leading community mental wellbeing

Queensland Alliance for Mental Health

MENTAL HEALTH SERVICE SYSTEM CHANGES: EXPERIENCES OF COVID-19 PROJECT

FINAL REPORT

Date: 31 July 2021

Queensland Alliance for Mental Heath

Queensland Alliance for Mental Health (QAMH) is the peak body representing the Community Mental Wellbeing Sector in Queensland. We represent more than 100 organisations and stakeholders involved in the delivery of Community Mental Wellbeing Services across the state.

Our role is to reform, promote and drive community mental wellbeing service delivery for all Queenslanders, through our influence and collaboration with our members and strategic partners.

At a federal level, we collaborate with Community Mental Health Australia. We work alongside our members to add value to the sector and act as a strong advocate on issues that impact their operations in Queensland communities.

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Acknowledgements of lived experience

We acknowledge the lived experience of those impacted by mental health issues, substance use disorders and suicide, and the contributions made by those who support them including family members, friends, and service providers towards their recovery.

Disclaimer

The views or opinions in this report do not necessarily reflect all the stakeholders that were consulted during the life of the Project.

Many of the service examples that have been showcased throughout the document have been chosen because their values and frameworks align with the vision articulated. QAMH has not formally evaluated the efficacy of these approaches but has provided references for the further interest of readers.

Every effort has been made to ensure this document is accurate, reliable, and up to date at the time of publication. QAMH does not accept any responsibility for loss caused by reliance on this information and makes no representation or warranty regarding the quality or appropriateness of the data or information.

Availability

The report is available online at www.qamh.org.au.

Language and definitions

Terms such as *consumer*, *service user*, *patient*, *client,* or *participant* are often used interchangeably to describe people who access mental health services, and *carer* for those who support them. In this report, QAMH intentionally does not use such terms. Instead, we have used person-first language to simply describe the person or people who access mental health services and the people who support them (Jensen et al., 2013).

Throughout this report, QAMH has also used terms that may not be widely recognised or have agreed definitions. To clarify, QAMH have included definitions for each of these terms below.

Lived experience	Lived experience refers to the personal or lived/living experience of mental illness. A person with lived experience may identify as someone who is living with (or has lived with) mental illness or as a person (such as a family member or friend) who support them.
Mental health	Mental health is defined as a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community (World Health Organisation, 2014).
Mental Illness	"Mental illness is a health condition that significantly affects how a person thinks, feels and interacts with other people. A mental illness is diagnosed according to standardised criteria" (Department of Health, 2007, para. 3).
Model of care	"A new 'Model of Care' broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place" (NSW Agency for Clinical Innovation, 2013, p. 3).
Telehealth	Telehealth is the use of telecommunication technologies, such as phone, videoconferencing, and the internet, to provide health services (Mohr, 2008).

Abbreviations

CALD	Culturally and linguistically diverse
COVID-19	2019 Novel Coronavirus Disease
CCU	Community care unit
GP	General practitioner
HCQ	Health Consumers Queensland
HHS	Hospital and Health Service/s
LGA	Local Government Area
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex and queer/questioning, and the + represents other identities not captured in the letters of the acronym (Public Service Commission, 2017).
MHAODB	Mental Health Alcohol and Other Drugs Branch
MSAMHS	Metro South Addictions and Mental Health Services
NSQDMH Standards	National Safety and Quality Digital Mental Health Standards
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
PPE	Personal protective equipment
PHN	Primary health network
QAMH	Queensland Alliance for Mental Health
QMHC	Queensland Mental Health Commission

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Executive summary

Introduction: The impact of the COVID-19 pandemic has been, and continues to be, devastating across the world. While Australia as an island nation has largely escaped the worst effects of the virus, its impact has still reverberated across our society. Financial stress and loss of income from the lockdowns and adapting to the "new normal" have contributed to higher levels of anxiety, panic, depression, and anger being experienced across the population.

In March 2020, the Queensland Government introduced a range of restrictions and social distancing measures in an attempt to stop the spread of the virus. All elements of the mental health service system were required to rethink traditional models of care including significantly reducing face-to-face service delivery. This presented an opportunity to review and reflect on these changes, and to identify innovations and service models that might enhance care and improve outcomes in the long term.

To investigate this, the Mental Health, Alcohol and Other Drugs Branch of Queensland Health funded the Queensland Alliance for Mental Health to undertake this Project in partnership with Health Consumers Queensland, Metro South Addictions and Mental Health Services and Brisbane South PHN.

Methods: The overall aim of the Project was to map the specific changes that have occurred across the mental health service system through both the initial and longer-term impact of the COVID-19 pandemic across the Brisbane South region, and to understand people's experiences of these changes.

To achieve this, the Project was carried out in three phases:

1. Service mapping (October to December 2020)
2. Consultations with people who access mental health services and those who support them (January to March 2021)
3. Data analysis and final report (April to June 2021)

Data collected through Phases 1 and 2 were uploaded to a computer software program (QSR NVivo) for coding and thematic analysis.

Results: Thirty-three service providers, and 33 people who access mental health services and those who support them agreed to participate in the Project.

Service changes: The most common service delivery change was replacing face-to-face services with telehealth. Some mental health services were able to offer both face-to-face and telehealth options while other services continued to deliver services as they were prior to the pandemic whilst still abiding by the Queensland Government's social distancing and COVID-19 rules and regulations.

Experiences of service changes: Overall, the experiences of people accessing mental health services and those who support them noted more positive than negative experiences, whilst the opposite was true of service providers, whose experiences were more negative. **Virtual connection** was identified by most people as a key positive theme, while **continued support** resulting from service changes emerged as a smaller theme among people accessing services and those who support them. **Isolation,** and **change and uncertainty** emerged as key negative themes. Service providers similarly reported change and uncertainty as a negative experience resulting from the service delivery changes, and some also noted that working from home was a negative experience for their staff.

Effective service changes: **The use of technology** was clearly identified as key to implementing effective service delivery changes. Key sub-themes relating to the use of technology included:

(a) **Choice** – in how people access mental health services (face-to-face and/or telehealth).
(b) **Improved access to mental health services** – by overcoming traditional barriers to care such as travel time and cost.
(c) **Online environment** – enabling people to be in their preferred space, one where they were more comfortable and relaxed.
(d) **Social connection** – reducing social isolation during the pandemic.

Unsuitable service changes: Not all service delivery changes that occurred were experienced positively by providers and people accessing services. While perceived by some as an effective service delivery change, the **online environment** emerged as a dominant issue for others. This included:

(a) **Virtual service delivery** – is not always appropriate for doing assessments and some types of therapy.
(b) **Preference and professional considerations** – many preferred face-to-face but recognised telehealth was better than nothing during the lockdown.
(c) **Privacy** – concerns were raised about using online platforms, including for telehealth, as well as issues around safety and confidentiality in the home environment.
(d) **Building trust and rapport** – is difficult to establish online.

Enablers to care: Four key themes emerged as enablers to care during the pandemic. These included:

1. **Access to technology**, including training and financial assistance to purchase data and devices provided by services.
2. **Communication** across the sector for staff and people accessing services and those supporting them to have the latest updates and changes to service delivery.

3. **Flexibility** in funding models, including grants and existing contracts, which enabled service changes and innovations to meet individual needs during lockdown, giving people more choice and control.
4. **System and organisational response** which supported service providers to continue delivering mental health services.

Barriers to care: The main barrier to care during active COVID-19 restrictions was **access to technology**. This included limited or **no access to devices,** the **internet and data,** and **poor IT skills**. Other key themes identified as barriers to care included:

1. **Limited access to mental health services** due to fewer appointments being available and services temporarily closing down.
2. **COVID-19 restrictions** and social distancing rules prevented people from accessing services face-to-face.
3. **Communication**, including new information and daily updates causing confusion and the spreading of misinformation.

Discussion: While telehealth provided a safe means for mental health services and supports to continue during the COVID-19 pandemic, there remains a preference for face-to-face service delivery. The wider implementation of telehealth across the mental health service system is likely to benefit service providers and people accessing these services in the longer term; however, it is important to note that telehealth should only be seen as one of a range of options.

The use of technology to deliver virtual services has demonstrated its potential to overcome traditional barriers to care such as access to transport, travel time, financial barriers, health issues, significant mental health symptoms, caregiving responsibilities and crises such as homelessness.

It is important for processes and procedures in the provision of digital mental health services, funding and supervision to become integrated into mental health training programs, and for contracting and accrediting bodies to consider adding this as a necessity.

The online environment is not always suitable. Service providers should assess individual needs and preference for digital therapy including capacity to access and use technology, severity of symptoms and risks of harm. Building trust and rapport without face-to-face connection is difficult and initial contact should be face-to-face, at the very least, for the service provider and person accessing the service, to develop a therapeutic relationship.

Even with protections in place (e.g., the Privacy Act 1988), privacy should remain a concern as it is near impossible to guarantee privacy of digital platforms.

Conclusion: COVID-19 provided a catalyst for rethinking the way mental health services are delivered and the way people accessing services and those supporting them access and experience mental health care. The literature – both here in Australia and from across the world – has already shown the wider implementation of telehealth across the mental health service system is, on balance, likely a benefit, both to service providers and people accessing these services and those who support them. However, it is important to note that telehealth should only be seen as one of a range of options**.**

Project recommendations:

1. Integrate telehealth into the mental health service system with consideration of the following:
    - The flexible integration of telehealth into funding contracts and performance reporting to enable choice for people who access mental health services, and those who support them.
    - Ensure best-practice standards (including privacy and confidentiality), and support for service providers (such as guides and training programs).
2. Reduce existing barriers to using telehealth and other online services, including access to devices and data.
3. Develop telehealth guides to support uptake from people accessing mental health services.
4. Support ongoing evaluation of the effectiveness of telehealth across the mental health service system.
5. Engage with other sectors (e.g., education and housing) to identify successful service delivery changes and innovations during COVID-19 that may be relevant to the mental health sector.

Section 1: Introduction

Key points

- COVID-19 declared a pandemic by the World Health Organisation on 11 March 2020.
- Lockdown rules banning all non-essential services and social activity outside the home introduced in Queensland on 23 March 2020.
- The mental health service system had to quickly adapt and rethink traditional models of care, including significantly reducing face-to-face service delivery.
- This was an opportunity to reflect on the changes and identify innovations and new models of care that worked well.
- The Mental Health Service System Changes: Experiences of COVID-19 Project is a snapshot of the experiences of service providers and the people who access services and those who support them in the Brisbane South region during the COVID-19 lockdown and beyond.
- The Project findings share relevance across the wider Queensland mental health service system.

The impact of the COVID-19 pandemic has been, and continues to be, devastating across the world. While Australia as an island nation has largely escaped the worst effects of the virus, such as mass infections, health systems in crisis, and deaths in the thousands, its impact has been widespread across Australian society – from financial stress and loss of income resulting from the lockdowns to uncertainty and fear as we adapt to the "new normal". Higher levels of anxiety, panic, depression and anger have been experienced across the population, affecting individuals with pre-existing mental ill health in particular (Black Dog Institute, 2020). The Australian experience is merely a reflection of the global experience of COVID-19. At the height of the first wave of the pandemic in 2020, the Director-General of the World Health Organisation observed that "social isolation, fear of contagion, and loss of family members is compounded by the distress caused by loss of income and often employment" (Brunier & Harris, 2020, para. 2). This claim is supported by data from a meta-analysis of community-based studies that shows a threefold increase in anxiety and an even higher increase in depression (Bueno-Notivol et al., 2020; Santabárbara et al., 2021). Data from the Australian Institute of Health and Welfare (2021) similarly show there has been an increase in the use of mental health services and a rise in loneliness and psychological distress during the pandemic. These statistics point to the urgent need for more support for and better access to mental health services in Australia (Black Dog Institute, 2020; Productivity Commission, 2020).

The Queensland Government introduced a range of restrictions and social distancing measures in an attempt to stop the spread of the virus (Queensland Government, 2020a). The lockdown rules severely curtailed freedom of movement and limited human contact beyond one's immediate family. Most public places, including community centres, libraries and even hospital wards were closed, and people were banned from going out except for work, exercise, shopping or medical reasons. Lockdown was a challenging experience for everyone, but vulnerable population groups and individuals who were already at risk for a range of social and health reasons were not well placed to adapt to the changed circumstances (Black Dog Institute, 2020). Among these groups were people living with mental health issues in the community who rely on a range of psychosocial supports and services to enable them to manage their mental wellbeing, support their recovery, and maintain social networks in their communities. This situation required an immediate response by health services and service providers in an attempt to limit or prevent the negative effects of a hard lockdown on people who were already known to be vulnerable (Moreno et al., 2020).

