerations

COMPONENT	CONSIDERATIONS
Co-designed and Remove Barriers to Access	▪ Engage consumers and carers to co-design a physical space that is warm, friendly and non-medicalised. ▪ Don't make the processes for signing up/accessing support convoluted or burdensome. ▪ Should be discrete in a non-stigmatising way. ▪ Empower potential consumers by allowing them visit to explore the services on offer and decide if/when they want to engage, i.e. decision to engage is consumer-led and non-pressured. ▪ Allow potential consumers to be accompanied by a support person.
Flexible and Welcoming Physical Layout	▪ Multiple spaces/zones to accommodate consumers varied backgrounds and needs (i.e. quiet spaces, open spaces, garden/green zone, area for families/children) ▪ Multiple entry/access points. ▪ Natural light and nice views
Inclusive Visual Cues	▪ Rainbows and trans pride flags. ▪ Flags/artworks representing Aboriginal and Torres Strait Islander peoples and other non-mainstream cultures. ▪ Visible information (brochures/flyers, posters) in your first language/languages other than English.
Leverage Peer, Lived Experience and Volunteer Support	▪ Should include a lived experience peer workforce, including people with lived experience of mental illness, as well as people who are peers. ▪ Peer workforce should have undertaken appropriate training and learn how to 'hold space', i.e. without sharing their experiences with consumers. ▪ Recognise the cultural and linguistic expertise of skilled migrants who are underemployed or unemployed and engage them to support CALD consumers.
Comfort	▪ Café on site. ▪ Being able to access food yourself. ▪ Being able to see your children while accessing a service. ▪ Therapy animals, i.e. dog, chickens.

6.5.3 Key Attributes #3: Collaborative and Integrated

Stakeholders emphasised that an integrated and collaborative service delivery model would contribute to successful outcomes for a hub service. A hub service delivery model that prioritises collaboration and integration would also help to address several of the key concerns raised by stakeholders described above (specifically long wait times, and poor visibility and lack of service clarity/transparency).

A survey respondent provided the following advice, highlighting the opportunities for more collaborative and integrated services:

> [U]nfamiliar mental health places are very stressful for my family members so having everything in one place would help alleviate these fears/barriers of going to different places. Also a place where they could cover most wellbeing needs would be a dream - we always said a headspace for adults would be amazing. Also staff could coordinate services and work together, which hopefully would reduce delays in treatment. Education and employment support is also vital, which could then help improve the other areas of a person's wellbeing
>
> Survey Respondent (CAC)

Key components and considerations identified by stakeholders that underpin collaborative and integrated services are summarised below in Table 7.

Table 7: Collaborative and Integrated Hubs – Components and Considerations

COMPONENT	CONSIDERATIONS
Multidisciplinary and Diverse Teams	▪ Team should include: GPs; MHCs; nurses; pharmacist; dietician; exercise physiologist; public health, population health and digital health professionals; spiritual support/chaplaincy; peer lived experience workforce; family therapist, relationships counselling, mediation, financial counsellor. ▪ Volunteer/community workforce with cultural/linguistic expertise. ▪ Offer training/credentialling to volunteers.
Cross-sectoral	▪ Work with/access to: Centrelink liaison; SAPOL liaison; DCP liaison. ▪ Joined up planning between State and Commonwealth funded primary mental health care programs and services. ▪ Better sharing of information/data ▪ Collect baseline data to support future modelling. ▪ Utilise existing spaces/infrastructure. ▪ Leverage existing partnerships.
Flexibility	▪ Support multiple entry point for consumers. ▪ Virtual /Project ECHO for GPs.
Collaboration Best Practice	▪ Shared purpose, commitment, leadership and investment. ▪ Clear objectives, outcomes and role expectations. ▪ Equitable, respectful and funded collaboration and integration. ▪ Engage lived experience stakeholders every step of the way. ▪ Ego is out and commit time to working through challenges. ▪ Prioritisation through financial investment. ▪ Use of partnership tools, i.e. collective impact model. ▪ Decision making grounded in data and evidence.

7. Recommendations

The following six recommendations outlined in Table 8 are supported by the key findings of the stakeholder consultations, and should be considered by stakeholders in the redesign of Adelaide PHN commissioned primary mental health care services.

Table 8: Recommendations for the Redesign of Primary Mental Health Care Services

	RECOMMENDATION	EXTENDED EXPLANATION	STAKEHOLDERS RESPONSIBLE
#1	**Continue to play to our strengths**	Continue to play to our strengths by offering flexible, person-centred primary mental health care programs and services that are underpinned by a strong evidence base.	CSPs, Lived Experience, Adelaide PHN
#2	**Devise and implement waitlist strategies**	Devise and implement waitlist strategies to ensure that consumers and carers are adequately supported throughout their mental health care journeys and to alleviate any stress associated with protracted waiting times.	CSPs, GPs, MHCs, Lived Experience, Adelaide PHN
#3	**Expand service offerings for children aged 0-11 years**	Expand service offerings for children aged 0-11 years and their families, with a particular focus on reaching children and families with unmet need for care.	CSPs, GPs, MHCs, Lived Experience, Adelaide PHN
#4	**Devise and implement marketing and communication strategies**	Devise and implement marketing and communication strategies to enhance awareness of Adelaide PHN commissioned primary mental health care services and programs within the community, particularly among vulnerable populations, and to enhance understandings across stakeholder groups in relation to service and program availability, efficacy of low intensity modalities, eligibility and referral processes, and consistent use of risk language	CSPs, GPs, MHCs, Lived Experience, Adelaide PHN
#5	**Devise and implement workforce strategies to address workforce shortages and address consumer needs**	Devise and implement workforce strategies to address workforce shortages and consumer needs, particularly for those needing access to psychiatric assessment, psychological therapies, additional social support and cultural or linguistic support.	CSPs, Lived Experience, Adelaide PHN
#6	**Incorporate the key attributes identified by stakeholders in the design of primary mental health care hubs**	Incorporate the key attributes identified by stakeholders in the design of primary mental health care hubs: accessible and convenient; safe and welcoming; and collaborative and integrated.	CSPs, GPs, MHCs, Lived Experience, Adelaide PHN

Appendix 1: List of Organisations Represented in FGDs

FGD #	DATE	ORGANISATION
1 – CSPs	14 October 2021	Anglicare
		Brian Burdekin Clinic
		CASSA (Community Access and Services SA)
		Centacare
		Developing Mind
		MIND
		Neami National
		PsychMed
		SHINE SA
		Sonder
2 – GPs	18 October 2021	GP Partners
		Refugee Health Service
		SA Health
		Adelaide PHN Clinical Council Members
3 – Peaks/ LHNs/ SA Govt.	19 October 2021	Carers SA
		CALHN (Central Adelaide Local Health Network)
		LELAN (Lived Experience Leadership and Advocacy Network)
		Hutt Street Centre
		MCCSA (Multicultural Communities Council of SA)
		MHCSA (Mental Health Coalition of SA)
		NALHN (Northern Adelaide Local Health Network)
		OCP (Office of the Chief Psychiatrist)
		SA Health
		South Australian Mental Health Commission
		Thorne Harbor Health
4 – Lived Experience	21 October 2021	*Adelaide PHN Community Advisory Council Members*
5 – MHCs	25 October 2021	Eastern Community Mental Health Service
		RASA (Relationships Australia South Australia)
		Adelaide PHN Community Advisory Council Members

i The services that were excluded during the 2021 redesign are planned to be explored in a similar stakeholder consultation process in 2022.
ii Includes: psychologists, psychiatrists, mental health nurses, other mental health clinicians (i.e. social workers) and mental health service managers.