



An Australian Government Initiative
connecting you to health

MENTAL HEALTH & ALCOHOL AND OTHER DRUGS SERVICE REFORM

Detailed consultation findings
February – March 2016

Postal PO Box 313, Torrensville Plaza SA 5031
Office Level 1, 22 Henley Beach Road, Mile End SA 5031
Phone 08 8219 5900 Fax 08 8125 6691
Email enquiry@adelaidephn.com.au
www.adelaidephn.com.au

Contents

1. Introduction.....	2
2. Adelaide PHN approach to engagement and consultation.....	2
3. Summary of findings	4
4. Overall key findings	24
5. Where to from here?	25

Tables

Table 1 – Consultation Methods and Target Groups	3
--	---

1. Introduction

The Adelaide PHN is committed to improving the efficiency, effectiveness and coordination of primary health services across the Adelaide metropolitan region, spanning from Sellicks Hill to Angle Vale and between the foothills and the sea, encompassing a community of approximately 1.2 million people. Adelaide PHN is not a service provider but is responsible for commissioning services to best address local needs. Guided by community, clinical and stakeholder input, Adelaide PHN has a clear goal of improving health outcomes for the community.

Adelaide PHN has deliberately chosen to jointly approach reforms across both mental health and alcohol and other drug sectors to acknowledge comorbidities that often occur with mental health and addiction, and to increase access to services.

Mental Health Reform

The Australian Government recently announced reforms to primary mental health care, to be rolled out over a three year period between 2016 and 2019. The reforms included a number of measures, most significantly, the rollout of a *Stepped Care Model* of primary mental health services.

Adelaide PHN has welcomed the opportunity to be innovative in developing a more responsive, focused and effective system. Further information about the Commonwealth Reforms can be found at www.health.gov.au.

Alcohol and Other Drugs Reform

The Australian Government has developed a comprehensive package of action to tackle the problem of ice (crystal methamphetamine) and alcohol and other drugs through the delivery of locally-based and targeted solutions. Of particular importance to PHNs, the Australian Government has decided to improve access to treatment, and ensure our workforce is supported to deliver effective and flexible treatment approaches. Further information about the Commonwealth Reforms can be found at www.health.gov.au.

2. Adelaide PHN approach to engagement and consultation

To commence the consultation process, three public forums were held in February 2016 to discuss Mental Health and Alcohol and Other Drugs (MH&AOD) reform, and encourage wide participation in the process. Over 320 service providers and community members attended indicating a high level of interest, excitement and commitment to the reform process.

Additionally, the Adelaide PHN created an online platform to enable service providers, consumers and other interested parties to actively contribute to an online conversation about MH&AOD service reform, and provide information regarding consultation outcomes and MH&AOD data. The Adelaide PHN MH&AOD Online Platform can be accessed here: <http://forum.adelaidephn.com.au/index.php>

An intensive consultation process was undertaken between February to March 2016 involving 210 people, aimed at improving the relevance and quality of commission processes for MH&AOD services. The consultation activities included online surveys; workshops with relevant sectors, service providers, consumers, carers, community organizations, specialist groups, and other interested parties (government and non-government); and the formation of a Working Advisory Group. The consultation methodologies and target groups are summarized in Table 1 – Consultation Methods and Target Groups.

Table 1 – Consultation Methods and Target Groups

Consultation Method	Description of methodology	Target Groups
Enzyme Workshops – Value Discovery (run by Enzyme Group: http://www.enzymegroup.com.au/)	There are five (5) steps in the overall process: 1. Positioning – Participants introduced to the context, background and topic under review. 2. Discovery – Relevant open-ended questions asked and participant's thoughts recorded in workbooks in silence. 3. Integration/Synthesis – Participants record six (6) most important Irritants/Value Factors onto Stikki sheets. Selection of most important individual ideas to develop common themes using an 'affinity diagram' technique. 4. Prioritisation/Ranking - Headings for each theme sets are entered into the computer for electronic voting by participants on most important Value and Opportunity Factors - participants prioritised a list developed by themselves. Staff from the Adelaide PHN were involved in the workshops as Observers and with the analysis of the results. 5. Interpretation/Impact – Results were analysed and results presented in graphs and Pareto charts, reflecting the participants overall experience with MH&AOD care and support services. The results presented the most severe Irritants (Issues) as identified by participants and how often Irritants occur. Similarly, the results identified most important Value Factors (Opportunities) as identified by participants and the current performance of the system meeting participant's needs.	<ul style="list-style-type: none"> • Aboriginal community • Consumers and carers (x3) • Community organisations • General Practitioners • Psychiatrists • Working Advisory Group • Executive Management Team
Community Advisory Committee Workshop – Appreciative Inquiry (run by Adelaide PHN)	The “ <i>Appreciative Inquiry</i> ” (AI) methodology has a twofold purpose: <ul style="list-style-type: none"> • Appreciation – to recognize and value the contributions or attributes of things and people around us. • Inquiry – to explore and discover, in the spirit of seeking to better understand, and being open to new possibilities. It enables discussion to focus on possibilities not problems, and encourages the discovery of more effective, positive ideas for the future through a five (5) phase approach: “ <i>Define</i> ”, “ <i>Discovery</i> ”, “ <i>Dream</i> ”, “ <i>Design</i> ” and “ <i>Deliver</i> ”/“ <i>Destiny</i> ”.	<ul style="list-style-type: none"> • Northern CAC • Central CAC • Southern CAC
Clinical Council Workshop – Appreciative Inquiry (run by Adelaide PHN)	The workshop was based on an appreciative enquiry approach, identifying elements of the current systems that do work well, drawing from the knowledge and experience of participants.	<ul style="list-style-type: none"> • Northern Clinical Council • Central Clinical Council • Southern Clinical Council • Comprising GPs, Medical Specialists, Allied health, Aboriginal health, Nursing, and Pharmacy.
Survey Monkey – Online Survey (run by Adelaide PHN)	Online survey consisting of four (4) questions.	<ul style="list-style-type: none"> • APHN Membership/ Governance Groups • General Practices, Practice Managers, Practice Nurses, Other

3. Summary of findings

a) Enzyme Group Workshops

As part of the '*Mental Health & Alcohol and Other Drugs*' (MH&AOD) consultation process, Enzyme Group Consultants completed a round of consultation workshops with a range of targeted participants. The consultation workshops involved 'Affinity Diagramming' and 'Paired Comparison Analysis' to develop two significant sets of data.

The participants initially identified *Irritants/Issues* i.e. to find out whether there were any issues within the delivery of MH&AOD services and how this was impacting on their access to health services, and scored their **severity** and **frequency of occurrence**.

Similarly, the participants also identified a set of *Value Factors/Opportunities* i.e. the MH&AOD primary health services that in an ideal world would keep them happy and healthy, and scored their **relative importance** and **current performance**.

The following tables summarize the *Key Irritants/Issues* and *Value Factors/Opportunities* i.e. comprising 50% of total irritants/issues score and 50% of total value factors/opportunities score, for the various targeted groups involved in the Enzyme MH&AOD consultation workshops including:

- i) Aboriginal and Torres Strait Islander Workshop – Irritants/Issues
- ii) Aboriginal and Torres Strait Island Workshop – Value Factors/Opportunities
- iii) Consumer and Carers Workshop – Irritants/Issues (Overall – Northern, Central, Southern)
- iv) Consumer and Carers Workshop – Value Factors/Opportunities (Overall – Northern, Central, Southern)
- v) Consumer & Carers Workshop – Irritants/Issues and Value Factors/Opportunities (Northern)
- vi) Consumer & Carers Workshop – Irritants/Issues and Value Factors/Opportunities (Central)
- vii) Consumer & Carers Workshop – Irritants/Issues and Value Factors/Opportunities (Southern)
- viii) Community Organisations Workshop – Irritants/Issues
- ix) Community Organisations Workshop – Value Factors/Opportunities
- x) GPs Workshop – Irritants/Issues
- xi) GPs Workshop – Value Factors/Opportunities
- xii) Psychiatrist Workshop – Irritants/Issues
- xiii) Psychiatrist Workshop – Value Factors/Opportunities

In addition, a *Working Advisory Group* comprised of MH&AOD service providers was formed to identify and prioritize the issues, blockages, risks, challenges, opportunities and critical success factors involved in the successful response to and implementation of the Federal Government reforms for MH&AOD i.e. the *Stepped Care Model*. The key Issues/Opportunities are presented in the following table:

- xiv) Advisory Working Group Workshop – Issues & Opportunities

Finally, an *APHN* workshop comprised of the Executive Management Team and representatives across the organisation's portfolios, was undertaken with the following key objectives: review the findings and conclusions of the MH&AOD consultation process, identify and prioritize the required initiatives to ensure a successful rollout of the Stepped Care Model, and determine the next steps. The initiatives are summarized in the following table:

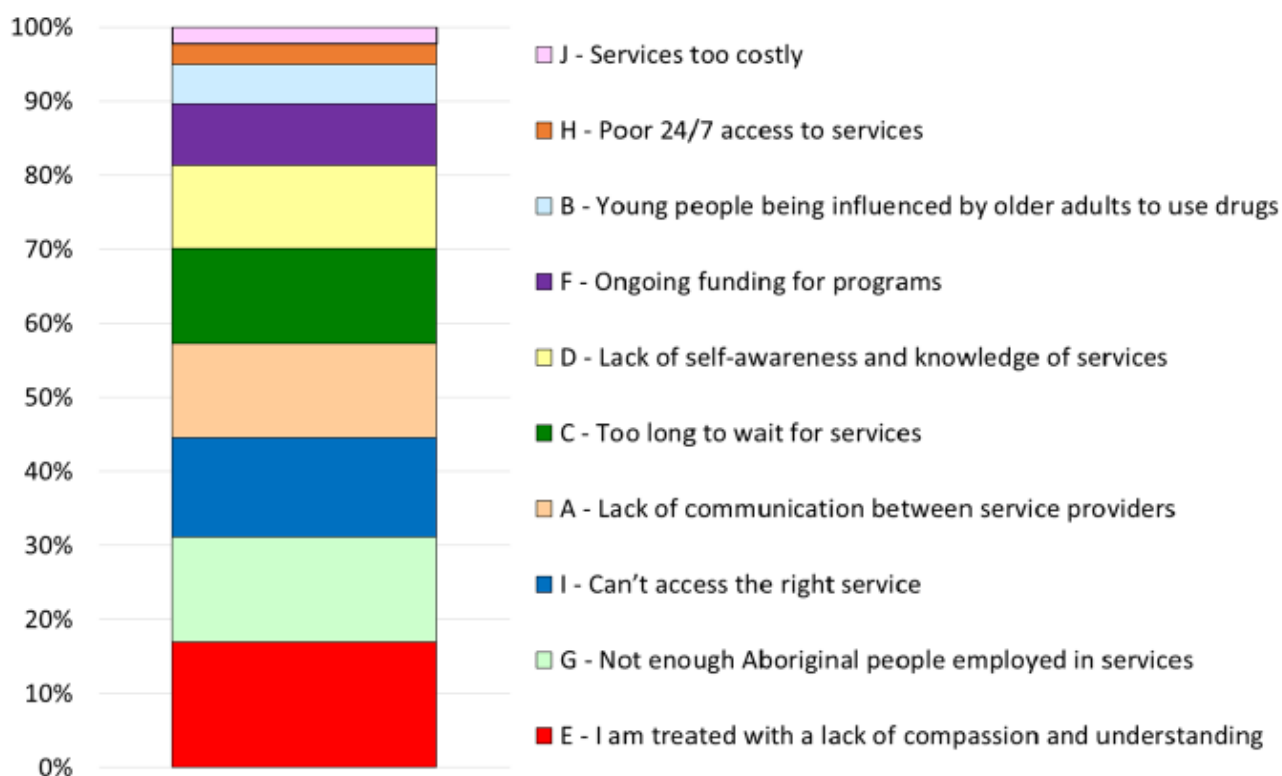
- xv) Results & Action Planning Group Workshop – Initiatives