All elements of the mental health service system were therefore required to rethink their traditional models of care including significantly reducing face-to-face service delivery. Services had to act quickly to deliver innovative service models to ensure continuity of support. A public health crisis resulting from an increase in demand for mental health services combined with disruptions to service delivery necessitated a rapid transformation of service models, and equally, forced service providers and people accessing mental health services to adapt to new ways of doing things (KPMG, 2020; Taylor et al., 2021; Turner, 2020).

This presented an opportunity to review and reflect on these changes and to identify innovations and service models that might work better in the long term. In addition to this, the higher demand for mental health services during COVID-19 restrictions suggests there is a need to make services available to a wider cohort of people who previously have not been linked to services or were unable to access services.

To investigate these questions, the Mental Health Alcohol and Other Drugs Branch (MHAODB) of Queensland Health funded Queensland Alliance for Mental Health (QAMH) to undertake the *Mental Health Service System Changes: Experiences of COVID-19* Project (the Project)[1] in partnership with Health Consumers Queensland (HCQ), Metro South Addictions and Mental Health Services (MSAMHS) and Brisbane South PHN. The scope of the Project was limited to the services and supports provided

[1] The Project was initially called *Consumer & Carer Perceptions of Mental Health Service System Changes Resulting from COVID-19* but was later changed to better reflect the broader scope.

as part of the acute and community mental health sector in the Brisbane South region; however, it shares relevance to the wider Queensland mental health service system.

This report is presented in five sections. The **Introduction** provides an outline of the Queensland mental health service system and a brief overview of the Brisbane South region. Section two, **Methods**, describes the steps undertaken to complete the Project and the methodology used in the data analysis. Thirdly, the **Results** section presents the key themes that emerged across consultations with service providers and people who access mental health services and those who support them. This is followed by the **Discussion** section, where the results are discussed with reference to current literature and in relation to the Project objectives. Limitations of the Project will conclude this section. The final section of the report contains a **Conclusion** and **Recommendations**.

1.1 The mental health service system in Queensland

Mental health services in Queensland are funded at both a federal level, through Primary Health Networks (PHNs) and the National Disability Insurance Agency (NDIA), and at a state level by Queensland Health through the Hospital and Health Services (HHS) and MHAODB.

The 31 PHNs across Australia have adopted the Stepped Care model, which offers a spectrum of service interventions. The PHN Guidance document, produced by the Department of Health, defines stepped care as "an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, which can be matched to the individual's needs" (Department of Health, 2019, p. 8). In the same document the Government describes its unequivocal stance on stepped care as being "central to the Australian Government's mental health reform agenda" (p. 5), stating that it should be used by PHNs to guide all regional mental health planning and commissioning. Commissioned services are provided by non-government organisations (NGOs) based in the community and offer a range of psychosocial supports, including peer support and services with a resilience-building and wellbeing focus.

General practitioners (GPs) are often the first point of contact for help with mental health issues and facilitate access to these commissioned mental health and suicide prevention services through designated pathways set up by the HHSs and PHNs.

1300 MH Call is the main point of access into public mental health services in Queensland. This mental health telephone triage service "can provide support, information, advice and referral; provide advice and information in a mental health emergency or crisis; is staffed by trained and experienced

professional mental health clinicians; will provide a mental health triage and refer to acute care teams where appropriate" (Queensland Government, 2019, para. 4).

Public mental health services are focused primarily on acute care through Queensland Health which funds acute inpatient care in public hospitals across the state, as well as a range of community support services and community bed-based services managed by local HHSs. Mental health community support services provide individual recovery and peer support programs, group-based peer support, and programs for people at risk of homelessness, and people transitioning from acute mental health wards or correctional centres. These services provide up to 12 months of support and are available to those who access support through HHS mental health programs (Queensland Health, 2020).

In addition to these services, there are a range of state and federally funded online and telephone-based supports such as Lifeline, Beyond Blue, Kids Helpline, SANE Australia Helpline, Parent Line, PANDA and Diverse Voices (Queensland Government, 2020b).

The staged roll-out of the National Disability Insurance Scheme (NDIS) across Australia brought significant changes to the community mental health sector. The NDIA funds support for people who have a psychosocial disability through the NDIS (National Disability Insurance Agency, 2020).

The increase in mental health issues, depression and anxiety during the lockdown appears to be reflected in the higher numbers of people receiving NDIS plans during that time. For example, the number of NDIS participants in Queensland with a psychosocial disability who received a plan during the first lockdown period (April – June 2020) increased by 3% from the previous quarter to 12% of all NDIS participants in the state (National Disability Insurance Agency, 2020).

1.2 The role of telehealth

Before COVID-19, the uptake of telehealth[2] as a service option had been low. The reasons for this were in part due to funding anomalies (KPMG, 2020) accompanied by a reluctance on the part of mental health professionals to adapt to technological change, as well as other barriers, whether real or perceived (Cowan et al., 2019). While some service providers already offered telehealth as an option or had been in the process of developing telehealth options before lockdown restrictions came into effect towards the end of March 2020, many were forced to make radical changes to their service models at short notice. The switch to digital health, which may in different circumstances have taken years to achieve, therefore occurred of necessity in a matter of weeks (Shaw, 2020). For some, the

[2] Telehealth is the use of telecommunication technologies, such as phone, videoconferencing, and the internet, to provide health services (Mohr, 2008).

COVID-19 pandemic is seen as an opportunity for people to do things differently and offers the needed impetus for fundamental reform of Australia's mental health system (Moreno et al., 2020; Rosenberg et al., 2020).

1.3 Brisbane South region

The Brisbane South region is a geographically large area covering 3,770 square kilometres spanning four Local Government Areas (LGAs) in South-East Queensland (Queensland Government, 2019b). While predominantly a metropolitan area, the region includes pockets designated rural and remote (e.g., Beaudesert and Bay Islands). At the time of the 2016 census, the population of the Brisbane South region was 1.1 million and is predicted to reach 1.4 million by 2036, representing an annual growth rate of 2% (Brisbane South PHN, 2018). Population distribution by gender and age is similar to Queensland as a whole; however, compared to the rest of the state, the proportion of children and youth (0-17 years) is slightly higher, and the number of older adults (65+ years) is lower.

In terms of socioeconomic indicators of health and wellbeing such as income, education, employment, disability and housing, there is considerable disparity across the Brisbane South region, with Logan LGA experiencing the highest rates of socioeconomic disadvantage, not only in the region but in the state, 50% vs. 40% for Queensland (Brisbane South PHN, 2018). Additionally, more than a third of the population has an income of less than $500 per week,[3] 5% are living with a profound or severe disability, and the unemployment rate is at least 6% (Brisbane South PHN, 2018; Davidson et al., 2020). All these factors can affect health and wellbeing as well as a person's ability to access services.

Vulnerable populations

The health needs of individuals change over time and vary between different population groups. The *Brisbane South PHN Needs Assessment* (2018) identified several vulnerable populations in the region, including Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse (CALD) populations, LGBTIQ+ communities, and people living with a disability (Brisbane South PHN, 2018).
Mental health, alcohol and other drugs, and suicide constitute some of the most important health challenges in the Brisbane South region. The region also deviates from national and state averages in several key respects – for example, instances of intentional self-harm are higher in the Brisbane South region than the national average (Brisbane South PHN, 2018).

[3] This figure is close to the poverty line of $457, or 50% of median income before household costs are deducted.

Despite comprising just 2% of the population of the Brisbane South region (slightly lower than the state average of 4%), Aboriginal and Torres Strait Islander peoples have a higher burden of mental illness, are over-represented in the alcohol and other drugs treatment services (9%) and have had experience of suicide at twice the rate of the non-Indigenous population (Brisbane South PHN, 2018). In contrast, the region has the largest CALD population in the state, with nearly 30% of Queensland's population born overseas and a large proportion of Queensland's refugee intake settling in the Brisbane and Logan LGAs each year. Within the CALD sub-group, many of the region's high refugee population experience chronic and complex health concerns, including issues affecting mental health and wellbeing related to their experiences of deprivation, torture and trauma (Brisbane South PHN, 2018).

While there are limited publicly available statistics relating to LGBTIQ+ residents in the region, national estimates suggest approximately 11% of the population identify as LGBTIQ+, equating to up to 120,000 in the region. People from LGBTIQ+ communities have health needs specific to that population group on top of additional health challenges that stem from discrimination, exclusion and violence. Consequently, they experience disproportionately high rates of mental illness, suicide and drug issues while they also suffer from a lack of services that are both suited to and understanding of their health needs (Brisbane South PHN, 2018).

Around 5% of the region's population are living with a profound or severe disability and are more likely to experience chronic conditions, including mental health issues, as a result (Brisbane South PHN, 2018).

The health needs of individuals also vary according to geographic location. For example, Beaudesert is a rural area in the Scenic Rim LGA with just 1% of the region's total population, yet it is also an area of high relative socioeconomic disadvantage and high health needs. Similarly, Bay Islands in the Moreton Bay region of Redlands LGA is a remote area that faces significant challenges, including poor access to services, or indeed, no services. Both these regions have higher Aboriginal and Torres Strait Islander populations, high numbers of older people, and higher percentages of people living with a profound or severe disability, reflecting the health challenges experienced by these population groups in the more populated metropolitan areas of the Brisbane South region (Brisbane South PHN, 2018).

Section 2: Methods

The overall aim of the Project was to map the specific changes that have occurred across the mental health service system through both the initial and longer-term impact of COVID-19 across the Brisbane South region, and to understand people's experience of these.

The Project objectives include:

1. Map out the specific service delivery changes and identify new models of care that have emerged across the mental health service system throughout COVID-19, particularly the increase in use of virtual models of care.
2. Understand the experiences of service providers, and people who access mental health services and those who support them, in relation to these changes.
3. Understand which changes have been effective and in what circumstances they have been effective.
4. Identify practice changes that have not been useful and in what circumstances they have been unsuitable.
5. Identify any barriers and enablers to care during the COVID-19 pandemic.
6. Make recommendations to the MHAOD Branch on findings of the Project and recommendations for future suitable service models.

2.1 Project Reference Group

The Project was developed and delivered by QAMH in partnership with HCQ, Brisbane South PHN, and MSAMHS. QAMH employed a dedicated Project Lead who liaised between the partners. A Project Reference Group with representation from each partner agency and a representative from both the MHAOD Branch and the Queensland Mental Health Commission (QMHC) was established in October 2020 to provide oversight and guidance to the Project Lead.

2.2 Project design

The Project sought to engage both service providers working across the mental health service system in the Brisbane South region and people who access these services and those who support them, to understand their views and experiences of changes made to service delivery. To achieve this, the Project was carried out in three phases:

1. Service mapping (October to December 2020)
2. Consultations with people who access mental health services and those who support them (January to March 2021)

3. Data analysis and final report (April to June 2021)

See **Appendix 1**: Project Timeline.

Service mapping

A retrospective mapping of service model changes that occurred from the imposed lockdown period (23 March 2020 to 1 June 2020 when restrictions began to ease)[4] up until the end of this phase of the Project was undertaken through semi-structured interviews (virtual and face-to-face) with services and practitioners across the mental health service sector in the Brisbane South region. Alternatively, there was an opportunity for providers to participate by completing an online survey (via Survey Monkey) if unable to be interviewed during business hours.

Questionnaire design and content

The design of the questionnaire was guided by the Project objectives and followed a collaborative approach, working closely with members of the Project Reference Group, to develop the key questions targeted to service providers.

The questionnaire included both open and closed questions to capture a mixture of qualitative and quantitative data. The questions covered the following key areas:

1. Key characteristics (e.g., service type, target cohort)[5]
2. Height of COVID-19 restrictions (March to June 2020)
3. Present day (at the time of the service provider interview)
4. Future

See **Appendix 2** for the complete list of questions.

Recruitment

In consultation with the Project Reference Group, a list of mental health service providers in the Brisbane South region was generated. This included:

- Community mental health programs
    - brief psychological interventions
    - mild to moderate mental health services
    - severe and complex mental health services
    - social and emotional wellbeing services

[4] According to ABC News (2020, September 25), *Queensland's coronavirus timeline: How COVID-19 cases spread around the state* https://www.abc.net.au/news/2020-03-28/coronavirus-timeline-queensland-tracking-spread/12077602?nw=0

[5] Prior to participating in the interview, service providers were asked to complete a short pre-interview survey to identify key characteristics about the service, including types of services delivered. For those who nominated to participate via the online survey, these questions were included in the questionnaire.

- child and youth mental health (12 to 25 years)
- suicide prevention services
- alcohol and other drugs treatment services

- Children's Health Queensland Mental Health
  - Hospital-based teams
  - Community-based teams
  - Day programs (south)
  - Youth residential
  - Speciality teams
- MSAMH service providers in the Princess Alexandra, Logan and Redlands hospital areas
  - Access services
  - Community treatment services
  - Community bed-based services

From the list of service providers generated, at least one representative from each service was invited to participate in this phase of the Project. QAMH utilised relevant networks, (i.e., Project partners and QAMH members) to promote this opportunity and contact service providers directly (see **Appendix 3**). This included an initial email invitation outlining the Project objectives and an invitation to participate in this phase of the Project (see **Appendix 4**). Attached to this email was the Participant Information Sheet and Consent Form (see **Appendix 5**). A time and date were organised for interviews during November and December 2020. For service providers who nominated to complete the online survey, a Survey Monkey link was sent out with a request to complete by 31 December 2020.

Consultations with people who access mental health services and those who support them

Consultations with people who access mental health services and those who support them were held throughout the Brisbane South region. This was coordinated by the Project Lead and Lived Experience Advisor at QAMH with guidance from the Project Reference Group.

Consultations were conducted through online focus groups, individual interviews and an online survey to ensure maximum reach to as many people as possible. The overall aim of the consultation was to capture representation across mental health service types and streams,[6] sub-regional coverage and demographics.

[6] Public mental health service (provided in a hospital ward or in the Brisbane South, Logan or Redlands community); private mental health service (provided through private practice and inpatient care in private

Online focus groups

Two-hour sessions, consisting of six to 10 people per group. QAMH aimed to facilitate up to six focus groups to engage with a diverse range of people including:

1. Young people aged 16 to 24
2. People who support those accessing mental health services (also including children and youth)
3. People accessing mental health services provided by HHSs
4. People accessing mental health services funded by Brisbane South PHN
5. People accessing community mental health services
6. People living in regional areas within identified catchment (Department of Home Affairs, 2019).

People engaged in the online focus groups were remunerated $80 for their time (Health Consumers Queensland, 2015).

Individual interviews

20 x one-hour, one-on-one interviews with people who access mental health services and those who support them from priority populations[7] or for people who chose individual consultations in preference to focus group participation.

People engaged in the individual interviews were remunerated $40 for their time (Health Consumers Queensland, 2015).

Online survey

The survey aimed to reach people who access mental health services and those who support them across the Brisbane South region, including people from priority population groups. The survey was voluntary.

Questionnaire design and content

The design of the questionnaire was guided by the Project objectives and the service provider consultation questions to ensure consistency and support data analysis. The Lived Experience Advisor and the Project Reference Group further informed the development of the questionnaire to ensure the language and style was appropriate.

hospitals); and supports provided in the community (e.g., individual and group-based community mental health support, peer-support, family and carer groups).

[7] Priority populations: LGBTIQ+, CALD, Aboriginal and Torres Strait Islander peoples, older persons (65+ years), and people living with a disability and/or chronic condition.

A predetermined set of questions was used to guide the interview, but the semi-structured design of the questionnaire allowed for a wider discussion of emerging themes. The questions were grouped into four key sections:

1. Demographics[8]
2. Height of COVID-19 restrictions (March to June 2020)
3. Present day (at the time of consultation)
4. Future.

See **Appendix 6** for the complete list of questions.

Recruitment

Opportunities to be involved in this phase of the Project were promoted throughout relevant QAMH, HCQ and Project Reference Group member networks. In addition, service providers involved in Phase 1 were contacted directly and encouraged to inform people of opportunities to contribute to the Project across their own networks. Promotional material, including content to use in newsletters, social media and emails, was provided (see **Appendix 7**).

People were recruited for the individual interviews and focus groups via an expression of interest process (see **Appendix 8**). The aim was to ensure a diverse range of experiences were represented. Email invitations were then sent out to eligible applicants, together with the Participant Information Sheet and Consent Form (see **Appendix 9**). Following this opportunity to make an informed decision whether or not to proceed, interview times were organised to take place via the preferred method (phone, videoconference, or face-to-face) during February and March 2021. Focus groups were organised based on numbers.[9]

2.3 Data analysis

Key points from each audio recording of the service provider interviews were entered into an Excel spreadsheet and organised under each consultation question which was grouped according to the Project objectives. Data from the online survey were exported from Survey Monkey and added to the Excel spreadsheet accordingly. The same process was applied to the individual interview and focus group data, which were then entered into two separate Excel spreadsheets. All the information entered in the Excel spreadsheets was de-identified.

[8] Demographic information was collected consistently across the consultations – either through the expression of interest forms or at the beginning of the online survey.
[9] It was difficult to organise the focus groups because (a) the numbers were low and (b) it was very difficult to arrange a time that suited everyone.

The spreadsheet data were imported into the QSR NVivo computer software program for coding and analysis (QSR International, 2020). The data were organised and categorised manually by the Project Lead. Thematic analysis of the qualitative data was carried out in six steps: (1) familiarisation; (2) coding; (3) generating initial themes; (4) reviewing themes; (5) defining and naming themes; and (6) writing up (Nowell et al., 2017).

Section 3: Results

Key points

- Many face-to-face services were replaced with telehealth.
- The effective use of technology was key to implementing service delivery changes – enabling choice, improving access and facilitating social connection.
- Major concerns around privacy, access to technology, and therapeutic environment.
- Access to technology was an enabler to care for people with good IT skills, access to devices and data, and a safe environment.
- Access to technology was identified as a major barrier to care for people with poor IT literacy and limited or no access to devices, and without a safe environment.
- Data saturation was achieved during consultation phases.[10]

3.1 Characteristics of mental health services

Thirty-eight mental health service providers were invited to participate in this phase of the Project, and 33 accepted, agreeing either to an interview (23) or to contribute through an online survey (10). A majority of personnel who participated were managers or team leaders; a number of CEOs, directors and frontline staff (e.g., care coordinators, social workers and nurses) also contributed to these consultations. Twenty-seven community mental health organisations and six MSAMH service providers were represented. Six services provided NDIS supports which included capacity building, core supports and capital supports.[11]

Some participants represented services funded by Brisbane South PHN and delivered the following service types:

- brief psychological interventions
- mild to moderate mental health services
- severe and complex mental health services
- social and emotional wellbeing services
- child and youth mental health (12 to 25 years)

[10] Data saturation occurs when no new information is discovered in qualitative data analysis (Saunders et al., 2018).

[11] "**Core**: A support that helps a participant complete daily living activities. **Capital**: A support for an investment, such as assistive technologies, equipment and home or vehicle modifications, or funding for capital costs (e.g., to pay for Specialist Disability Accommodation). **Capacity building**: A support that helps a participant build their independence and skills" (National Disability Insurance Agency, 2021, para. 3).

- suicide prevention services
- alcohol and other drugs treatment services.

Some participants represented services funded by Queensland Health and delivered by NGOs. Types of services included:

- individual recovery support
- individual peer support
- group-based peer support
- transitions from corrections
- individuals at risk of homelessness
- Aboriginal and Torres Strait Islander social and emotional wellbeing program
- clubhouses
- support services for culturally and linguistically diverse populations
- step up step down.

Community mental health services and community child and youth mental health were the most common types of services delivered by MSAMH. Other types of services identified by participants included:

- alcohol and other drug treatment services
- acute care team
- Access and triage services
- 1300 MH call services
- Acute inpatient services (child, youth, adult, and older adult)
- Community bed-based services including community care unit (CCU), step up step down (adult or youth) youth residential).

Some participants represented services funded by Children's Health Queensland. Community-based teams and speciality teams were the most common types of services. Other types included:

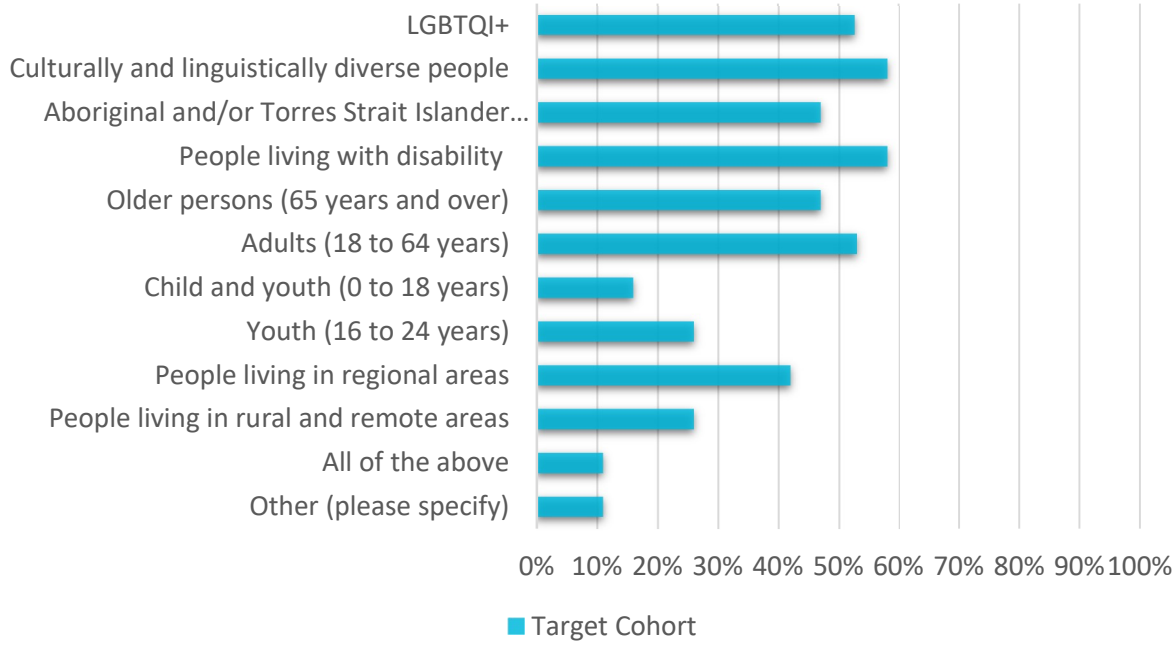
- telepsychiatry
- hospital-based teams (including acute response teams), adolescent mental health unit, child mental health unit, consultation liaison service
- youth residential rehabilitation unit.

Other service types identified by participants included:

- wellness programs
- inclusive health and wellness hub
- community arts programs.

The service providers involved in the Project identified the vulnerable population groups referred to in **Section 1.3** as the main target of mental health services offered, namely, members of CALD communities and people living with a disability (both 58%), followed by adults (18 to 64 years) and LGBTIQ+ (both 53%). Two services identified target cohorts as "all of the above". The least represented target cohorts were child and youth (0 to 18 years) (16%), youth (16 to 24 years), and people living in rural and remote areas (both 11%). One service provider identified "carers" as their target cohort. See Figure 1 below.

Figure 1: Target cohorts of services represented in the Project



3.2 Demographics of people who access mental health services and those who support them

Twenty-one individual interviews and two online focus groups were conducted. While the opportunity was widely promoted, especially through social media,[12] there was less interest than initially anticipated. Individual interviews were the preferred way to participate, and only two focus groups were held (see **Methods** section). Also contra the Project Plan, and despite extending the consultation phase until mid-May 2021 and making direct contact through relevant networks, in the end it was not possible to arrange consultations with members of the Aboriginal and Torres Strait Islander

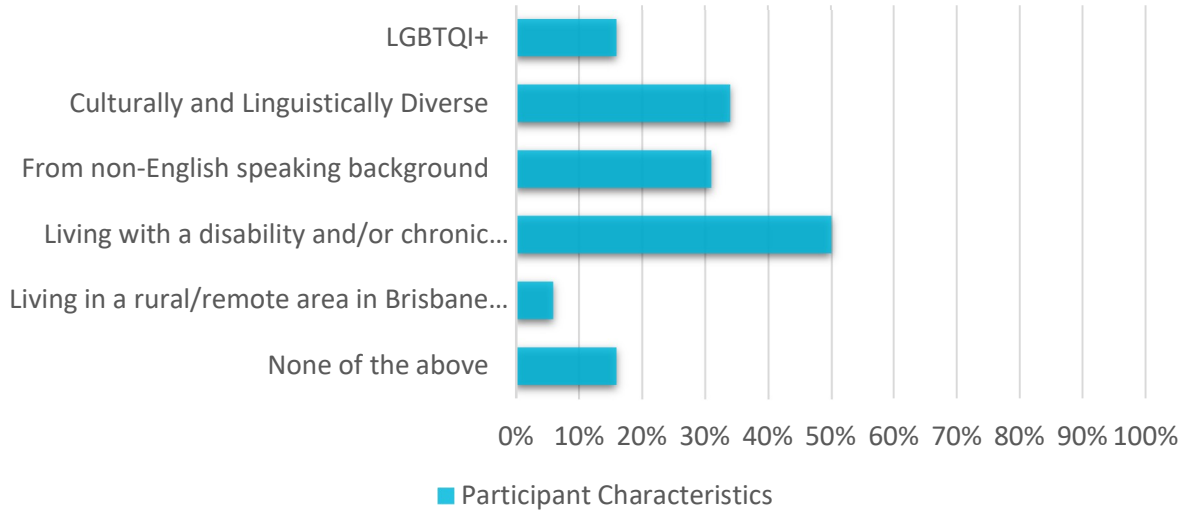
[12] One of QAMH's Facebook posts reached 1,207 people and had 71 engagements. Facebook *reach* is the number of unique users who see a post or page, regardless of whether they engage with it. Facebook *engagement* is the action made by viewers of a Facebook page to indicate their engagement with it (e.g., likes, comments and shares).

communities during this phase of the Project, so their views and experiences are not directly represented here.