i) *Aboriginal and Torres Strait Islander Workshop – Irritants/Issues*

Irritants/Issues	Key Issues/Needs
I am treated with a lack of compassion and understanding	<ul style="list-style-type: none"> Lack of cultural awareness about Aboriginal culture resulting in inappropriate response/service and lack of compassion/understanding by MH&AOD service providers and GP's. Complexity and history of MH&AOD problems within Aboriginal communities not taken seriously. MH&AOD issues affects whole family but response/service approach does not help whole family. Police harassment is a prevalent issue. Grief and loss a major issue within Aboriginal community – not addressed by MH&AOD service providers.
Not enough Aboriginal people employed in services	<ul style="list-style-type: none"> Doing it “white way” all the time. Need local Aboriginal people employed in high-level positions (not just receptionists) to work with Aboriginal communities. Cultural training and education necessary to avoid ignorance of cultural appropriateness.
Can't access the right service	<ul style="list-style-type: none"> Culturally appropriate services that are accessible when needed and address the needs of specific demographics e.g. the Elders, youth (self-harming). Services responsive to other social triggers e.g. housing, education, Families SA, etc. Culturally appropriate rehabilitation/wellbeing centres to prevent people ending up in jail. MH&AOD counselling support for loss, grief.
Lack of communication between service providers	<ul style="list-style-type: none"> Lack of communication between MH&AOD service providers. Support systems “pass the buck”. Ring drug/alcohol service – they say it's a mental health issue. Ring mental health service – they say it's a drug/alcohol issue. Fragmented/silo service coordination. Need one (1) point of entry for MH&AOD service to avoid having to repeatedly explain story many times over.

The Pareto Chart is calculated by adding together the scores for all Irritants/Issues and expressing each as a percentage of the total. It identifies the Key Irritants/Issues that comprise the majority of the weight of severity. The *Irritant/Issue Pareto* chart summarizes all the irritants/issues identified during the workshop and indicates that 57% of the weight of severity is comprised of the four (4) irritants/issues.

Issue/Irritant Pareto



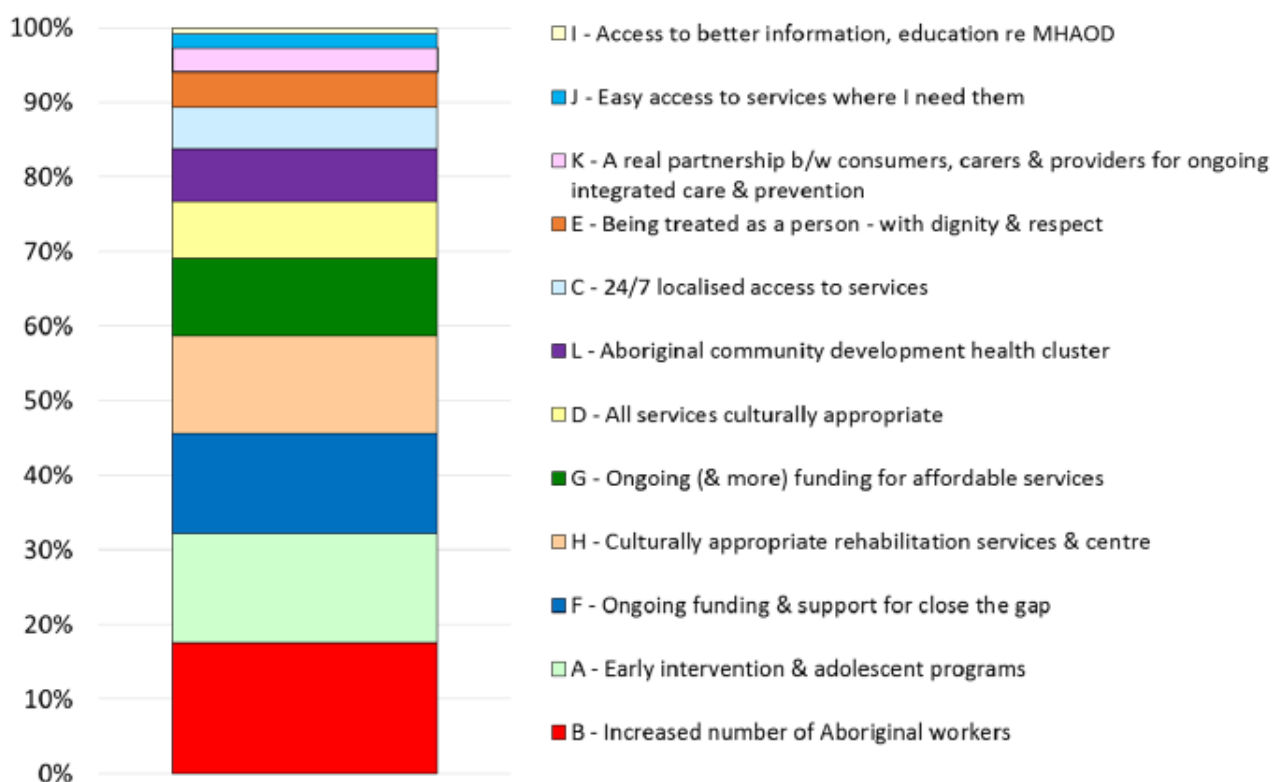
ii) *Aboriginal and Torres Strait Islander Workshop – Value Factors/Opportunities*

Value Factors/Opportunities	Key Needs
Increased number of Aboriginal workers	<ul style="list-style-type: none"> • Need more local, qualified, experienced and identified Aboriginal workers across the board e.g. counsellors, Centrelink, courts, CAFHS, mental health services, etc. • Support workers need to work one-to-one within Aboriginal communities. • Incentives required to retain Aboriginal workforce. • Elders can support in identifying appropriate, experienced Aboriginal workforce.
Early intervention and adolescent programs	<ul style="list-style-type: none"> • Educating children needs to start early and should involve mentors, Elders, camps, whole families. • Word-of-mouth (Nunga Telstra) works well and should be utilized in educating Aboriginal communities around MH&AOD issues and support services/programs. • Mobility of support workers/services works well in Aboriginal communities.
Ongoing funding and support for Close the Gap (CTG)	<ul style="list-style-type: none"> • 'Close the Gap' initiative to expand! • Needs more funding to expand its reach across the Aboriginal population and services provided.
Culturally appropriate rehabilitation services and centre	<ul style="list-style-type: none"> • Greater coordination of services. • More sustainable funding agreements with longer timeframes. • Provide a rehabilitation/wellbeing centre and/or accommodation for Aboriginal people to meet health needs within culturally appropriate settings and approaches.

The Pareto Chart is calculated by adding together the scores for all Value Factors/Opportunities and expressing each as a percentage of the total.

The *Value/Opportunity Pareto* chart summarizes all the value factors/opportunities identified during the workshop and indicates that 60% of the weight of severity is comprised of the four (4) value factors/opportunities.

Value/Opportunity Pareto



iii) Consumer and Carer Workshop – Irritants/Issues (Overall – Northern, Central, Southern)

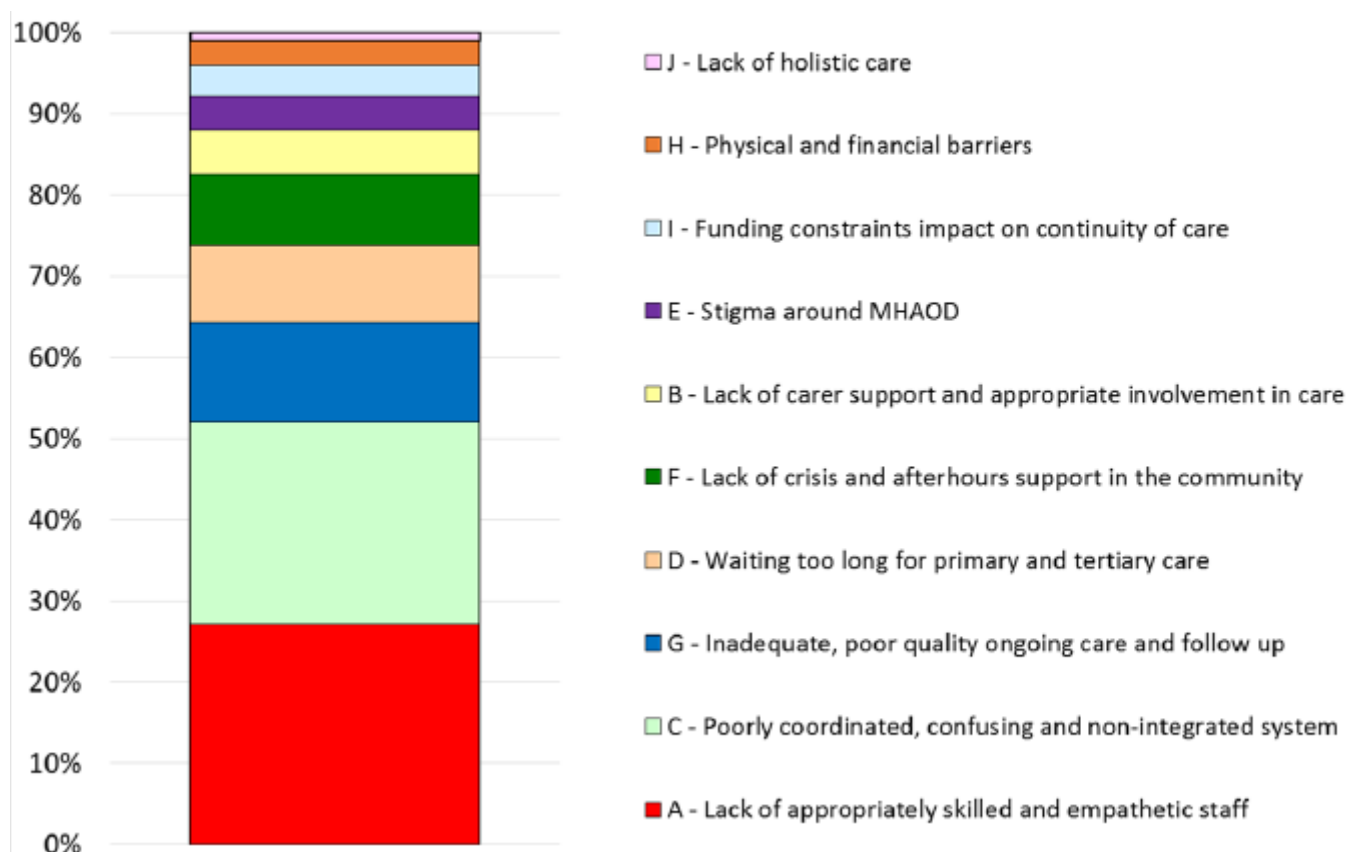
A **consolidated** affinity diagram was built using the *Irritant/Issues* identified during the three (3) Consumer and Carer workshops. The two (2) *Key Irritants/Issues* in the consolidated data are summarized and explained as follows.

Irritants/Issues	Key Issues/Needs
Lack of appropriately skilled and empathetic staff	<ul style="list-style-type: none"> • Lack of appropriately skilled, empathetic, supportive and understanding staff. • Poor attitude, incompetency and inadequate knowledge amongst staff. • Lack of respect and culturally appropriate awareness.
Poorly coordinated, confusing and non-integrated system	<ul style="list-style-type: none"> • System is confusing, not integrated creating barriers and leading to a lack of continuity of care and difficulty accessing the right information, people and timely services.

The Pareto Chart is calculated by adding together the scores for all Irritants/Issues and expressing each as a percentage of the total. It identifies the Key Irritants/Issues that comprise the majority of the weight of severity.

The *Irritant/Issue Pareto* chart summarizes all the irritants/issues identified during the workshop and indicates that 50% of the weight of severity is comprised of the two (2) irritants/issues.

Issue/Irritant Pareto



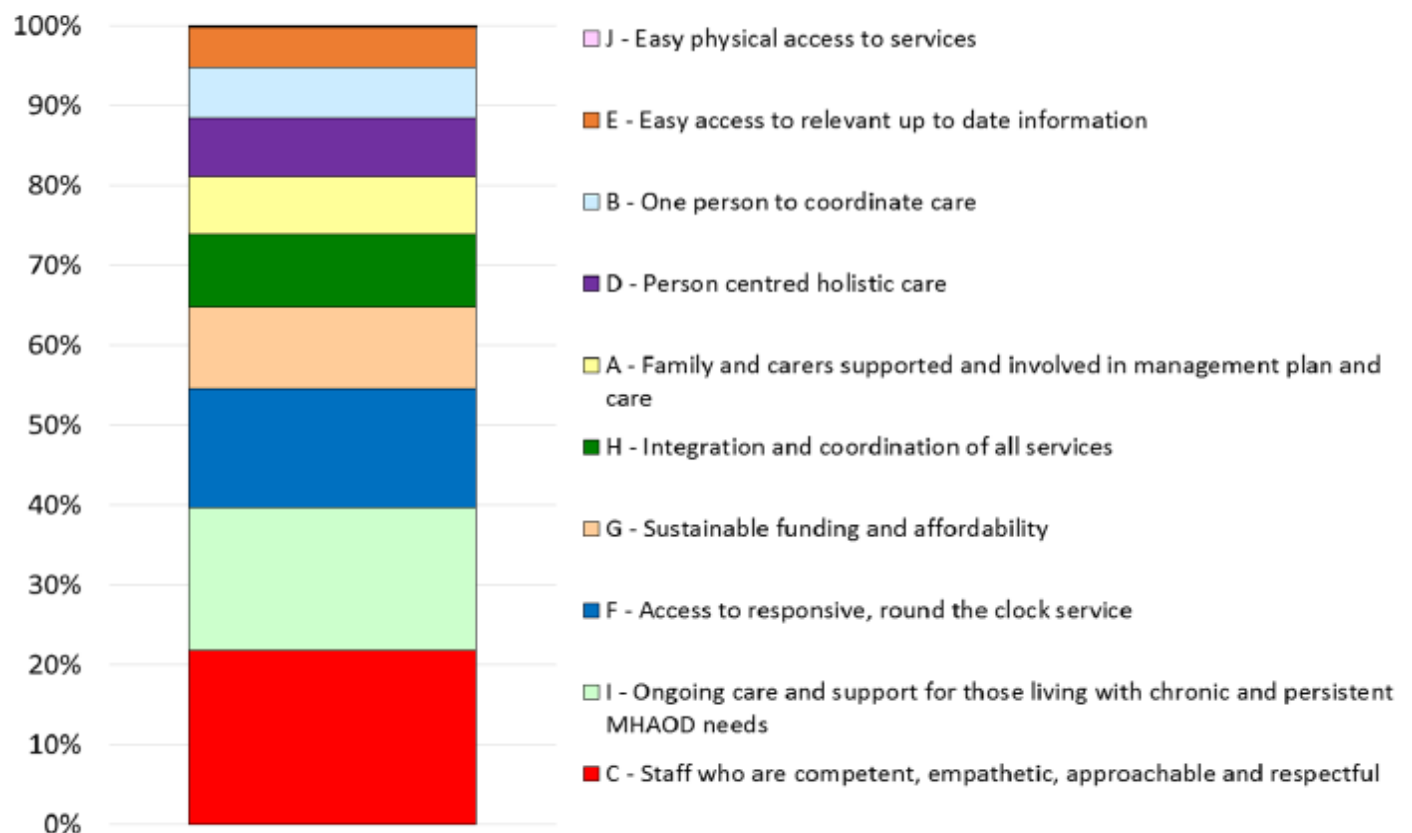
iv) *Consumer and Carer Workshop – Value Factors/Opportunities (Overall – Northern, Central, Southern)*

A **consolidated** affinity diagram was built using the value factors/opportunities identified during the three (3) Consumer and Carer workshops. The three (3) *Key Value Factors/Opportunities* in the consolidated data are summarized and explained as follows.

Value Factors/Opportunities	Key Needs
Staff who are competent, empathetic, approachable and respectful	<ul style="list-style-type: none"> Treated with dignity and respect and well supported by competent, empathetic, approachable, knowledgeable, experienced and respectful staff. Peer support.
Ongoing care and support for those living with chronic and persistent MH&AOD needs	<ul style="list-style-type: none"> Ongoing outpatient care and support. Additional services. Ongoing care when carer no longer able to be involved.
Access to responsive, round-the-clock service	<ul style="list-style-type: none"> 24/7 and better access to services and information. Responsive round-the-clock care.

The Pareto Chart is calculated by adding together the scores for all Value Factors/Opportunities and expressing each as a percentage of the total. The *Value/Opportunity Pareto* chart summarizes all the value factors/opportunities identified during the workshop and indicates that 55% of the weight of severity is comprised of the three (3) value factors/opportunities.

Value/Opportunity Pareto



v) *Consumer and Carer Workshop – Irritants/Issues and Value Factors/Opportunities (Northern)*

Irritants/Issues	Key Issues/Needs	Value Factors/ Opportunities	Key Needs
Lack of appropriately skilled and empathetic staff	<ul style="list-style-type: none"> • Inadequate staffing levels, wrong mix of staff, lack of staff capabilities/ knowledge/awareness/cultural appropriateness in dealing with MH&AOD clients with co-morbidities can lead to exacerbation, misdiagnosis and/or mistreatment of presenting issues. • Lack of staff empathy, respect, care, understanding, consideration and fobbing off of clients leads to client frustrations, mistrust in the system. <i>“Feel like a number”</i>. • Patronizing attitudes by clinicians to <i>“keep positive”</i> not helpful. • Poor ED attitudes towards and treatment of BPD presenting clients. • Staff qualifications not displayed. 	Staff who are competent, empathetic, approachable and respectful	<ul style="list-style-type: none"> • Lived-experience workers needed in communities. • Staff need to be more empathetic, hopeful, honest, compassionate, informed, respectful, trustworthy, and willing to help and not judge. • Better education, training, research, knowledge, treatment of MH&AOD issues to improve staff skills, capabilities, attitudes, approaches and clarity of processes in dealing with MH&AOD clients. • Need to improve BPD knowledge and therapy skills.
Poorly coordinated, confusing and non-integrated system	<ul style="list-style-type: none"> • Difficult to access correct, relevant information/service about MH&AOD due to lack of or inability to find resource/service. • Lack of information in plain, relevant and appropriate language for diverse population. • After hours support is poor/not easily understood or inadequate. • Poor/lack of information for RACF clients and staff. • No specialized BPD service in Adelaide. • High turnovers and lack of consistency in approach/attitudes within service providers requiring retelling of presenting issues, which can exacerbate the issues. • Varying levels of respect for different service providers within the Court system. • Silo and fractured system, <i>“passing the buck”</i> attitudes, lack of communication/connectedness between service providers, and lack of multi-disciplinary approach resulting in many entry points, which is confusing, confronting, obstructive and demands <i>“rehashing your story”</i> – can be stigmatizing. 	Ongoing care and support for those living with chronic and persistent MH&AOD needs	<ul style="list-style-type: none"> • Improvement needed for ongoing and long-term care. • Better management of anxiety and depression required. • Need to feel comfortable and trust service providers/clinicians/carers. • Accommodation support and respite care necessary and required. • <i>“What happens to person being cared for when carer dies?”</i> No answers anywhere!
Inadequate, poor quality ongoing care and follow-up	<ul style="list-style-type: none"> • Lack of or no long-term follow-up care from appropriate clinicians/ providers for MH&AOD clients. • Lack of accommodations services for MH&AOD afflicted clients/addicts. • Poor or no responses after seeking advice/support. 	Access to responsive, round-the-clock service	<ul style="list-style-type: none"> • Skilled staff/service available and accessible 24/7 i.e. can talk to someone quickly, can physically access. • EDs that respond appropriately and correctly. • Early interventions, and appropriate, timely responses from appropriately skilled staff/service.

vi) *Consumer and Carer Workshop – Irritants/Issues and Value Factors/Opportunities (Central)*

Irritants/Issues	Key Issues/Needs	Value Factors/ Opportunities	Key Needs
Lack of appropriately skilled & empathetic staff	<ul style="list-style-type: none"> • Lack of knowledge, ability to handle and/or understanding by staff – from receptionists to service providers – of complexity and impacts of MH&AOD issues. • Processes and relationships between providers confusing causing time wasting. • Judgmental, prejudiced, abusive and dismissive attitudes by staff, and lack of compassion towards addicts who are often treated like criminals. • Records contain false information leading to misunderstandings. • Complex paperwork – Health Care Plans not explained or understood. • GP's don't understand MH issues. • Staff capability and capacity – they try to do everything but don't do anything properly, which may explain why they're not properly trained. • Purpose, function, inter-activity of medications and affects not explained. 	Staff who are competent, empathetic, approachable and respectfully	<ul style="list-style-type: none"> • Staff who are empathetic, caring, educated, qualified, knowledgeable, trained, positive, non-judgmental, kind, honest, bi-lingual, highly-skilled, have integrity and expertise, and good bedside manner in diagnosing, treating and working with MH&AOD clients. • More <i>“peer workers who help navigate and negotiate the maze”</i>.
Poorly coordinated, confusing and non-integrated system	<ul style="list-style-type: none"> • System is confusing, not integrated creating barriers and leading to a lack of continuity of care and difficulty accessing the right information, people and timely services. 	Access to responsive, round-the-clock service	<ul style="list-style-type: none"> • 24/7 access to services and appropriately skilled staff. • Decreased waiting times.
Lack of crisis & afterhours support in the community	<ul style="list-style-type: none"> • Poor hours of service. Crisis services between 9-5 and not accessible for many for various reasons e.g. doesn't accommodate working people, doesn't cater for crisis after hours. • Services should be available 24/7. • Focus on crisis-driven hospital admissions for MH clients rather than good quality community-based services. • Hospitals ill-equipped to deal with MH&AOD issues. 	Integration & coordination of all services	<ul style="list-style-type: none"> • Remove silo service delivery. Have services available under one roof, create partnerships between services. • <i>“Centralize access to all forms of care and assistance.”</i> • Connected and integrated care and service provision. • Provide different modes of access to information and services e.g. online, phone-line.
		Family/carers supported and involved in management plan and care	<ul style="list-style-type: none"> • Acknowledgement, respect and support for carers and families in supporting MH&AOD clients. • Inclusion of carers/families and communities in developing Health Care Plans, particularly where culturally diverse groups are involved. • Provide low cost education/other programs and/or workshops for families and carers. • Clarity in what confidentiality and privacy means.