Most people who participated in the Project identified as someone who accesses mental health services (44%), while 28% identified as a person supporting those who access mental health services, and 28% identified as both. The majority of the participants accessed supports provided in the community[13] (18), followed by public mental health services[14] (13) and private mental health services[15] (11). Some people accessed more than one type of mental health service during this time.[16]

Half of participants identified as living with a disability and/or chronic condition, 34% were members of the CALD community (31% from non-English speaking backgrounds), 16% identified as LGBTIQ+, and 6% were living in a rural/remote area. See Figure 2 below.

Figure 2: Characteristics of people who participated in the Project



All age groups[17] 18 and over were represented, with people aged 45 to 54 representing the largest proportion of participants (28%) and 65 or older representing the lowest (3%).

[13] **Supports provided in the community**: include individual and group-based community mental health support, peer-support, family and carer groups.
[14] **Public mental health service**: provided in a hospital ward or in the South Brisbane, Logan, or Redlands Community.
[15] **Private mental health service**: provide through private practice and in-patient care in private hospitals.
[16] Time period between March 2020 and March 2021.
[17] Age groups were: 18 to 24, 25 to 34, 35 to 44, 45 to 54, 55 to 64, 65 or older.

3.3 Consultation themes

Objective 1: Service delivery changes and new models of care

Rapid changes to mental health services and supports across the Brisbane South region had to be made in response to the COVID-19 restrictions. The most common service delivery change was replacing face-to-face services with telehealth. Some mental health services were able to offer both face-to-face and telehealth options and some continued to deliver services as before, so long as they complied with government guidelines and social distancing rules. These changes are described in more detail below.

Telehealth

The lockdown meant that almost all services had to immediately cease providing face-to-face support and establish different ways of delivering services. Some programs were put on hold until restrictions eased. Before the lockdown restrictions were introduced, only a handful of service providers offered alternative formats such as phone or videoconference as well as face-to-face. These organisations were therefore better placed to adapt to the changes with less disruption than other organisations that had to develop new modes of service delivery from scratch.

In general, service providers aimed to do "whatever worked" to make services available. The options were phone and online formats such as Zoom, Teams, Skype or FaceTime. It was often a case of finding out by trial and error what system worked best.

Some service providers changed the way they managed incoming calls so that people accessing these services were able to contact their support worker directly. This innovation was not generally adopted, however, and in some cases the phone systems did not cope with higher call volumes, meaning that some people trying to access services could not get through.

A few services were stopped because a telehealth option was not possible (e.g., prison programs and street outreach services). One exception was a transition from corrections service that continued to support people on the day of their release from prison. Providers attempted to continue street outreach via phone where they could.

Group programs were also impacted. In some instances, group sizes were reduced to accommodate social distancing requirements, while other providers developed innovative ways to move group programs online, and some peer support groups successfully adapted to using online formats. Adapting group programs online was not generally successful (see **Unsuitable service delivery changes**).

Face-to-face and telehealth

A major challenge for service providers during the lockdown was how to continue to meet the needs of people accessing mental health services when safeguarding health and safety within the government guidelines took precedence over everything else. For some people, telehealth will always be impossible or impracticable (see **Unsuitable service delivery changes** and **Barriers to care during COVID-19**). Organisations had to devise ways to keep people safe so that face-to-face meetings could continue when necessary. For many others the online options also did not work well, and they quickly went back to face-to-face consultations when restrictions eased.

Most services, particularly those delivered by non-government organisations, implemented a fast transition to telehealth. The changes included staff working from home or working alternate days at home, having staff meetings online, and developing special resources/guides for staff to use when working with people accessing services virtually. To enable face-to-face services to take place, various protocols had to be introduced. These included social distancing measures to ensure 1.5m spacing per person, use of personal protective equipment (PPE) such as face masks and hand sanitiser, and conducting risk assessments by phone before appointments and additional health checks on arrival. Organisations had to decide who was urgent/non-urgent and limit face-to-face services for those most in need of them. One community mental health service was able to provide one-on-one supports (e.g., going to people's homes and taking them out to appointments) if regulations were adhered to. Similarly, support workers could continue doing home visits.

Lengthy delays to services were reported in cases where providers were slow to set up telehealth options. There were also individual stories pointing to service breakdowns (e.g., failure to communicate service changes to families or respond to messages) that adversely affected care programs over time.

Continued as normal

A few services continued as normal with social distancing. These included services for people requiring 24-hour support (e.g., people with severe mental illness, HHS services). Social distancing rules were implemented in Community Care Units (CCUs) so that residents continued to have access to a clinical team five days a week and peer workers out of hours, as before. Some NDIS recipients had to find a different support worker to provide in-home support when their existing support worker felt unable to continue home visits during the lockdown.

Additional new models of care

In addition to the extensive use of virtual models of care[18] that resulted as a response to the COVID-19 restrictions, a range of new models of care, supports and programs were introduced during the pandemic.

For example, one community mental health organisation devised an innovative response to high call volumes by establishing a helpline, the Multicultural Connect Line, that operated as a "virtual front door" and enabled them to manage the increased demand, connect with people who had been impacted by COVID-19, and continue to provide support and services (e.g., accommodation).

Further examples of innovation during the COVID-19 pandemic are demonstrated through an Aboriginal and Torres Strait Islander community health service where two new initiatives were implemented to simplify referral process and remove barriers to care. First, "COVID-19 call back" was developed to provide extra support to people in the community during lockdown. In this initiative, members of the public (i.e., family/friend, GP, nurse, liaison officer, police officer) could pass on information about people they knew were struggling to a designated social health worker, who would then reach out to that person and check up on them. This contact developed into regular yarn sessions with no structured agenda other than helping to identify what they needed, such as what services they could be linked in with (e.g., food security, housing services, Centrelink), and offering practical assistance as well (e.g., filling out forms). Second, the implementation of this call-back service allowed the organisation to simplify the referral system using call-backs, so that people could contact a social health worker directly, followed by a call-back that resulted in a fast-tracking of mental health care. A referral from a GP could then be obtained later. This service, which can prevent delays to people getting essential services, has been identified by the service as an urgent need among the Aboriginal and Torres Strait Islander community which they will continue to operate from a hub in the Brisbane South region if funding is made available.

To help people cope with isolation, some other supports and activities implemented by service providers included daily relaxation sessions via Zoom, exercise classes, and art classes where the materials needed for the class were sent to a person's home in advance. Basic food supplies were delivered to people who could not go out. One community mental health service purchased additional

[18] "A new 'Model of Care' broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place" (NSW Agency for Clinical Innovation, 2013, p. 3).

licences in GoShare (a supplier of digital health resources) to support people in managing their own mental health and wellbeing needs.

Objective 2: Experiences of service delivery changes

Overall, people accessing mental health services and those supporting them noted more positive than negative experiences, whilst the opposite was true for service providers whose experiences were more negative. Virtual connection was identified as a key positive theme while continued support emerged as a smaller theme. Isolation, change and uncertainty emerged as key negative themes. The key themes are described in more detail below.

Positive

Virtual connection: The experience of accessing mental health services and supports virtually opened new opportunities for social connection during the pandemic. People became more familiar with using Zoom and relied on it to reach out.

> **"I was living in isolation and suddenly we were setting up a calendar of Zoom appointments to connect with family and friends."**
>
> [Comment from a person who accesses mental health services]

While experiences varied and depended on individual circumstances, many people commented that they felt more supported than ever before due to the increased opportunities for virtual connection. Some services set up online social events to keep people as connected and engaged as possible (one person describing this as a "lifesaver").

Continued support: The service delivery changes enabled many people to continue to receive mental health services and supports, and they commented that for the most part they felt well supported. The knowledge that they could access the services and supports they needed provided reassurance during a time of uncertainty.

Negative

Isolation: Physical isolation during the lockdown contributed to increased feelings of loneliness, isolation, stress and anxiety across the community. The acute hospital wards were closed completely, no visitors were allowed, and no one could leave, exacerbating stress and anxiety and the sense of isolation in an already vulnerable population. CCUs were also closed to visitors.

Some people could not leave their homes due to a fear of getting COVID-19 (e.g., because of compromised immune systems and other health concerns), and others were isolated from their natural supports such as family and friends who were themselves vulnerable (e.g., grandparents or frontline workers). This left some people relying on "the kindness of strangers" to help them during the lockdown.

Change and uncertainty: Rapid change across the mental health service system was accompanied by much uncertainty, as lockdown rules and restrictions changed from day to day. No one knew how long the lockdown would last. Concerns about how the changes would impact services and supports caused frustration and anxiety.

This was an equally stressful and challenging time for service providers, particularly at the beginning of the pandemic when rules were frequently changing and information was confusing (e.g., about what was safe or not safe). Adapting to working from home was another challenge – for example, ensuring all staff had laptops and any other technology they needed to work remotely. Organisations also had to work out through trial and error which software systems to use, for staff meetings as well as service delivery.

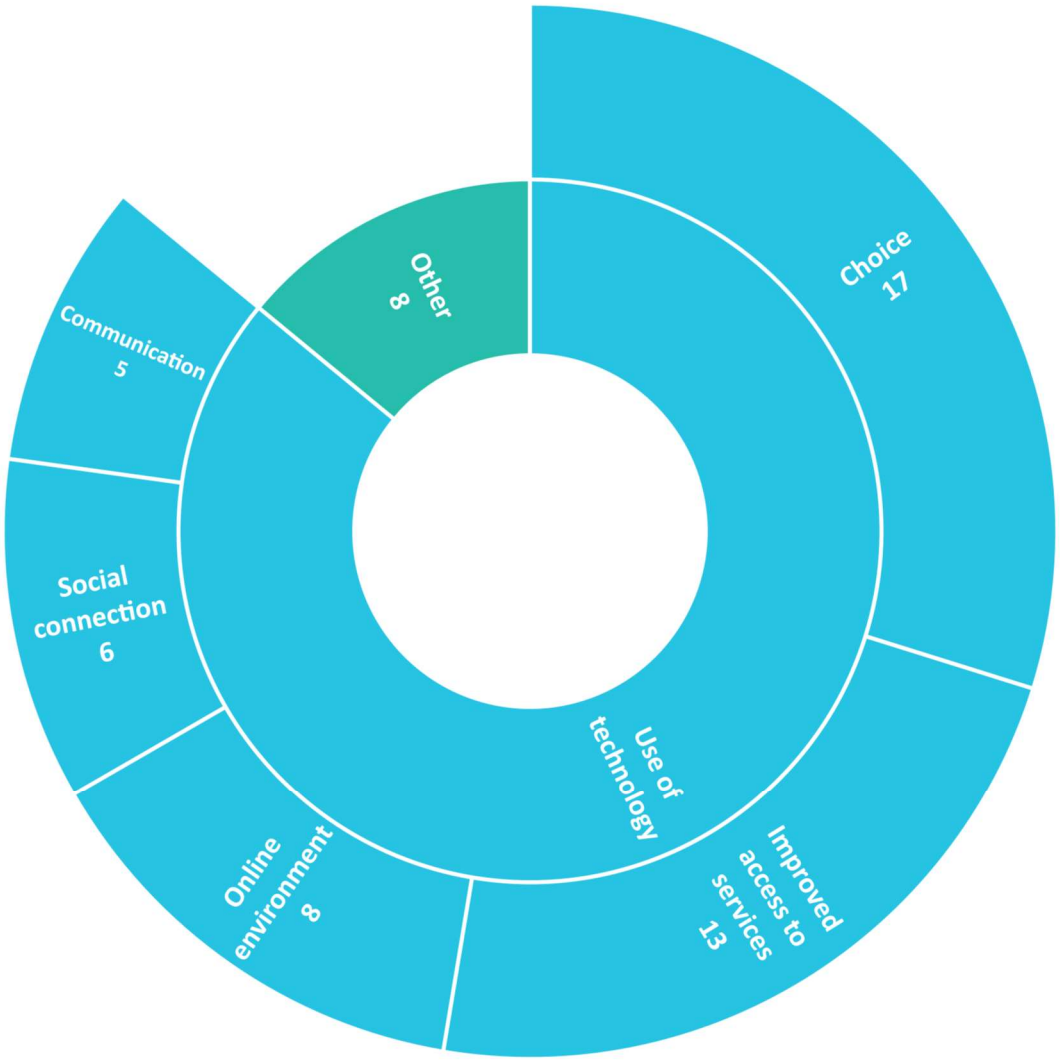
> **"One minute Zoom was in, next it was out…then Teams emerged and became the front runner."**
>
> [Comment from mental health service provider]

Since restrictions eased, snap lockdowns have occurred, which have contributed to heightened anxiety about returning to face-to-face as well as disrupting services and causing confusion.