vii) *Consumer and Carer Workshop – Irritants/Issues and Value Factors/Opportunities (Southern)*

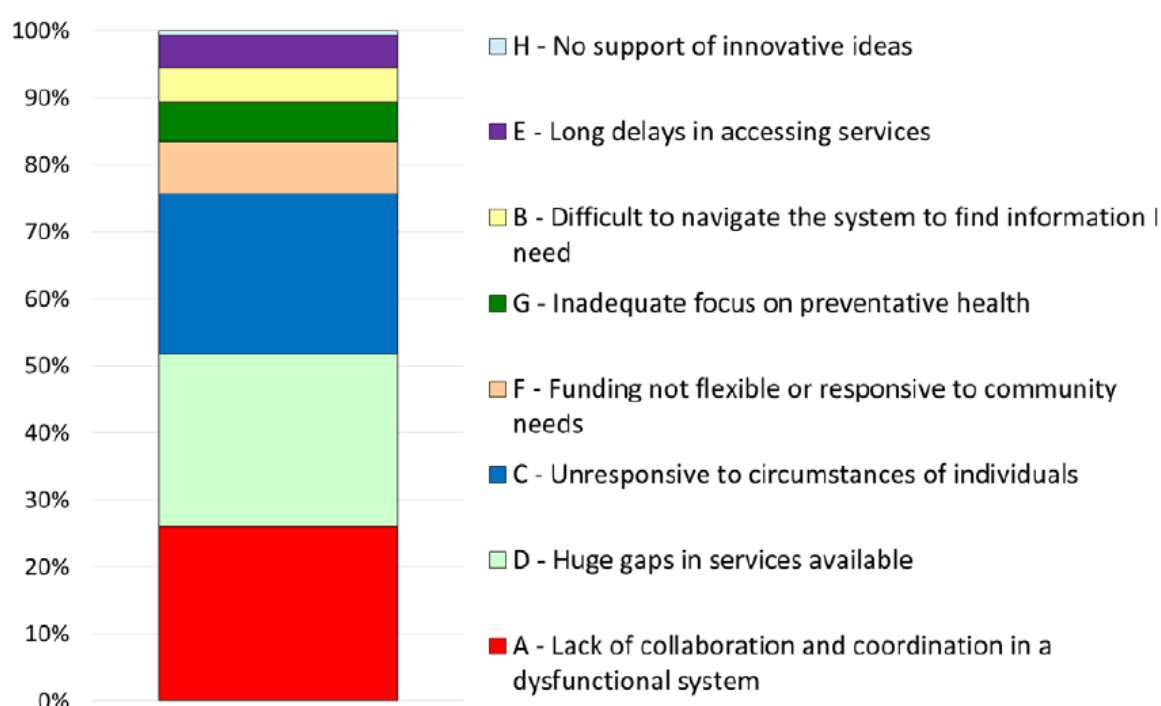
Irritants/Issues	Key Issues/Needs	Value Factors/Opportunities	Key Needs
Waiting too long for primary & tertiary care	<ul style="list-style-type: none"> • Lack of MH&AOD services. • Long wait times. • Incorrect and/or delayed treatment resulting in more problems. • Specialized assessments costly. 	Ongoing care and support for those living with chronic and persistent MH&AOD needs	<ul style="list-style-type: none"> • Specialized services are provided for chronic MH&AOD clients. • Services are connected allowing the development and implementation of relapse prevention strategies. Possible partnerships with 12 step or Smart Recovery. • Services coordinated to support family support/carer by encouraging and creating employment/training opportunities. • Holistic care provided. • Suitable, sustainable funding for ongoing care.
Lack of appropriately skilled & empathetic staff	<ul style="list-style-type: none"> • Major decisions made by service providers without whole picture of individual/family/ community. • Lack of empathy, honesty, integrity, understanding, knowledge, consistency and evidence-based approach. • Staff don't listen to understand. • Dismissive and/or superior attitudes. • Lack of cultural knowledge and awareness leading to inappropriate responses by service providers. • Individuals not treated as individuals but as a number. • Hard to access bulk-billing specialists. 	Staff who are competent, empathetic, approachable and respectful	<ul style="list-style-type: none"> • Treatment of and behaviour's towards MH&AOD clients involves fluidity, flexibility, honesty, integrity, respect, equity, compassion, confidentiality, absence of stigma, positivity, sensitivity, cultural awareness/respect and appropriateness, and non-judgment. • Important to remove stigma. • Communication and connection between service providers to enable person-centred care through one point of entry. • "One size does not fit all!" • Educated, highly skilled, positive, compassionate, empathetic, bi-lingual, culturally aware, motivated staff who develop respectful relationships with MH&AOD clients to achieve a common goal of encouraging good health and wellbeing.
Inadequate, poor quality ongoing care and follow-up	<ul style="list-style-type: none"> • Poor communication, lack of clarity, connectedness and coordination between service providers and service providers and their clients – about medications, side-effects and follow-up actions – as well as early or premature discharge from programs/facilities with little coordinated follow-up actions, can exacerbate MH&AOD issues and/or lead to homelessness in some cases. 	Sustainable funding & affordability	<ul style="list-style-type: none"> • More sustainable and long-term funding to increase program delivery that addresses issues and causes, and reduces wait and response times. • Lower costs for support services to make them affordable.

viii) Community Organisation's Workshop – Irritants/Issues

Irritants/Issues	Key Issues/Needs
Lack of collaboration and coordination in a dysfunctional system	<ul style="list-style-type: none"> • Lack of continuum and coordination of care; system fragmented, siloed and not referral pathways not flexible. • GP's most critical part of the system but have lack of knowledge, time, interest, care, expertise and passion. • System not able to deal with complex and co-morbidity HN&AOD conditions. • Most vulnerable/needy get lost in the system. • Too much bureaucracy, paperwork and obstacles preventing engagement with/ inclusion of MH&AOD clients and families.
Huge gaps in services available	<ul style="list-style-type: none"> • Lack of services to support most vulnerable e.g. clients discharged after suicide attempts, homeless, presenting with complex/co-morbidity issues, with limited health literacy/skills, presenting with Borderline Personality Disorder, supporting parents in families with MH or AOD issues. • Limited/inadequate services and/or support for children and adolescents; insufficient home-visiting or outreach services; lack of protection for children in families with problems resulting from MH or AOD issues. • Young people with drug/alcohol issues "<i>detoxing</i>" in youth detention centres, not hospitals or health care centres. • Lack of culturally appropriate community-based services or lack of access to them. • NDIS process – clients qualify but nothing eventuates.
Unresponsive to circumstances of individuals	<ul style="list-style-type: none"> • Lack of awareness/understanding, lack of/confusing services/support, stigmatization, dismissive attitudes, culturally inappropriate services, arbitrary inclusion/exclusion criteria, poor quality or lack of genuine care for clients presenting transcultural issues, suicide/DV survivors, young people, clients with complex/co-morbidity MH and/or AOD issues. • Language and operational barriers e.g. "<i>blaming</i>" language/culture. • Lack of cultural services for Aboriginal people in North/South of Adelaide. • "<i>No wrong door</i>" referral pathway but no support in the interim. • Lack of understanding/awareness/judgement/adherence to "<i>harm reduction</i>" approach. • Lack of holistic approach. Clients seen as numbers and pushed through the system.

The Pareto Chart is calculated by adding together the scores for all Irritants/Issues and expressing each as a percentage of the total. It identifies the Key Irritants/Issues that comprise the majority of the weight of severity. The *Irritant/Issue Pareto* chart summarizes all the irritants/issues identified during the workshop and indicates that 75% of the weight of severity is comprised of the three (3) irritants/issues.

Issue/Irritant Pareto

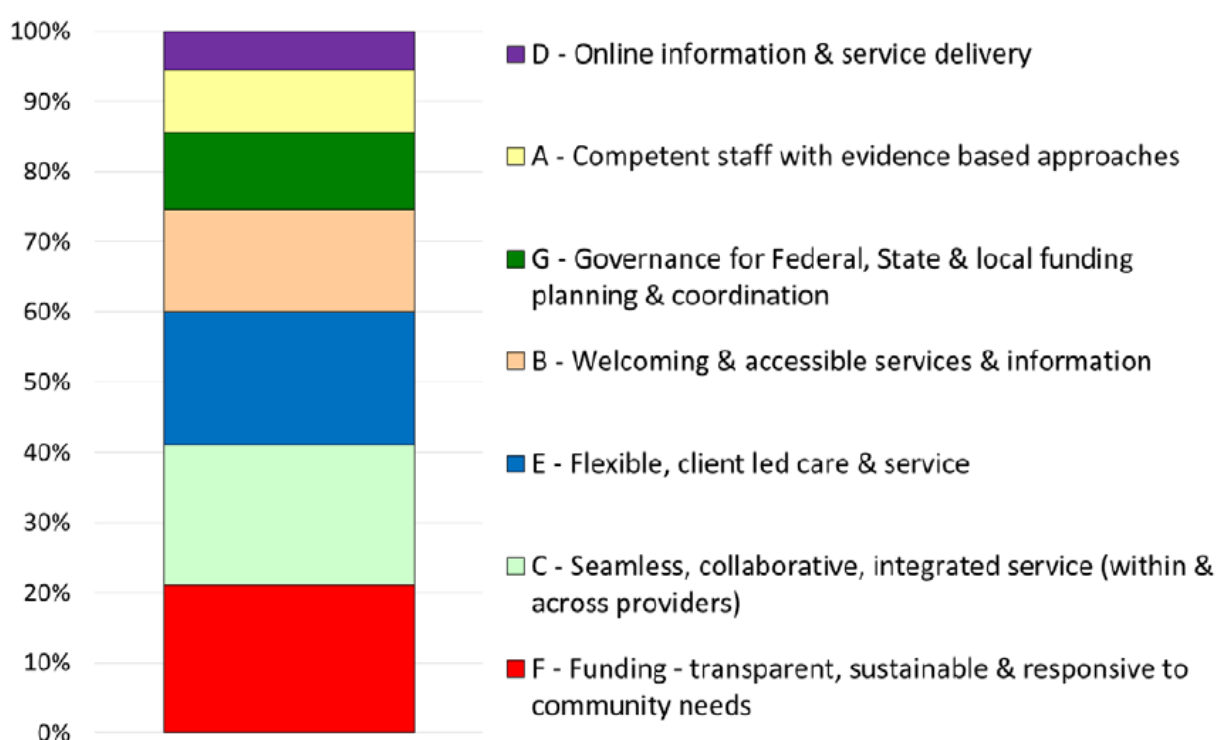


ix) Community Organisation's Workshop – Value Factors/Opportunities

Value Factors/Opportunities	Key Needs
Funding – transparent, sustainable and responsive to community needs	<ul style="list-style-type: none"> • Transparent, accountable, flexible, consistent, funding and resources to create affordable/responsive services with passionate/supportive workers. • A system with enough capacity to respond promptly to clients. • Simple, clearly defined processes and paperwork.
Seamless, collaborative, integrated service (within and across	<ul style="list-style-type: none"> • Integrated/coordinated/collaborated/co-located/co-operated/streamlined/communicated/seamless pathways of care that minimize duplication across the system; consumer-centred care plan; less rigidity in service models; <i>"care teams"</i>. • System is simple, easy to navigate but choice exists; flexibility and <i>"no wrong door"</i> to provide individualized responses to suit clients; broad triage entry points – guided/supported access; everyone gets some level of assistance/referrals/treatment. • Holistic care; holistic approaches with providers working in partnerships and sharing resources; <i>"no silos"</i> – every service/department works with each other e.g. linking in prison population, looking at <i>"harm reduction"</i> including. Clean Needle/Methadone programs to counselling, testing, treatment, monitoring blood borne viruses to specialized detox and rehab to help anxiety/depression.
Flexible, client-led care and service	<ul style="list-style-type: none"> • <i>"Customer service"</i> culture placing consumers at the centre; holistic, affordable, patient-centred care; case managers to provide support from beginning of treatment plan; services meet the needs of the consumer; clients (and families) listened to and appropriately responded to; respectful/supportive attitudes towards MH&AOD clients; appropriate services for vulnerable/transient clients and carers/families. • Develop a system that supports complex/co-morbidity needs; applies right service/support/treatment as early as possible; fits service to client, not client to service; enables service providers to <i>"walk alongside"</i> clients. • Language/approach to focus on <i>"wellbeing"</i> rather than <i>"illness"</i>; develop preventative measures/approaches and empower consumers with tools/resources and values that increase knowledge/skills/ability to self-care. • Measurable consumer experiences as <i>"Key Performance Indicators"</i>.

The Pareto Chart is calculated by adding together the scores for all Value Factors/Opportunities and expressing each as a percentage of the total. The *Value/Opportunity Pareto* chart summarizes all the value factors/opportunities identified during the workshop and indicates that 60% of the weight of severity is comprised of the three (3) value factors/opportunities.

Value/Opportunity Pareto

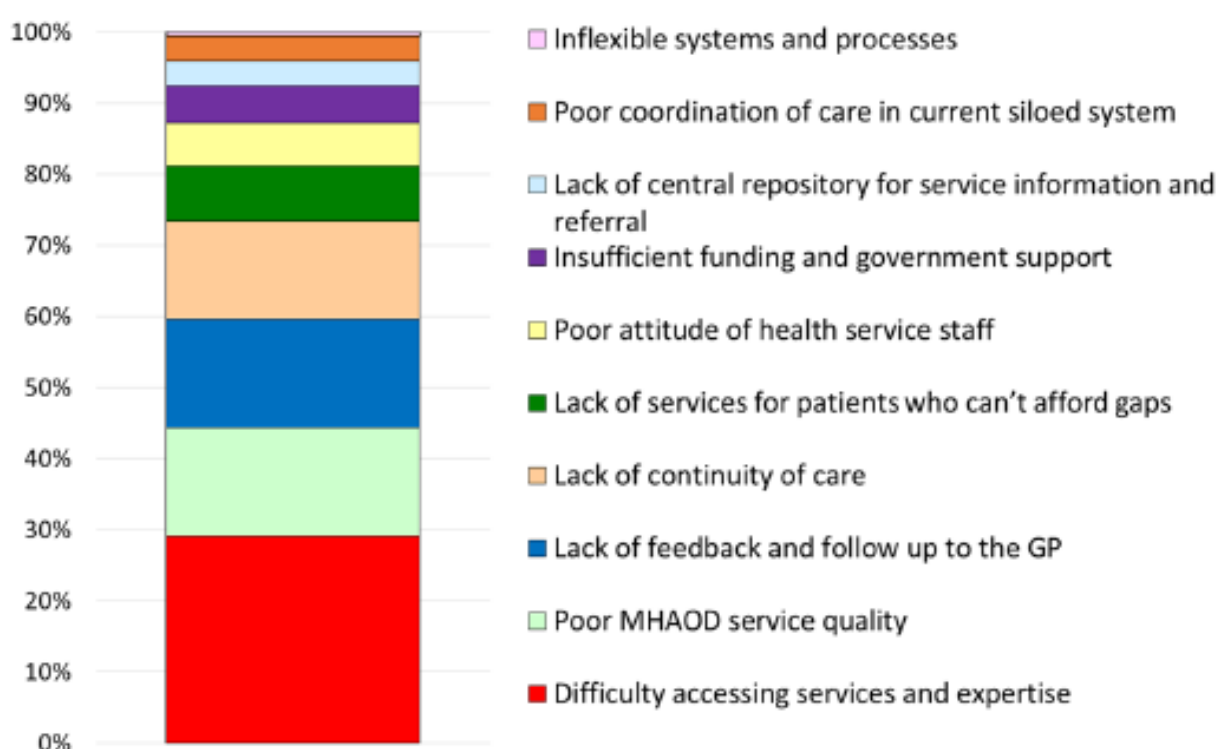


x) GPs Workshop – Irritants/Issues

Irritants/Issues	Key Issues/Needs
Difficulty accessing services and expertise	<ul style="list-style-type: none"> Reduced number of services/inconvenient locations/lack of transport facilities/inadequate referral pathways/lack of support system for most vulnerable communities/consumers (e.g. MH& and/or AOD issues presenting as urgent, in Aboriginal/CALD communities and older people); unavailability of service (e.g. Borderline Personality Disorder); difficulty accessing public specialists for ongoing care; lack of services to support “vicious cycle” factors (e.g. relationship, financial, housing, domestic violence problems); qualifying criteria for service/support too restrictive making clients “not eligible”. Long wait times for service/care. Lack of early intervention services for high need clients exacerbating issues. Inability for GPs to access further opinion within reasonable timeframes.
Poor MH&AOD service quality	<ul style="list-style-type: none"> Service doesn't last long enough to effect long lasting change. AOD services lack understanding of MH care/management. DASSA services – no referral taken, too far away for GPs, detox service can't access. Poor level of community-based care. Lack of recognition of cognitive impairment. Rules for detox too strict.
Lack of feedback and follow-up to the GP	<ul style="list-style-type: none"> Lack of detailed clinical handover between service providers; lack of or poor Outpatient Department letters or discharge information for clients of public and private MH services. Poor communication; lack of timely response after referral to a service; lack of adequate feedback regarding progress of clients i.e. not being notified when clients decline a service or are lost to follow-up.
Lack of continuity of care	<ul style="list-style-type: none"> Lack of continuity of care – chronic MH clients “dumped” after showing improvement. Lack of continuity of service provision – funds shifted from one provider to another, no information provided of who is taking over service making navigation through system confusing/difficult.

The Pareto Chart is calculated by adding together the scores for all Irritants/Issues and expressing each as a percentage of the total. It identifies the Key Irritants/Issues that comprise the majority of the weight of severity. The *Irritant/Issue Pareto* chart summarizes all the irritants/issues identified during the workshop and indicates that 75% of the weight of severity is comprised of the four (4) irritants/issues.

Issue/Irritant Pareto

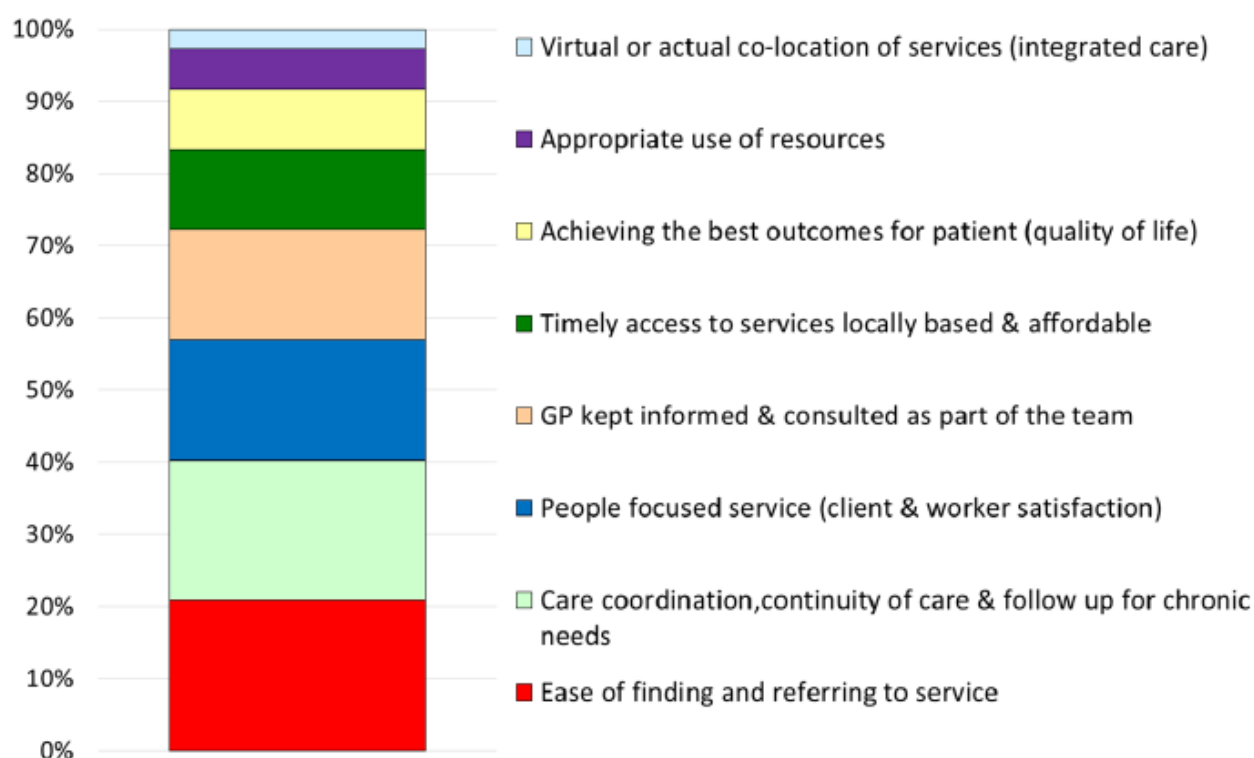


xi) GPs Workshop – Value Factors/Opportunities

Value Factors/Opportunities	Key Needs
Ease of finding and referring to service	<ul style="list-style-type: none"> The Smart Service Directory (NZ) could be good. Develop small multi-disciplinary teams to deal with whole person – “No wrong door”. Matthew Smout is a great resource.
Care coordination, continuity of care and follow-up for chronic needs	<ul style="list-style-type: none"> The key – having follow-up and long-term care plan. Initial treatment needs to be “right”.
People focused service (client and worker satisfaction)	<ul style="list-style-type: none"> Services meet the needs of clients.
GP kept informed and consulted as part of the team	<ul style="list-style-type: none"> Electronic acknowledgement of referrals; GPs to be notified; My Health records may help but low utilization. Greater use of clinical attachment/professional development e.g. GPs train in ED's, trainee Psychiatrists rotate in GP clinics, Psychiatrists co-consult in practices. Break down barriers with greater GP/Allied Health involvement in professional networks.

The Pareto Chart is calculated by adding together the scores for all Value Factors/Opportunities and expressing each as a percentage of the total. The Value/Opportunity Pareto chart summarizes all the value factors/opportunities identified during the workshop and indicates that 70% of the weight of severity is comprised of the four (4) value factors/opportunities.