Objective 3: Effective service delivery changes and circumstances

Overall, the use of technology was clearly identified as key to implementing effective service delivery changes. Key sub-themes relating to the use of technology included: (a) choice, (b) improved access to services, (c) online environment, and (d) social connection. Figure 3 shows the themes identified, and the proportion they represent, as they relate to Objective 3 of the Project. Each key theme is described in more detail below. Other smaller themes that emerged are summarised in **Appendix 10**.

Figure 3: Themes - Effective service delivery changes



Use of technology

Choice: The lockdown changes introduced an element of choice in service delivery that was equally new to most providers and people who access services. Service providers were initially concerned the transition from face-to-face service delivery to virtual would not suit the people accessing their services or be appropriate. As it turned out, some providers experienced excellent uptake during the lockdown. They also found that many of their clients were "tech savvy" and appreciated the opportunity to continue accessing mental health services virtually. A noted exception were members of the CALD community who preferred face-to-face service delivery (see **Unsuitable service delivery changes** and **Barriers to care during COVID-19**).

Choice and flexibility extended to the mode of virtual service delivery, and where appropriate, telephone and video options such as Zoom, Teams, Skype, and FaceTime were offered to better meet people's needs and preferences.

> **"Flexibility, additional support, and adapting to suit individual needs and preferences was key."**
>
> [Comment from mental health service provider]

Improved access to mental health services: New models of care implemented during the pandemic in response to lockdown restrictions have improved access to mental health services and supports. With many mental health services becoming available online, barriers that previously made it difficult or impossible for some people to access services were removed. The opportunity to access services virtually has saved travel time, removed existing barriers – including financial barriers (e.g., public transport costs) – and enabled people to still receive services when feeling too unwell to go out, or unable to leave their home due to disability or carer responsibilities. One service provider reported that geographical barriers and public transport were the main reasons for high drop-out rates and that the use of telehealth during the pandemic greatly improved access and will continue to be offered as an option.

Online environment: The online environment worked well for many people accessing services and service providers alike. Some service providers reported changing the size, frequency and duration of online sessions to make people more comfortable in an online environment. What this looked like in practice differed across services, but the aim was to work out what worked best according to need and preference. For example, smaller group sessions were held more frequently for shorter periods of time to help make the online environment more comfortable to engage. On the other hand, one service

switched from individual to group sessions online to cope with an increased demand for services. Lower dropout rates as well as anecdotal feedback from people accessing services suggests the changes generally worked well.

> **"As a result of having online options, we saw a 50% increase in engagement from carers in rural and remote areas."**
>
> [Comment from mental health service provider]

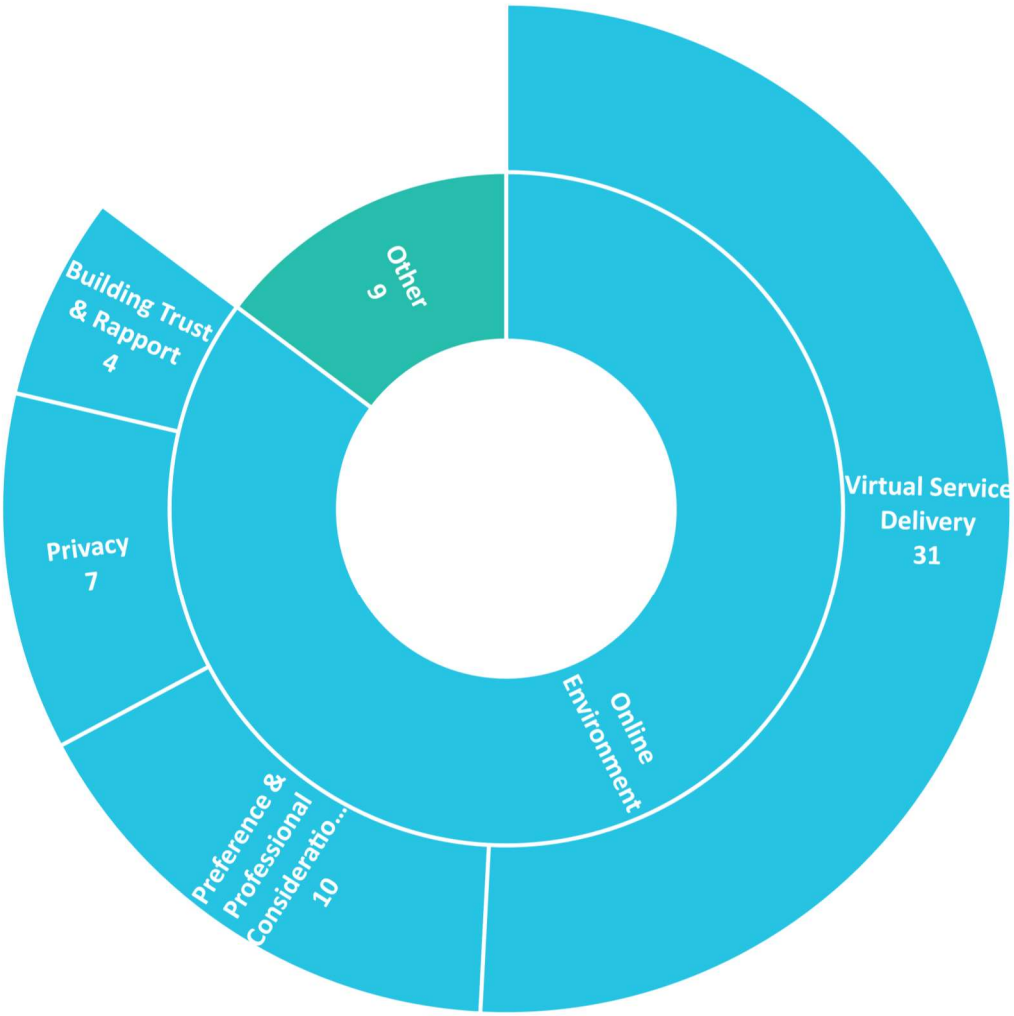
Virtual services and supports also enabled people to be in their preferred space – one where they felt most comfortable. Some people found being in the safety of one's own home helped reduce the anxiety often associated with face-to-face sessions. One service provider noticed that people accessing the service appeared more relaxed during online sessions and opened up more when they were in their own environment compared to sitting in a clinical environment with the added anxiety of travelling to and from appointments.

Social connection: The use of technology during the pandemic provided new opportunities to connect. One provider shared how they utilised Zoom to create opportunities each week for people accessing the service to socialise and catch up. Breakout rooms offered towards the end of online group sessions were another opportunity for people to catch up and check in with one another. These opportunities were often flexible with no set agenda other than to socialise and enjoy peer support. Overall, they were effective in keeping people connected and reducing social isolation during the pandemic.

Objective 4: Unsuitable service delivery changes

Consultations revealed that not all service delivery changes that occurred during COVID-19 were experienced positively. While perceived by some as an effective service delivery change, the online environment emerged as a dominant negative issue. This included: (a) virtual service delivery, (b) preference and professional considerations, (c) privacy, and (d) building trust and rapport. Figure 4 illustrates the themes identified, and the proportion they represent, as they relate to Objective 4 of the Project. Each key theme is described in more detail below while smaller themes that emerged are summarised in **Appendix 10.**

Figure 4: Themes - Unsuitable service delivery changes



Online environment

Virtual service delivery: While the switch from face-to-face services to online or phone was a positive change for some, it caused anxiety for others, especially vulnerable people who already had a fear of social media. Some people disengaged from services completely. Many people commented that telehealth could not replace the quality of face-to-face support given the drawbacks and limitations of telehealth they encountered.

> "Telehealth was not a good format for many people as you don't get the same quality of interaction with clients as face-to-face."
>
> [Comment from mental health service provider]

Telehealth by phone was found to be particularly inappropriate for doing assessments (e.g., NDIS assessments, mental health care plans) and for some types of therapy. Some children did not do well with online counselling and missed the sensory experiences of play and art therapy, even though individual counsellors developed some innovative online alternatives. One person commented that the change to online counselling for their adolescent daughter meant that they no longer got any "time out".

Aged care services and support to CALD communities were severely impacted by the lockdown. Outreach to older people was difficult to organise, and older people found it difficult to interact online. Similarly, the lack of emotional support that naturally occurs in face-to-face communication was a significant negative factor in services to people from a CALD background, and many people dropped out because they struggled to communicate over the telephone and became anxious. Service providers reported that many of their staff did not like the changeover to telehealth for the same reasons.

Overall, people commented that telehealth had a negative impact on the dynamics of the therapy session. Zoom sessions were sometimes viewed as social interaction rather than formal therapy, and people behaved (and dressed) informally as a result. The online formats did not generally work well for group therapy. Some organisations abandoned group programs altogether during lockdown and have been slow to return to them.

Preference and professional considerations: People responded differently to the changes depending in part on individual preference and other factors such as professional considerations. Many respondents stated that they preferred face-to-face to online support but recognised that telehealth

appointments were “better than nothing”. On the other hand, since the restrictions eased, having the choice of telehealth or face-to-face has equally been welcomed (see **Effective service delivery changes and circumstances**). Some group participants did not like having one-on-one sessions that were offered instead of the group activities they were used to, and others dropped out until face-to-face sessions returned.

Privacy: Concerns about privacy were a common theme. Some people felt uncomfortable with the videoconference format, and many had concerns about privacy and confidentiality in their environment – because they did not have access to a personal device, for example, or because they lived in crowded accommodation where privacy is impossible.

> **“I had phone consults with my psychiatrist on the side of the road.”**
>
> [Comment from a person who accesses mental health services]

Service providers noted that it was especially difficult to engage young men at this time because of privacy issues. Telehealth did not work well for children who had no access to privacy at home. Similarly, it was not a suitable format for people in immigration detention, or where there has been domestic violence, or where there are children at home. Some service providers reported concerns around privacy in using different online platforms, and it was necessary to introduce additional protocols and processes governing the use of these technologies.

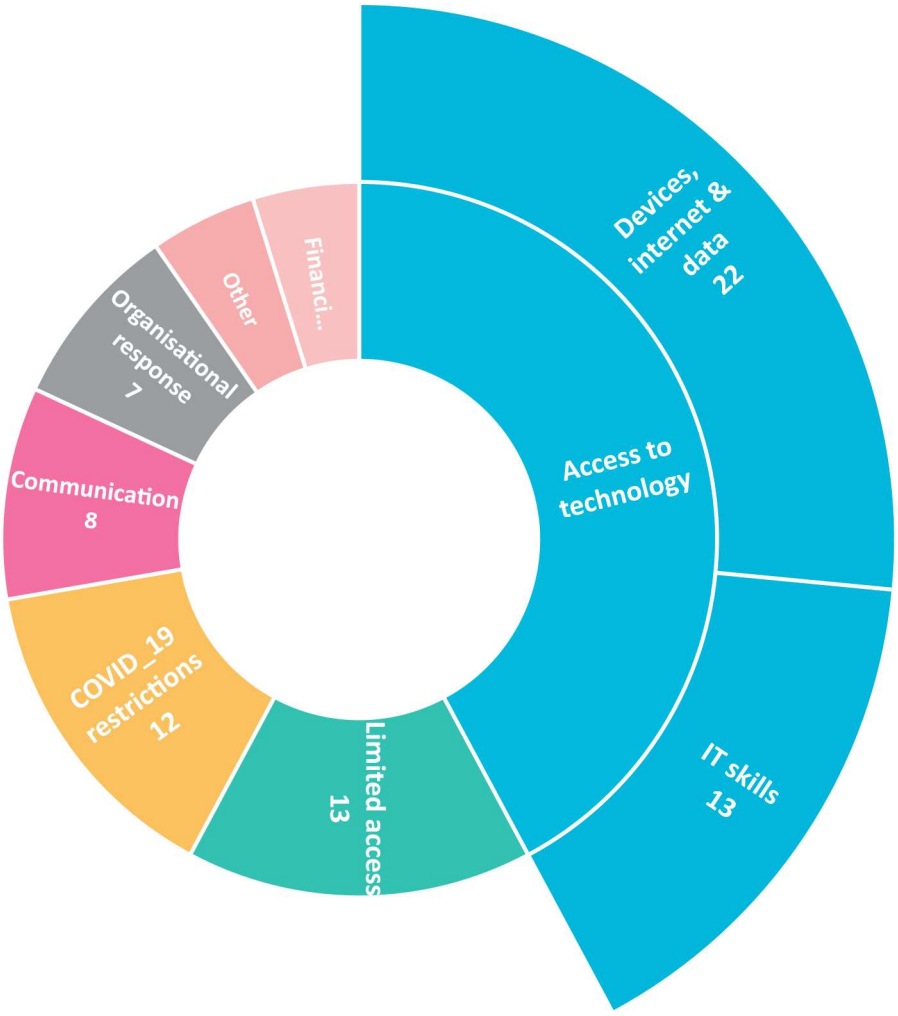
Building trust and rapport: People need face-to-face contact and human interaction. Many felt that virtual contact was isolating – an artificial barrier to communication that took away the sense of community. They found telehealth very impersonal, especially when face-to-face interaction and body language is so important to developing a therapeutic relationship – especially the initial contact – or in situations where there might be language or cultural barriers.