Value/Opportunity Pareto

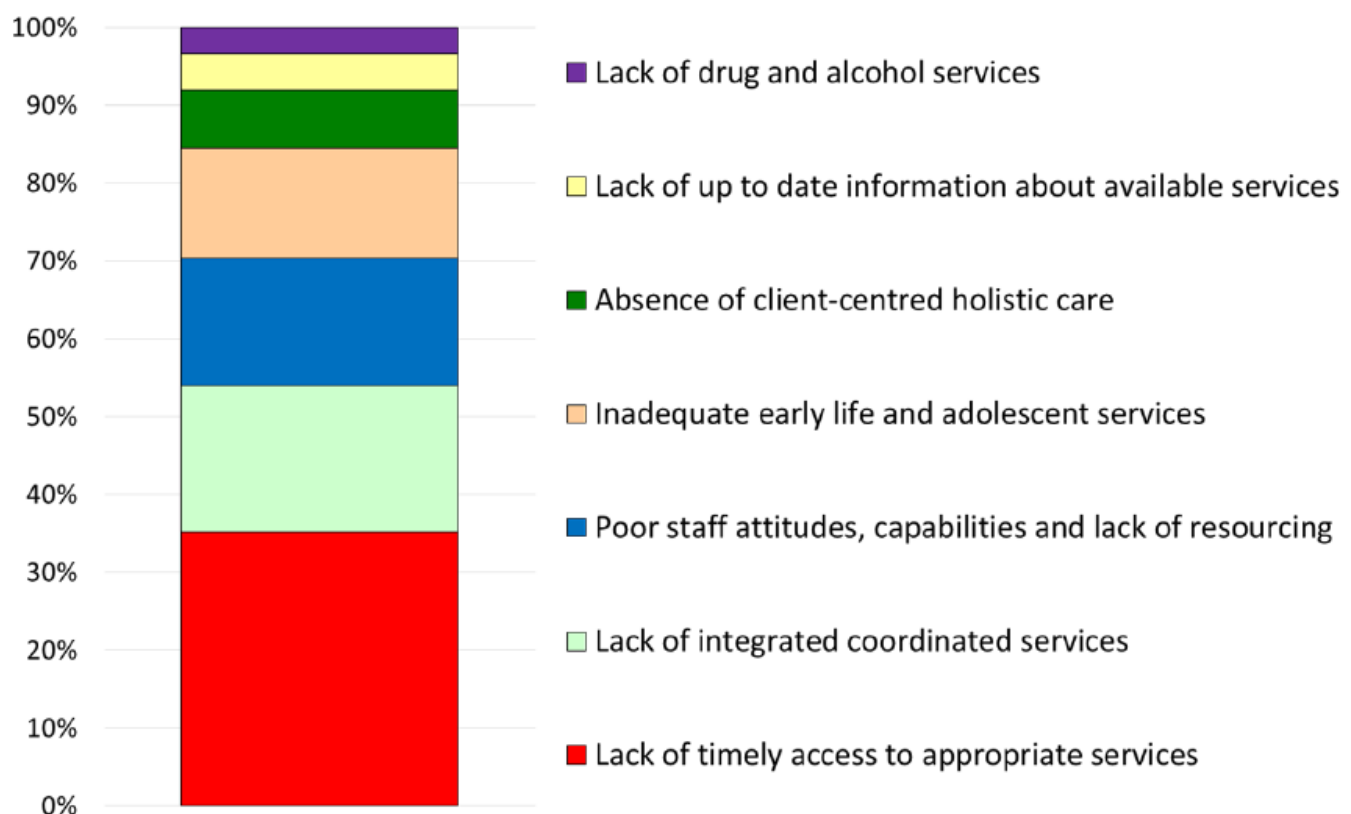


xii) Psychiatrists Workshop – Irritants/Issues

Irritants/Issues	Key Issues/Needs
Lack of timely access to appropriate services	<ul style="list-style-type: none"> Lack of services; lack of access for vulnerable populations/unwell but not aggressive or disruptive clients; lack of out-of-hours services (ED only place to go); poor social supports; lack of therapy for trauma/abuse victims; lack of hospital at-home teams; system ignorance of sub-acute care needs; barriers to groups disadvantaged by language/culture; disparity of services across metropolitan Adelaide. Services transient – feels like “perpetual change” without improvement. Waiting times too long.
Lack of integrated coordinated services	<ul style="list-style-type: none"> Poor coordination/communication between public and private service providers for patients with chronic MH issues. Separation between Drug & Alcohol and Mental Illness services with clients falling between the cracks. Lack of communication/coordination between service providers in general. Poor follow-up post hospital or emergency discharge.
Poor staff attitudes, capabilities and lack of resourcing	<ul style="list-style-type: none"> Poor attitudes amongst some service providers/EDs; discrimination/stigma/disrespect/lack of compassion and appropriate treatment. Lack in staff expertise/skill/capability. Lack of resources to sources workload for acute and community services resulting in decreased provision of care.
Inadequate early life and adolescent services	<ul style="list-style-type: none"> Inadequate resourcing for infant, child, adolescent and perinatal services. Families/children not getting services – No “right door”. Inadequate MH services for 16/17 year olds. No D&A services for adolescents.

The Pareto Chart is calculated by adding together the scores for all Irritants/Issues and expressing each as a percentage of the total. It identifies the Key Irritants/Issues that comprise the majority of the weight of severity. The *Irritant/Issue Pareto* chart summarizes all the irritants/issues identified during the workshop and indicates that 85% of the weight of severity is comprised of the four (4) irritants/issues.

Issue/Irritant Pareto

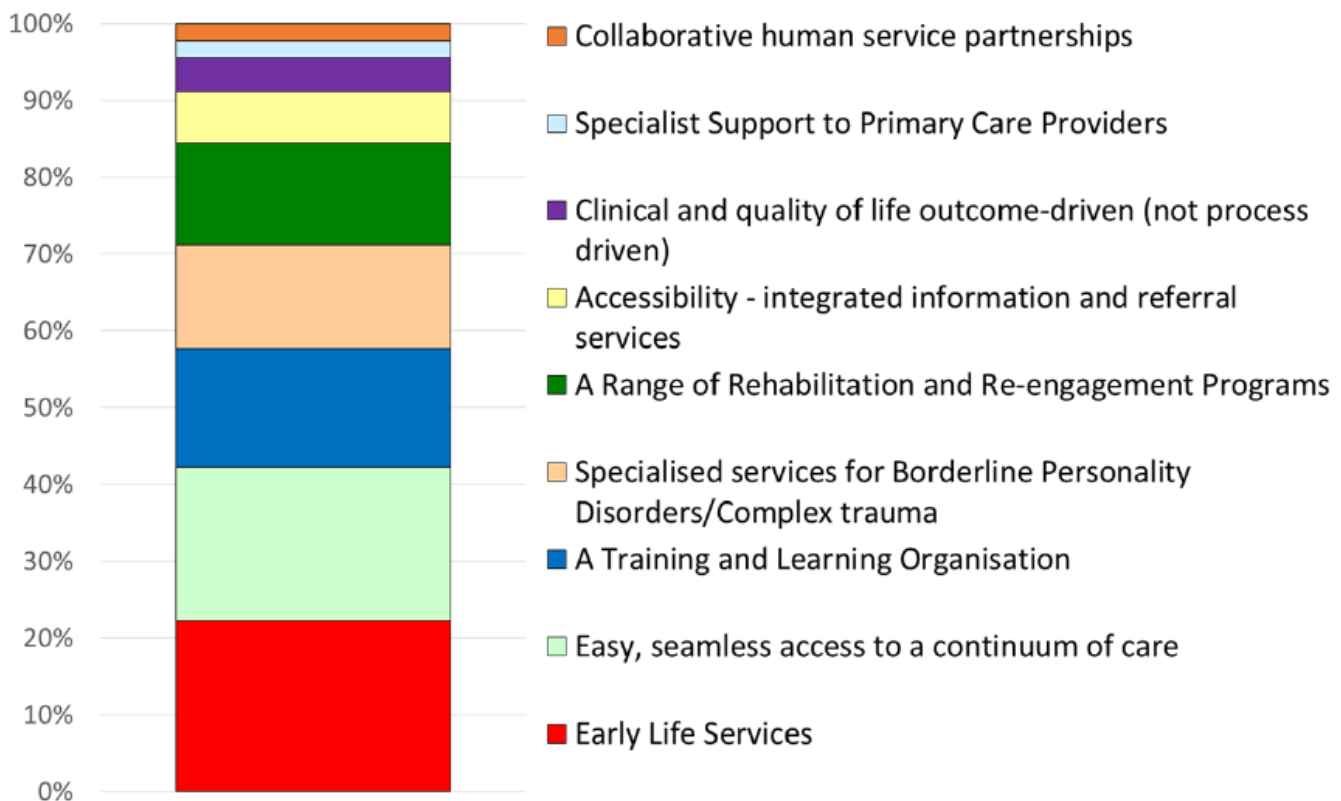


xiii) Psychiatrists Workshop – Value Factors/Opportunities

Value Factors/Opportunities	Key Needs
Early Life Services	<ul style="list-style-type: none"> Benchmark successful service provision and replicate across SA. Link in with GPs and other agencies to create an integrated system. Develop a better mental health triage service.
Easy, seamless access to a continuum of care	<ul style="list-style-type: none"> MH&AOD service provision needs improvement. Access to MH services should be easy, navigable and accessible when required. Community services should be available to assist clients instead of relying on ED's. Access to a "stepped service" would be useful. Need better detection/response and preventative measures to diffuse serious issues from developing.
A training and learning organisation	<ul style="list-style-type: none"> Staff need training and time for training – needs to be factored into framework of organization. Recruitment of good staff and staff movements, major issues – need incentives to retain good staff. Developing a training/education/public campaign for MH&AOD (similar to GP Diabetes campaign 20 years ago) could improve staff skills/expertise/retention.

The Pareto Chart is calculated by adding together the scores for all Value Factors/Opportunities and expressing each as a percentage of the total. The Value/Opportunity Pareto chart summarizes all the value factors/opportunities identified during the workshop and indicates that 60% of the weight of severity is comprised of the three (3) value factors/opportunities.