Objective 5: Barries and enablers to care during COVID-19

Barriers to care

Access to technology was identified as the main barrier to care during COVID-19. This included: (a) devices, internet and data, and (b) IT skills. Other key themes identified as barriers to care included: (1) limited access to mental health services, (2) COVID-19 restrictions, and (3) communication. Smaller themes included: (1) organisational response and (2) financial barriers, together representing less than 16% of data collected. Figure 5 shows each of the themes as they relate to Objective 5 of the Project. The key themes are covered in more detail below while the smaller themes are summarised in **Appendix 10**.

Figure 5: Themes - Barriers to care



Access to technology

Devices, internet and data: When services moved to online formats, access to devices and data, together with the capacity to use the technology, remained a significant barrier for people accessing mental health services. Many people could not use the new formats because they did not have the technology (computers, laptops or tablets) and in some instances lacked the technical skills to use them. Phone contact was often the only means of communication. Limited knowledge of technology was a major barrier among CALD communities, as was access to a device in situations where families are used to sharing one phone. The cost of internet access and poor connections, particularly in regional areas but also for some people in metropolitan areas, were additional barriers.

The effect on services due to difficulties with access was widespread. Some programs were shut down completely either because institutions did not support access to devices or the internet (e.g., acute wards, aged care facilities) or because devices were banned completely (e.g., prisons). Inpatients in hospital wards had no access to services unless they had their own mobile phone and data, and residents in aged care were reliant on the facilities providing devices and on individual staff members setting them up for their counselling sessions. Services to children and young people were negatively impacted because providers could no longer go into schools and had to support children at home, where often devices were not available. Individual providers attempted to address the problems of access by paying for data, providing limited training, and at times checking up on people at home when they could not be contacted by phone.

IT skills: The rapid changeover to telehealth was a challenge to service providers and people accessing services alike, and it was quickly apparent that poor digital literacy and access to technology was a serious barrier. Some service provider staff also had limited IT skills and needed training. Support in the form of training to people accessing services appears to have been ad hoc and depended on the capacity of different organisations to do this.

Limited access to mental health services

Many people commented on the difficulty of accessing services during the lockdown. Wait times were longer, it was harder to get an appointment for any service, phones were unanswered, some hospital wards were shut down completely, and the normal services people relied on were suddenly closed. As a result, people described feeling “neglected”, “frustrated” and “abandoned”.[19]

[19] This contrasts with the view that other people accessing services had said they felt well cared for at this time.

The lockdown also meant that it became harder for people to get a mental health care plan, and this had serious knock-on effects for people seeking NDIS support,[20] so people would just give up and thus not get the services they needed. An overall shortage of services combined with the difficulty of access added to people's feelings of isolation and their need for supports that were not there. Others dropped out because they could not find bulk-billed services but did not want to go to a hospital.

COVID-19 restrictions

The COVID-19 rules and regulations generated a lot of fear in the community, causing increased anxiety. The work of service providers was severely disrupted by rules that prohibited face-to-face interaction and prevented them from being with people physically when they were distressed.

> **"Fear was the biggest isolation for some people".**
>
> [Comment from mental health service provider]

In some instances, people missed out on services because therapists did not have the space to comply with the social distancing rules, or because support workers could not go to their home. Group programs and activities were shut down; visits to mental health wards and residential care were not allowed. All these changes added to the isolation described above (see **Experiences of service delivery changes**).

Communication

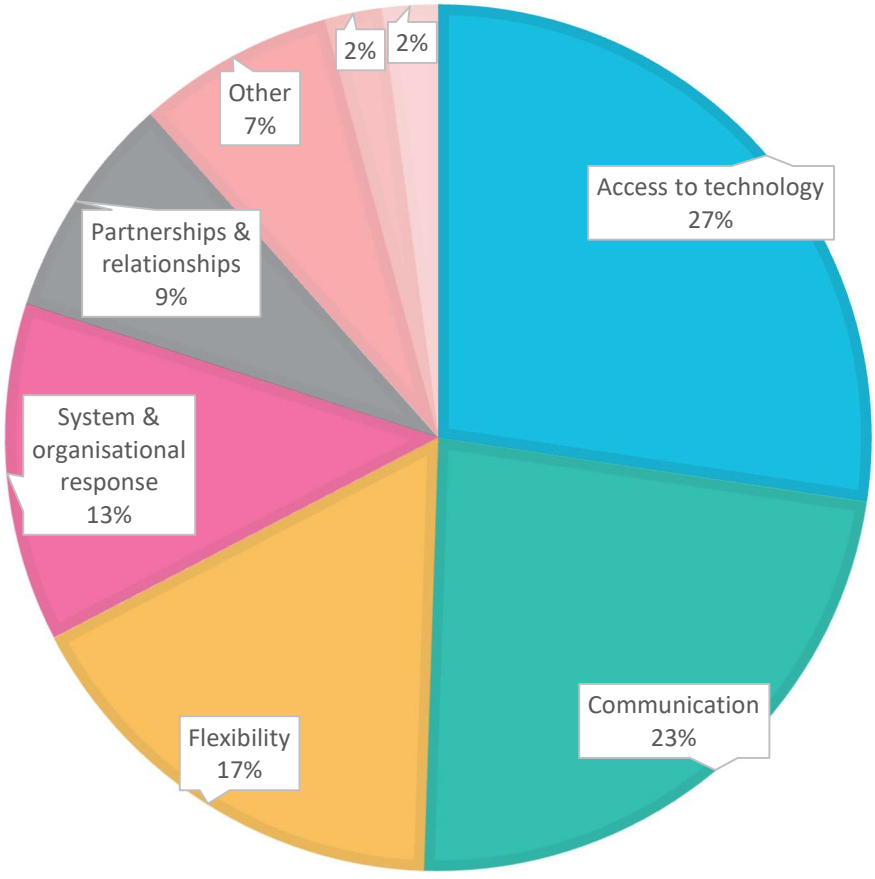
Service providers had the responsibility of communicating information to individuals in the community. Their task was made harder because new information and updates to rules and restrictions was coming out almost every day, causing confusion and adding to a growing sense of fear and anxiety. Misinformation and fake news easily spread in this environment. The rapid transition to online communication and almost complete reliance on technology was difficult for everyone, but particularly for non-English speakers and people with limited technical skills or knowledge. The range of technologies, and even multiple websites used by organisations and governments, was an additional barrier to effective communication. CALD communities found it difficult both to obtain and communicate information. Equally, service providers were challenged by the need to quickly adapt programs as well as manage communications within their own teams.

[20] A care plan and documented treatment history are required by the NDIA for every person seeking NDIS support.

Enablers to care

Four key themes emerged as enablers to care during the pandemic. These included: (1) access to technology, (2) communication, (3) flexibility, and (4) system and organisational response. Smaller themes identified included (1) partnerships and relationships, (2) bulk-billing services, and (3) access to PPE. Figure 5 illustrates the themes identified, and the proportion they represent, as they relate to Objective 5 of the Project. Each key theme is described in more detail below while the smaller themes are summarised in **Appendix 10.**

Figure 5: Themes - Enablers to care



Access to technology

The transition to telehealth was easy for those who were already familiar with the technology and had access to a laptop and phone. However, others required a range of supports such as training and financial assistance to help with the transition. The transition to telehealth was supported in a number of different ways: for example, tablets were provided by the Queensland Government or the NDIA to eligible recipients, some organisations used brokerage to purchase equipment for people accessing their services, and in some instances community organisations helped out.

Services also found it necessary to provide training and support to their staff. In general, the education included software training and instruction on online protocols and how to engage people online (compared to face-to-face). Services that supported their staff and provided training found that staff felt more confident in their work during the pandemic. Many service providers commented that working from home improved productivity because it saved time (e.g., travel time to meetings).

Communication

Most providers were conscientious in communicating the service changes to people accessing their service and contacted them directly within a few days of lockdown. As already mentioned, organisations that had good outreach and communications in place before COVID-19 adapted well. Many services kept in touch with people accessing their service via text messages, regular phone calls and emails to provide the latest updates on COVID-19 and information about how their services were changing to keep people safe and how to access them. Some providers quickly set up private Facebook groups which worked as a means of giving out information as well as enabling people accessing these services to stay in touch, while others wrote letters and did letterbox drops for people who did not have a phone or internet access. These initiatives also worked as an additional form of support and risk assessment. It was especially important to maintain communications with at-risk groups such as CALD communities, the homeless, and Aboriginal and Torres Strait Islander populations. Regular communication served to reassure people and reduce feelings of isolation.

It was also important for organisations to look after their staff and ensure they stayed connected – for example, setting up communication channels for checking in and discussion forums to share resources and information, introducing group supervision, and sending out regular communiqués. Service providers were in constant contact with Queensland Health, enabling rapid response to any new information or health advice that they could pass on as appropriate.

Flexibility

The lockdown and accompanying switch to telehealth triggered huge changes and innovations in previously accepted models of care. Some service providers felt they had a licence to be creative and have been able to respond better to the needs of people accessing mental health services as a result. Many of the changes and innovations introduced at this time have been retained precisely because they have given flexibility and choice.

> **"Online should be complimentary, not the only option available."**
>
> [Comment from mental health service provider]

Some participants noted that wait times have been significantly reduced or eliminated, providers have been able to contact people directly by phone, daily or weekly call-backs have been introduced, and accessibility of services has improved, although this was not everyone's experience (see **Barriers to care**). One factor in reducing wait times has been that resources were moved to telephone and online chat services, and in some cases, volunteers continued in different roles and were able to assist with providing extra phone services.

Service providers have emphasised the benefits of adapting to individual needs and preferences and allowing choice, especially where people have previously experienced barriers to access (e.g., due to physical disability or transport costs). Having the option of telehealth has also created flexibility of time in that people have been able to talk to their service provider out of hours or at weekends and in some instances were able to contact them directly. Equally, the changes have highlighted the importance of giving choice of access when face-to-face is the better or only option.

> **"Give people as much choice and control as you can."**
>
> [Comment from a person who accesses mental health services]

System and organisational response

The COVID-19 restrictions required rapid response, leadership and teamwork to enable service providers to continue delivering mental health services and supports. On reflection, service providers recognised the system response, led by the government, enabled them to be innovative, adaptive and responsive in meeting the needs of people accessing mental health services and those supporting them.

At an organisational level, leadership and teamwork further enabled services to overcome many challenges. One service provider noted that there was a sense of collective responsibility among staff that helped to create a positive team environment while working remotely. Another service provider noted how coordinating all the changes was a huge challenge but was amazed at how everyone came together. One mental health service established a COVID-19 Response Group which was very effective in identifying any difficulties being experienced both by individual staff members and people accessing the service.

Section 4: Discussion

Key points

- While telehealth provided a safe means for mental health services and supports to continue during the pandemic, there remains a preference for face-to-face service delivery.
- The wider implementation of telehealth across the mental health service system is likely to benefit service providers and people accessing these services. However, telehealth should only be seen as one of a range of options.
- Training and supervision in digital mental health must be integrated into mental health services and training programs.
- Financial support and training to support people to access telehealth is needed.
- Service providers must be responsive to individual needs and preferences as well as a person's capacity to access and use technology, severity of symptoms and risk of harm.
- Initial contact should be face-to-face to enable a trusting therapeutic relationship to develop.
- Privacy is likely to remain a concern.

The overall aim of the Project was to map the specific changes that have occurred across the mental health service system through both the initial and longer-term impact of the COVID-19 pandemic across the Brisbane South region, and to understand people's experiences of these changes. This section of the report presents a review and discussion of the main findings to inform the recommendations.

4.1 Service delivery changes

The pandemic, especially during lockdown, presented many challenges. Yet, at the same time, it has transformed the way mental health services and supports are delivered. The Project found that mental health services in the Brisbane South region primarily shifted to providing services via telehealth, in place of face-to-face, to maintain service delivery. With COVID-19 restrictions enforced, including multiple lockdowns and social distancing requirements, this finding is not surprising (Queensland Government, 2020a). The available literature similarly outlines how mental health services, in Australia and overseas, rapidly moved services to be delivered virtually during the pandemic (Barr et al., 2020; NSW Ministry of Health, 2021; Reay et al., 2020).

Consistent with the findings of the Project, other studies show the mode of telehealth service delivery varied, with telephone and videoconferencing options (e.g., FaceTime, Zoom and Skype) commonly

used during the pandemic (Productivity Commission, 2020). Unpublished data from Queensland Health, based on summary statistics of mental health activity in the Metro South region of Queensland Health (Bayside, Logan-Beaudesert, Princess Alexandra Hospital) between December 2019 and December 2020 indicate there was an almost 60% increase in the number of people receiving care by telephone in that period. This mode of service delivery was described by many Project participants, although quantitative data was not collected. The Project found mental health services were also delivered via text, web chat, WhatsApp and Facebook Messenger, but often in addition to telephone or videoconference – a practice reflected in recent literature (Monaghesh & Hajizadeh, 2020; Nicholas et al., 2021).

While telehealth provided a safe means for mental health services and supports to continue during the pandemic, a recent study published by Orygen, the National Centre of Excellence in Youth Mental Health, identified a preference for face-to-face service delivery (Nicholas et al., 2021). This is consistent with the findings of the Project.

What worked well

Prior to the pandemic, telehealth was used sporadically to delivery mental health services and supports across Australia. The Project identified some services in the Brisbane South region that already utilised telehealth as a means of providing mental health services and supports to their clients. However, for the majority, COVID-19 accelerated the implementation of telehealth to maintain service delivery. With this has come greater flexibility and choice in how people access mental health services, and despite variations in preference (face-to-face vs. telehealth) and access to technology noted in the Project findings, the wider implementation of telehealth was identified as a key enabler to care during the pandemic. A recommendation to fund wider access to online treatment options is included as Recommendation 11 of the Productivity Commission (2020), following submissions by mental health peak bodies across Australia (e.g., Australian Psychological Society, National Mental Health Commission, NSW Council of Social Services, Centre for Mental Health Research, Mental Health Victoria, Victorian Healthcare Association). The Report emphasises that it is important to note that telehealth should only be seen as one of a range of options and cautions further that "consumers should still have the choice of other treatment methods (such as face-to-face therapy) . . . [and] . . . that supported online mental health treatment should be one choice among a range of treatment options" (Productivity Commission, 2020, p. 494). The importance of giving people choice in how they access health care, combined with careful oversight of digital programs, is echoed by Mental Health Victoria and the Victorian Healthcare Association in their submission to the Productivity Commission: "Digital consultations cannot be seen as the panacea for filling gaps in a stretched system. . . . We

welcome the PC's requirement that online treatment programs have a strong evidence base and suggest that online treatment programs should be available for consumers only as an alternative to direct consultations with a practitioner or counsellor, rather than as a substitute" (Mental Health Victoria & Victorian Healthcare Association, 2020, p. 8). The Project findings support this view that choice is valuable when it comes to the mode of service delivery, while also indicating that the wider implementation of telehealth across the mental health service system is likely to be of benefit both to service providers and people accessing these services.

The use of technology to deliver services virtually has demonstrated its potential to overcome traditional barriers to care. The Project found telehealth improved access in various ways. For example, people unable to leave their home due to disability or caregiving responsibilities were now able to access mental health services virtually. Furthermore, access to telehealth saved travel time and removed some existing financial barriers (e.g., travel costs). These findings are very similar to that of a recent Australian study reviewing the transition to telehealth during COVID-19. In a survey which aimed to identify key factors to consider when determining whether to offer telehealth in the future, Nicholas et al. (2021) found that telehealth can help young people overcome barriers such as access to transport, travel time, financial obstacles, health issues, significant mental health symptoms, caregiving responsibilities and crises such as homelessness. While this study captures the perspective of service providers, it is limited to the views of young people accessing mental health services. The Project findings add to this knowledge by capturing the experiences of other population groups, including CALD, LGBTIQ+, people living with a disability/chronic illness, and those living in regional areas. The Productivity Commission reports that telehealth has improved access for people living in regional and remote areas (Productivity Commission, 2020). In addition, there is growing international evidence supporting the delivery of mental health services via telehealth to overcome existing barriers. For example, in a recent UK study, Johnson et al. (2021) surveyed mental health care staff to explore the impact of COVID-19 on mental health care and people accessing mental health services and identified improved access for people who experienced challenges with travel and public places as a key factor among the benefits of telehealth. Further, a systematic review conducted prior to the pandemic exploring the association of telehealth and patient satisfaction found reduced travel time as one of the key factors relating to effectiveness and efficiency in service delivery (Kruse et al., 2017). The Project findings add to these results and reinforce the potential for telehealth to improve access to mental health care by reducing traditional barriers to care.

There is considerable evidence that telehealth works for many people. The Project found that virtual delivery of mental health services enabled people to feel more relaxed, and as a result, they opened

up more during a therapy session (compared to the traditional clinical setting when meeting face-to-face). This was noted by both service providers and people who access mental health services, and those who support them. There is some evidence to support this notion. For example, Mozer et al. (2008) suggest that having therapy sessions at home, in privacy, may ease worries about stigma related to mental health care. The Productivity Commission (2020) highlights research claiming that telehealth (e.g., psychological therapy delivered by videoconference) can be equally as effective as face-to-face, and moreover, that psychological therapy delivered by phone was also just as effective in the treatment of depression and may be as effective as face-to-face more generally. Some other studies, which are limited due to small sample sizes, also suggest that psychiatric services via videoconference and/or telephone are equivalent to face-to-face. Ultimately, decisions about what mode is best need to be made by the individuals involved.

For many service providers, the rapid transfer to virtual mental health service delivery in response to COVID-19 was their first experience of delivering digital therapy. One of the key enablers to care identified in the Project findings was the training and support given to service providers, including software training and instruction on online protocols and how to engage people online (compared to face-to-face). The importance of training, including how therapy may need to change when provided virtually, is well recognised (see, e.g., Barr Taylor et al., 2020; Nicholas et al., 2021), and specific recommendations on the use of telehealth in specific clinical contexts are being developed (Waller et al., 2020). With many service providers continuing to offer virtual therapy after restrictions eased, allowing face-to-face consults, it is important for training and supervision in digital mental health to become integrated into mental health training programs and for overseeing bodies to consider adding this as a necessity.

What didn't work well

The online environment is not always suitable. The Project findings revealed telehealth is not an appropriate environment for certain types of therapy, and these are strongly supported in the literature. For example, Nicholas et al. (2021) notes that telehealth is inappropriate for people with complex problems or acute symptoms, or for people experiencing suicidality or transitioning from hospital. This is echoed in other literature which highlights telehealth may not be suitable for clients with severe mental illness such as schizophrenia (Reay et al., 2020). The Project also found telehealth was considered inappropriate by some clinicians (e.g., face-to-face is necessary for doing NDIS assessments and mental health care plans, and certain types of therapy). While digital therapy may not be suitable for some, it may offer others a graded step in receiving care (Nicholas et al., 2021; Reay et al., 2020). The available evidence, together with the Project findings, highlight the need for service

providers to assess individual needs and preference for digital therapy as well as the person's capacity to access and use technology, severity of symptoms and risks of harm.

Access to technology, including devices, data and internet was identified as a key barrier to virtual mental health care, primarily for people accessing mental health services. Recent studies suggest similar findings. For example, Kopelovich et al. (2021) looked at telehealth in community mental health settings to identify practical strategies for improving care for people with serious mental illness during the pandemic. Published during the early stages of COVID-19, this paper suggests people may not have access to appropriate data plans or the software or hardware required for telehealth. The Project findings reveal this is similarly the case in the Brisbane South region. A more recent study, a survey designed in collaboration with seven Australian community mental health organisations, explored how people engaged with services during COVID-19 and their experiences (Flourish Australia et al., 2020). While a third of participants reported no challenges associated with using online platforms, including videoconference and text, almost 38% described internet connection as a challenge. Further, Nicholas et al. (2021) identified the most common technological difficulties experienced by young people were poor platform usability, internet connectivity, access issues and challenges around IT literacy and support. As described in the findings of this Project, the lack of access to technology may have been a factor in causing some people to disconnect with the mental health system during the height of the COVID-19 restrictions.

Protecting the privacy of interactions during virtual therapy is a key concern and barrier. The Project findings highlight privacy concerns with online formats, platforms, and environment (e.g., access to a safe, private space). The literature similarly highlights privacy and confidentiality concerns that continue to affect or constrain the use of digital mental health services (PricewaterhouseCoopers, 2020). For example, Nicholas et al. (2021) found limited space, shared living and homelessness were clear barriers, especially for young people, emphasising the importance of a safe private space. Furthermore, a systematic review of research articles published since 2000 to explore the potential of telehealth as an effective alternative to traditional in-person mental health services found information privacy to be a key challenge (Langarizadeh et al., 2017). In Australia, there are standards as well as legislation to promote and protect the privacy of individuals receiving virtual mental health care. For example, the Privacy Act 1988 sets out the Privacy Principles that digital mental health providers operating within the mental health service system must observe (PricewaterhouseCoopers, 2020), while the *National Safety and Quality Digital Mental Health* (NSQDMH) *Standards*, released by the Australian Commission on Safety and Quality in Health Care in 2020, aim to "improve the quality of digital mental health service provision, and to protect service users, and their support people from

harm" (Australian Commission on Safety and Quality in Health Care, 2020, p. 4). One of the three standards, the Clinical and Technical Governance Standard, covers safe environment, including the privacy, transparency, security and stability of digital systems. The NSQDMH Standards are complementary to existing legal obligations. Even with protections in place, Barr Taylor et al. (2020) suggests privacy should remain a concern as it is near impossible to guarantee privacy of digital platforms. These findings support the need to provide people with choice regarding mode of delivery, and ensure effective protocols and procedures are implemented to protect the privacy of those involved – people accessing mental health services and the service provider.

Another factor identified as a barrier to virtual mental health care was the difficulty of building trust and rapport without face-to-face connection. Recent research has also found that communication and building trust over telehealth is challenging (Flourish Australia et al., 2020; Reay et al., 2020), particularly with clients who may experience paranoia (Kopelovich et al., 2021). Nicholas et al. (2021) found that young people reported the shift to telehealth had not impacted their existing relationship with their clinician; however, they noted it may be more difficult to establish trust and rapport with young people via telehealth. This is consistent with the Project findings, suggesting that initial contact should be face-to-face, at the very least, to allow the therapeutic relationship to develop.

4.2 Limitations

The main limitation of this Project is the retrospective nature of some of the consultation questions which may be prone to recall bias.

While a diverse range of people were involved in this Project, no one who accesses (or supports someone accessing) a mental health service identified as Aboriginal and/or Torres Strait Islander. A recommendation for future work is to draw on the stories of Aboriginal and Torres Strait Islander peoples in the Brisbane South region to understand their experiences of the changes across the mental health service system through both the initial and longer-term impact of COVID-19.

Section 5: Conclusion and recommendations

COVID-19 provided a catalyst for rethinking the way mental health services are delivered. This Project has identified the specific changes that have occurred across the mental health service system through both the initial and longer-term impact of COVID-19 across the Brisbane South region, and explored people's experiences of these changes. In general, mental health services across the Brisbane South region have shown resilience in the face of uncertainty, with most providers adapting services and programs to be delivered online within days of the imposed lockdowns. While face-to-face appeared to remain the preferred way to deliver services, the move to virtual service delivery has opened up opportunities for innovation, leading to improved access to services. Barriers to care have also emerged during this time, including poor internet connectivity, poor IT skills and limited access to devices, while communication and choice have been key enablers to care.

This Project adds to the growing body of evidence supporting the delivery of mental health services via telehealth. The literature – both here in Australia and from across the world – has already shown that the wider implementation of telehealth across the mental health service system is, on balance, likely a benefit, both to service providers and to people accessing these services and those who support them. However, it is important to note that telehealth should only be seen as one of a range of options and continue to be an additional way for people to access mental health services and supports.

QAMH presented the key Project findings and draft recommendations at a Project Launch Event held on 23 June 2021. Attendees, including representatives from Queensland Health, the Queensland Mental Health Commission and Brisbane South PHN, discussed what needs to happen next, and who needs to be involved. Feedback received was integrated into the recommendations presented in this report.

While the Project focused on the Brisbane South region, the available national and international literature suggests these recommendations share relevance to the wider Queensland mental health service system.

Project recommendations:

1. Integrate telehealth into the mental health service system with consideration of the following:
    - The flexible integration of telehealth into funding contracts and performance reporting to support choice for people who access mental health services and those who support them.
    - Ensure best-practice standards (including privacy and confidentiality), and support for service providers (such as guides and training programs).

2. Reduce existing barriers to using telehealth and other online services, including access to devices and data.
3. Develop telehealth guides to support uptake from people accessing mental health services. These should be co-designed with people who access mental health services and those who support them.
4. Support ongoing evaluation of the effectiveness of telehealth across the mental health service system. This should include measuring effectiveness from the perspective of both service providers, and people who access mental health services and those who support them.
5. Engage with other sectors (e.g., education and housing) to identify successful service delivery changes and innovations during COVID-19 that may be relevant to the mental health sector.