Value/Opportunity Pareto

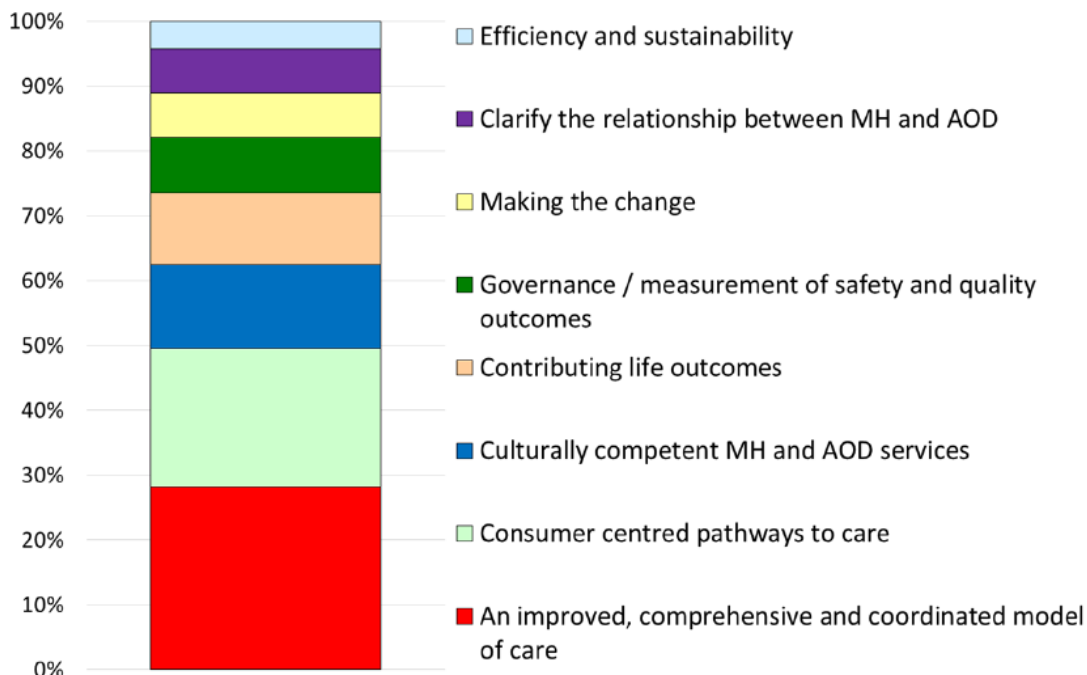


xiv) Advisory Working Group Workshop – Issues & Opportunities

Issues and Opportunities	Key Issues/Needs
An improved, comprehensive and coordinated model of care	<ul style="list-style-type: none"> Improved communication, coordination, collaboration between service providers, and between service providers and clients/carers (where appropriate or required). Use of technology to create improved partnerships, communication. Potential for “case manager” model e.g. Return to Work SA. Design new, innovative ways of delivering and measuring success of services. Reduction of administrative red tape that impacts on connection between primary and tertiary settings (can’t be discharged from public MHS with a psychological package). Move away from medical model. MH&AOD partnered, not treated in isolation. Agreed priorities – partners in recovery learnings show clear needs regarding psychological support.
Consumer centred pathways to care	<ul style="list-style-type: none"> “No wrong door” to enter the system; create flexibility in the system. System improvement to enable easy navigation, cross-navigation and referrals, and best service provision regardless of where a client enters the system; create greater access to services. Involve community pharmacists – they’re often the first point of call. Use pharmacies to educate and inform best use of medication. Develop targeted services and referral pathways for vulnerable groups and clients with extreme/complex needs. Optimise the system by breaking down protected silos. Change culture of MH&AOD service to person-centred care rather than system-centred care and enable a “whole of system” response. Greater use of Social Workers to “conduct a holistic psychosocial assessment and capture holistic data for client issues and profile”. Overcome client resistance to treatment. Western Australian MH Commission identified highest levels of unmet needs in community services – need to increase balance of investment in community support.
Culturally competent MH&AOD services	<ul style="list-style-type: none"> Cultural understanding of Aboriginal history/culture/trauma. Employment/training needed for appropriate Aboriginal mental health workers.

The Pareto Chart is calculated by adding together the scores for all Issues/Opportunities and expressing each as a percentage of the total. It helps to identify the few Issues/Opportunities that constitute the majority of the weight of importance. The Issues/Opportunities Pareto chart shows that approximately 65% of the total weight is comprised of three (3) Issues/Opportunities.

Issues and Opportunities Pareto

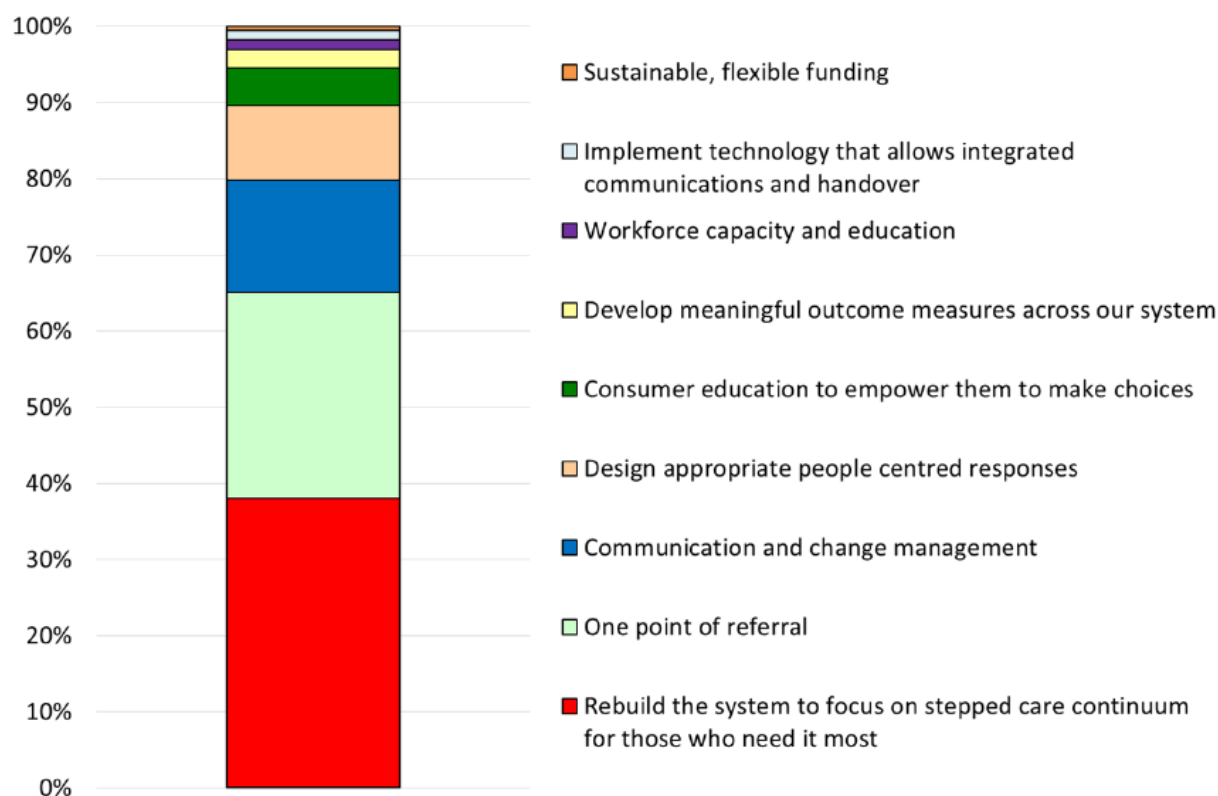


xv) Results & Action Planning Group Workshop – Initiatives

Initiatives	Key Issues/Needs
Rebuild the system to focus on stepped care continuum for those who need it most	<ul style="list-style-type: none"> Improved policy, processes, procedures that connect and create a system. Ensure that services exist across the continuum – identify the gaps and fill them. Re-organise, re-orientate and refund services based on the stepped care continuum. Identify starting points and at-risk populations and what can (realistically) be done in first 12 months. Ensure seamless transition points of stepping up/stepping down. Be innovative, create initiatives e.g. phone a friend by GPs, Psychiatrists. Greater focus on early intervention in childhood and adolescence including self-management and school initiatives/improving health literacy. Early intervention investment: lifespan/children/adolescence.
One point of referral	<ul style="list-style-type: none"> Referral pathways – “No wrong door” to enter the system; create flexibility in the system. Improve visibility of and access to services. One point of entry/triage regardless of where client sits in the stepped care continuum.
Communication and change management	<ul style="list-style-type: none"> “Change” requires clear messages, good management and including all users and providers along the journey. Communication needs to be clear, informative, on-point and accessible to and between consumers and service providers. Manage the transformation of health effectively in collaboration with consumers and service providers. Create opportunities for monitoring, evaluation and feedback from users and providers, of how well health transformation is working. Support service providers to adapt to changes. Engage and influence the tertiary sector (and everyone else). Create a strategic plan identifying short/medium/long term objectives addressing issues across the stepped care continuum for key populations.

The Pareto Chart is calculated by adding together the scores for all Initiatives and expressing each as a percentage of the total. The chart shows that approximately 80% of the total weight is comprised of three (3) initiatives.

Initiatives Pareto



b) Community Advisory Committee Consultation Workshop

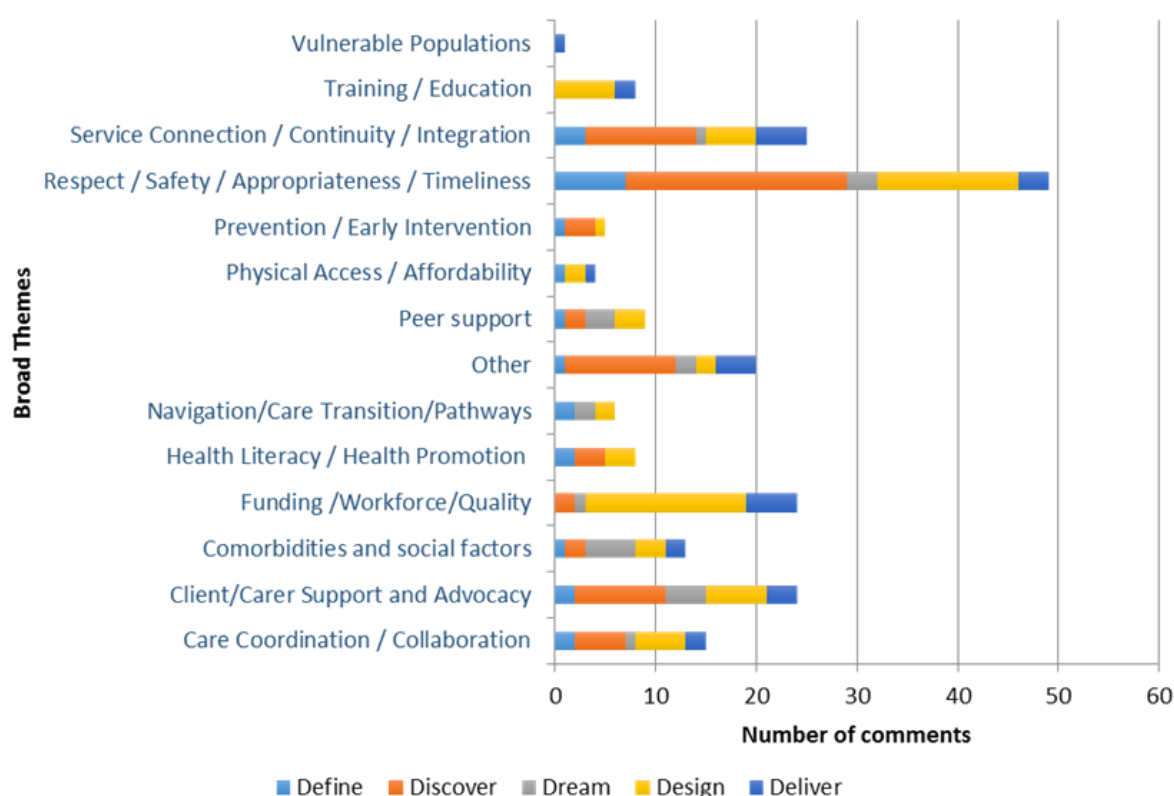
Additional to the Enzyme workshops, on Friday 26th February 2016, Adelaide PHN facilitated a joint CAC Workshop with the Northern, Central and Southern CAC members, with an aim of ascertaining the key principles and elements of service delivery that address consumer and carer needs in regards to mental health, and alcohol and other drug services.

The methodology used was an *Appreciative Inquiry* approach, which aimed to recognize and value the positive attributes of MH&AOD service delivery; and explore and discover new ideas that could contribute to improving the delivery of MH&AOD services, through a five phase process i.e. “Define”, “Discovery”, “Dream”, “Design” and “Delivery/Destiny” stages.

The responses derived from the five phases were merged and analysed to result in a number of key “themes”, four (4) of which presented more significantly as shown in the following graph:

- **Respect, Safety, Appropriateness and Timeliness** – Respect relates to experiences of feeling safe and respected within the MH&AOD system of care. Appropriateness relates to the “fit” of the service to meet the needs of a particular place, population, culture or other. Timeliness relates to whether a service can be provided within a timeframe that will meet the need of the client/consumer to prevent escalation, unmet need and the ceasing of help-seeking behaviour.
- **Service Connection, Continuity and Integration** – Relating to continuity of service provision over time and connections/integration between services, sectors and modes of care.
- **Funding, Workforce Quality** – Relating to sustainable funding to ensure longevity, continuation and integration of MH&AOD programs/services, and to enable the continuation of a highly skilled and empathetic workforce that provides good quality, accessible, affordable care.
- **Client, Carer Support and Advocacy** – Relating to the provision of support for and advocacy on behalf of clients and carers by way of including them in decision-making processes e.g. including them in the development of care plans, empowering their choices through improving health literacy.

Broad Theme Analysis – Appreciative Inquiry “Themes”



c) Clinical Council Consultation Workshop

On 1st March 2016, APHN facilitated a consultation workshop with the APHN Clinical Councils (CCs), with an aim of considering, discussing and presenting ideas regarding MH&AOD service delivery reform. Attendees included members from each of the Northern, Southern and CCs comprising GPs, Medical Specialists, Allied Health, Aboriginal Health, Nursing and Pharmacy. The workshop was based on an Appreciative Inquiry approach, identifying elements of the current systems that do work well, drawing from the knowledge and experience of participants who determined that ten (10) elements were required for a well-functioning MH&AOD system, which are summarised as follows:

1. **Flexible, patient centred community-based service for urgent care, regardless of co morbidities:** accessible, walk in options, facilitated, community based (e.g. Salisbury walk in), good liaison with other providers, access via referral or self-referral. Extended hours. GP mental health locum for after-hours provision for urgent care. Harm minimisation approach to sobering up, with next step of care available, social support, mental health support.
2. **Simple system access, referral and treatment for consumers and providers:** good triage by skilled staff, skilled expert; levels of expertise across all levels; good case management to implement plan; including shared care – GP, Psychiatrist, ongoing access and advocacy, access via referral, self-referral. Single entry point to appropriate care underpinned by a consistent metro wide service model/central repository of information. As many services together as possible. Enables access by a range of service providers including GP, Ambulance, self, ED, etc. Services that provide for patient literacy/comprehension level. Central expertise with knowledge of all services (to speak to); visibility of available services, support to navigate. Well known and understood services (e.g. ATAPS). Affordable for clients.
3. **Health Service model that addresses MH, AOD, social, cultural and physical health needs:** service that responds to need without exclusions; and deals with co-morbidities, disability, culture, language; one stop shop – providers have to structure their service to meet client need. Cross agency collaboration and integrated care. Navigation to social support agencies, NGOs, including housing, Centrelink etc.
4. **Care navigation – enabled by formal agreements:** to enable stepped care and partnership approach to care, integrated care with patient at the centre. Case manager to navigate enabled by MOUs, pathways and single case manager (LHN, provider, GP, NGO. Cross agency collaboration e.g. MH – Aboriginal PH – AOD services.); Pathways to community, GP, via nurse from ED. SALHN InterCare. Out of Hours.
5. **Clinical handover mechanisms across services:** Clear channels of communication and common language. Communication – clinical h/o, referral, between service providers, reporting.
6. **Carer involvement as part of the treating team, carer support:** support person/carers/family involvement in treatment, good communication, supporting the carer role.
7. **Social and community services** which recognise and respond to MHAOD needs of clients including Community Aged Care, RACF, Schools, Police, Judiciary, Housing, Welfare, Centrelink, etc., links to case managers, social workers, mental health workers to promote engagement with health services
8. **Service size, structure and workforce balanced to be expert and also local:**
 - Critical mass of service size/maintaining expertise, communication, local knowledge (scalability? – right size).
 - MH workers who can work expertly in community services e.g. aged care, disability, in-reach.
 - MH literacy – staff, clients.
 - General health workforce requires MH literacy to support step up and step down. MH first aid, skills base across health systems and general population.
 - Providing services where needed, home visiting, early intervention services in schools, extended care paramedics.

- More upskilling of GPs (free) in mental health issues to support step down, GP as part of the model.
 - MH nurses in general practice.
 - Consistency of service provider.
 - Using people with lived experience in peer education as part of workforce.
- 9. System that encourages community independence and empowerment** - mental health literacy approach with apps, etc. Use of visual scales, technology. Communication with consumers – health literacy appropriate levels. Service provision at appropriate literacy levels/ visual/ email communication to encourage understanding and self-management
- 10. Accountability mechanisms for health outcomes** – access, pathways, health measures, literacy levels, bundled care approaches, funding that allows good outcomes, supported by appropriate KPIs, more flexibility in funding (MBS item numbers), ongoing monitoring, build system over time, Consistency – staff, relationships – and build over time. Adelaide PHN should under promise and over deliver!

d) Adelaide PHN Online Survey

As a part of the MH&AOD consultative process, in February 2016, the APHN Governance Group members (CACs, CCs and HPGs) completed a short online survey. Additionally, primary health care clinicians (General Practitioners, Practice Nurses, Practice Managers and others) completed the same online survey. The survey consisted of four questions as follows:

Question 1: *What governance group are you a member of? (Membership Model)*

Question 1: *Please identify your profession. (General Practice)*

Question 2: *In your experience or opinion, what would improve mental health and alcohol and other drug services in metro Adelaide?*

Question 3: *What would improve the experience for people accessing and using mental health and alcohol and other drug services?*

Question 4: *The following list are national considerations for Mental Health Alcohol and Other Drug reform. Please rank them in order of what is most important to you (1 being most important, 6 being least important).*

- *Person-centred care funded on the basis of need.*
- *Thinking nationally, but acting locally – a regional approach to service planning and integration.*
- *Delivering services within a stepped-care approach – better targeting services to meet needs.*
- *Effective early intervention across the lifespan and across the care continuum – shifting the balance to provide the right care when it is needed.*
- *Making optimal use of Australia's world leading digital technology.*
- *Strengthening national leadership – facilitating systemic change at all levels and promoting the partnerships needed to secure enduring reforms.*

The results were analysed and key themes identified, defined as follows:

Navigation, Care Transition and Pathways: Hand-over of a client or patient to other services in an effective clinical manner with a level of ease.

Stigma, Appropriateness and Timeliness: Consumers' need of not being stereotyped within the MH&AOD system and receiving services in a timely manner to prevent escalation.

Service connection, Continuity and Integration: A system which enables service provision to be integrated between services ensuring continuity of care.

Funding, Workforce and Quality: Funding or workforce related needs or opportunities from a provider/system perspective.

Care Coordination and Collaboration: Coordinating person-centred care to ensure timely and appropriately met client needs, in a multidisciplinary approach requiring cooperation, collaboration and communication amongst care providers.

Respect, Safety, Appropriateness, Timeliness: A coordinated and multidisciplinary approach to care whereby the consumer feels respected, safe and receiving services that are appropriate in a timely manner to prevent escalation.

Client/Carer Support and Advocacy: Consumers need to have support as required or an advocate to receive the best care available.

Physical Access and Affordability: Consumers' ability to access services in relation to transport and cost.

In response to the survey questions, the Membership Group and General Practice respondents most frequently mentioned issues related to themes summarised as follows.

Question 2: In your experience or opinion, what would improve mental health and alcohol and other drug services in metro Adelaide?

Membership Groups	General Practice Sector
Navigation, Care Transition and Pathways	Navigation, Care Transition and Pathways
Stigma, Appropriateness and Timeliness	Service connection, Continuity and Integration
Funding, Workforce and Quality	Care Coordination and Collaboration Respect, Safety, Appropriateness, Timeliness

Question 3: What would improve the experience for people accessing and using mental health and alcohol and other drug services?

Membership Groups	General Practice Sector
Stigma, Appropriateness and Timeliness	Physical Access and Affordability
Navigation, Care Transition and Pathways	Navigation, Care Transition and Pathways
Client/Carer Support and Advocacy	Service Connection, Continuity and Integration

Respondents were also asked to rank the six national considerations outlined by the Commonwealth Government for MH&AOD reform. The items were ranked as follows:

Membership Groups	General Practice Sector
Person-centred care funding on the basis of need	Effective early intervention across the lifespan and across the care continuum – shifting the balance to provide the right care when it is needed
Effective early intervention across the lifespan and across the care continuum – shifting the balance to provide the right care when it is needed	Person-centred care funding on the basis of need
Delivering the services within a stepped-care approach – better targeting services to meet the needs	Delivering the services within a stepped-care approach – better targeting services to meet the needs

4. Overall key findings

The consultations undertaken by Adelaide PHN from February to March 2016, provided rich information from a range of community, consumer and service provider perspectives.

Consumers and carers clearly highlighted the importance of empathetic, skilled health service providers across all roles, who can consistently make consumers feel valued and respected. Aboriginal community members highlighted the importance of employing Aboriginal workers to enhance culturally appropriate service provision.

Consumers, carers, health professionals and community organisations all discussed the need for visible, recognisable, connected MH&AOD service systems with clinical handover and team care among professionals, and appropriate and timely responses to individual client needs as they present including children, youth, older people, people with disability, people with co-morbidities, CALD communities.

Additionally, the consultation process highlighted a number of key findings related to MH&AOD service delivery, as summarised and reported in APHNs Needs Assessment Report to the Commonwealth Government as follows:

- **Access to services:** Removing geographical/physical/financial/cultural barriers, improving service flexibility/afterhours and crisis care, improving clarity of navigation through the system, supporting client/carers and advocating on their behalf.
- **Access to information, health literacy and education:** Improving awareness of information and services across population demographics and increasing self-help resources.
- **Care coordination:** Engaging with family/significant others, improving clear referral pathways across systems and services, providing central repository for information and referral options, sustainable funding to enable continuity of care.
- **Integration of system:** Improve communication and collaboration between services and sectors (at Federal, State, Local and NGO levels) to improve pathways, responsiveness and flexibility of service delivery, improve gaps in care, and consider other social determinants.
- **Appropriate person-centred care:** Address co-morbidity issues and at-risk/vulnerable groups appropriately (CALD, LGBTIQ, Aboriginal and Torres Strait Islander, youth, elderly), remove stigma, and respond to individual circumstances.
- **Early intervention and prevention:** Focus on preventative health, improve education to consumers and professionals across health sector, and improve access to promoting well-being and recovery-orientated measures.
- **Workforce:** Improve aptitude, attitude and cultural appropriateness of health workforce to respond to changing dynamics within the health sector and across different population groups.
- **Quality and clinical governance:** Improve quality of health care, development and implementation of treatment plans, and follow-ups.

5. Where to from here?

The APHN Staff Action Planning Group consolidated the consultation findings to determine the three (3) key initiatives to inform the development of the Adelaide PHN commissioning of Mental Health & Alcohol and Other Drugs programs and services over the next twelve months.

The initiatives include:

- Rebuilding the system to focus on a stepped care continuum for those who need it most.
- One (1) point of referral.
- Communication and change management.

This consultation summary will inform the:

- Development of a Mental Health and Alcohol and Other Drugs Request for Proposal (RFP) released in April 2016.
- Adelaide PHN Needs Assessment, to inform our ongoing commissioning of programs and services.
- Mental Health and Alcohol and Other Drug service organisations as they develop their responses to the RFP.
- Adelaide PHN Membership Groups and Board.
- Broader Adelaide community.