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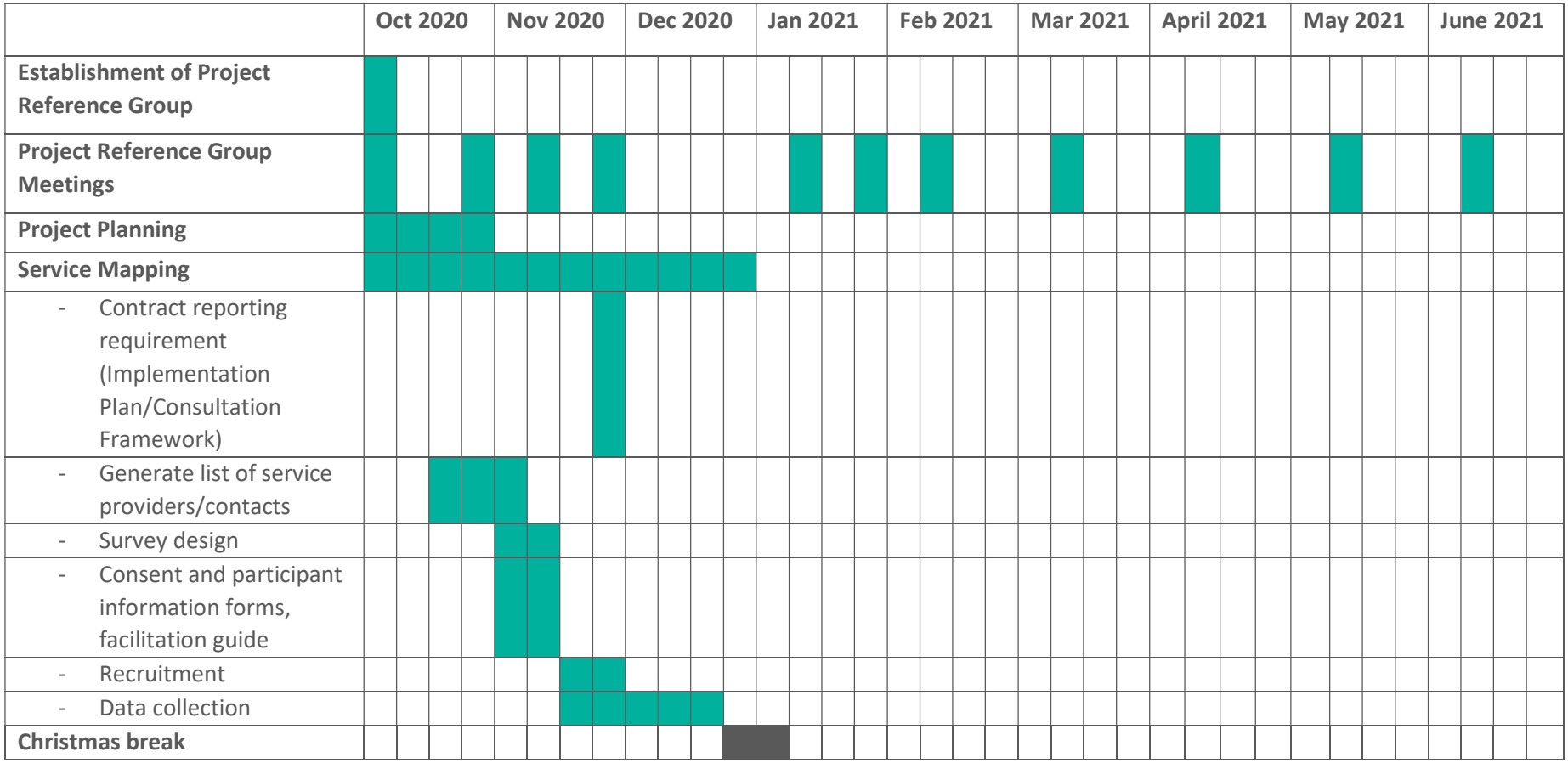
Appendices

Appendix 1: Project timeline



	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	April 2021	May 2021	June 2021
Consultations with people who access mental health services and those who support them									
- Design survey/interview questions									
- Consent and participant information forms, facilitation guide									
- Recruitment (focus groups, interviews)									
- Promote survey									
- Consultation (focus groups, interviews)									
Data analysis and report									
Thematic analysis: - familiarisation - coding - generating initial themes - reviewing themes - defining and naming themes									
- Draft report and recommendations									
- Final report									
Project launch event									

Appendix 2: Service provider consultation questions

1. What is your job title?
2. Can you briefly describe your role?
3. Which of the following describes the types of services delivered? (Tick all that apply)

Brisbane South PHN funded programs

- ☐ Brief psychological interventions
- ☐ Low intensity and/or mild to moderate mental health services
- ☐ Severe and complex mental health services
- ☐ Social and emotional wellbeing services
- ☐ Child and youth mental health
- ☐ Suicide prevention services
- ☐ Alcohol and other drugs treatment services

Services provided by Metro South Addiction and Mental Health Services

- ☐ Acute Care Team (including Emergency Dept mental health)
- ☐ Access/Triage/1300MHCALL services
- ☐ Acute inpatient services (child and youth, adult, older adult)
- ☐ Community mental health services
- ☐ Community bed-based services (CCU, Step up/step down (Adult or Youth), Youth Residential)
- ☐ Community child and youth mental health
- ☐ Alcohol and other drugs treatment services
- ☐ Step up step down

Services Funded by Queensland Health delivered by NGOs

- ☐ Mental Health Community Support Services:
  - Individual Recovery Support
  - Individual Peer Support
  - Group Based Peer Support
  - Transition from Corrections
  - Individuals at Risk of Homelessness Program
- ☐ Clubhouses

- ☐ Aboriginal and Torres Strait Islander social emotion wellbeing program
- ☐ Support services for culturally and linguistically diverse populations
- ☐ Step up step down

Services funded by Children's Health Queensland

- ☐ Hospital Based Teams (including acute response teams, adolescent mental health unit, child mental health unit and consultation liaison)
- ☐ Community based teams (including Inala, Mount Gravatt and Yeronga Child and Youth Mental Health Service)
- ☐ Day Program (South)
- ☐ Telepsychiatry
- ☐ Youth residential rehabilitation unit
- ☐ Speciality teams

4. **NDIS Support Services**
   - ☐ Yes
   - ☐ No

5. **If yes, what type of NDIS service supports are provided [select all that apply]**
   - ☐ Core Supports (a support that helps a participant complete daily living activities)
   - ☐ Capacity Building Supports (a support that helps a participant build their independence and skills).
   - ☐ Capital Support (a support for an investment, such as assistive technologies, equipment and home or vehicle modifications, or funding for capital costs. E.g., to pay for Specialist Disability Accommodation).

6. **Who is the target cohort for your service? [select all that apply]**
   - ☐ LGBTIQ+
   - ☐ Culturally and linguistically diverse people
   - ☐ Aboriginal and Torres Strait Islander people
   - ☐ People living with a disability *(including intellectual, physical, psychosocial, psychiatric)*
   - ☐ Older Persons (65 years and over)
   - ☐ Adults (18 to 64 years)

- ☐ Child and Youth (0-18 years)
- ☐ Youth (16-24 years)
- ☐ People living in regional areas
- ☐ People living in rural and remote
- ☐ Other (please specify)

Height of COVID-19 restrictions

7. Thinking back to the height of when COVID-19 restrictions were in place (from March 2020), what specific practice changes were made? *[For example, changes to mode of delivery or scope of service]*
   a) Can you outline why these practice changes needed to be made?
   b) How was the decision made about what sort of service/s would be useful?

      Probe:

      - Recognising that there was limited time to make changes to services, did you have an opportunity to consult/involve people using the service/system?
      - To what extent were the suggestions/challenges identified implemented?

8. Can you describe your experience of these changes?

9. What barriers were overcome to enable new practice changes to be introduced in a short timeframe?
   a) What training/support was provided to service providers to implement changes?
   b) What training/support was provided to people who access mental health services, and those who support them, to respond to changes?

10. What practice changes **worked and why?** Can you describe the circumstances?
    a) From your perspective, what practice changes **worked** for people accessing this service, and those supporting them? Why?
    b) What evidence, if any, does the service have for the success of these changes?

11. What practice changes **didn't work well?** Can you describe the circumstance?
    a) From your perspective, what practice changes **did not work well** for people accessing this service, and those supporting them? Why not?

12. Were any **new services** implemented as a result of extra funding being made available at this time?
    a) How was the decision made about what sort of service would be useful?
    b) Describe any new service/s and what worked/did not work so well.
    c) From your perspective, what new service/s **did/did not work** for people accessing this service, and those supporting them? Why/Why not

Present day

COVID-19 restrictions have since eased, and we are adapting to our "new normal".

13. What practice changes have you kept and why?
    a) What improvements would/are you making to this?
    b) What are the barriers to maintaining these?

14. What other opportunities are emerging that you have not yet been able to act on?

15. In hindsight, what would you have done differently?

Future

Despite the challenges, innovation ideas and practice changes may present new opportunities for the delivery of mental health services post pandemic.

16. What are your ideas for the future?

17. What priorities and recommendations should inform decision making for the "new normal" of the mental health sector in the Metro South Region?
    a) Should restrictions come into place again, what should be prioritised? Have you made plans for potential future outbreaks?
    b) What are the key learnings you would take from this experience?

18. Do you have any other feedback you would like to provide?

Appendix 3: Service provider consultation promotion

Mental Health System Changes: Experiences of COVID-19 Project

About the Project

Queensland Health has funded the Queensland Alliance for Mental Health (QAMH) to undertake the Mental Health Service System Changes: Experiences of COVID-19 Project. This Project seeks to understand and map the specific changes that have occurred across the mental health service system and how these decisions were made, through both the initial and longer-term impact of COVID-19. It specifically seeks to understand the experiences of people who access mental health services and those who support them, as well as understanding the perceptions of care from the service providers viewpoint.

The Project aims to:

- Map out the specific service delivery changes and identify new models of care that have emerged across the mental health service system throughout COVID-19, particularly the increase in use of virtual models of care.
- Understand the experience of people who access mental health services and those who support them, and service providers in relation to these changes.
- Understand which changes have been effective and in what circumstances these have been effective.
- Identify practice changes that have not been useful and in what circumstances these have been unsuitable.
- Identify any barriers and enablers to care during the COVID-19 pandemic.
- Make recommendations to the Mental Health and Alcohol and Other Drugs Branch (MHAOD) on findings of the project and recommendations for future suitable service models.

Your opportunities to be involved!

Consultation with service providers (2020)

We are undertaking interviews (virtual or face-to-face) with services and practitioners across the mental health service sector in the Metro South region to understand their views in relation to the effectiveness of these changes.

It is anticipated the interview will take **up to 30 minutes** and will take place between **Monday 16 November to Friday 18 December 2020.**

Consultations with people accessing mental health services (2021)

To understand the experiences of people who access mental health services and those who support them, we are facilitating online focus groups (up to 2-hours with 6-10 participants) and individual interviews (up to 1-hour). **Remuneration will be provided.**

These consultations will take place between **January to March 2021.**

To register your interest, or for more information, please contact Project Lead, Leanne Kelly via LKelly@qamh.org.au or 07 3394 8480.

Appendix 4: Email invitation to service providers

Subject Title: Invitation – Mental Health Service System Changes: Experiences of COVID-19 Project.

Good morning *[enter name],*

I would like to invite you, or someone from your team at *[service provider name],* to participate in an interview (virtual or face-to-face) to understand your views to practice changes that have occurred and how these decisions were made, through both the initial and longer-term impact of COVID-19.

About the Project

Queensland Health has funded the Queensland Alliance for Mental Health (QAMH) to undertake the Mental Health Service System Changes: Experiences of COVID-19 Project.

The project is being delivered through a partnership between QAMH, Health Consumers Queensland (HCQ), Metro South Addictions and Mental Health Services (MSAMHS) and the Brisbane South PHN as a pilot which can be adapted to consider regional differences in approach.

The project aims to:

- Map out the specific service delivery changes and identify new models of care that have emerged across the mental health service system throughout COVID-19, particularly the increase in use of virtual models of care.
- Understand the experience of people who access mental health services and those who support them, and service providers in relation to these changes.
- Understand which changes have been effective and in what circumstances these have been effective.
- Identify practice changes that have not been useful and in what circumstances these have been unsuitable.
- Identify any barriers and enablers to care during the COVID-19 pandemic.
- Make recommendations to the Mental Health and Alcohol and Other Drugs Branch (MHAOD) on findings of the project and recommendations for future suitable service models.

Your opportunity to be involved

QAMH is undertaking interviews (virtual or face-to-face) with services and practitioners across the mental health service sector in the Metro South region to understand their views in relation to the effectiveness of these changes, and perceptions of care.

It is anticipated the interview will take approximately **30 minutes** and will take place between 8am and 4pm on a weekday **before 18 December 2020.** If you are unable to participate in an interview, there is an opportunity to provide feedback via an online survey. The online survey will close 31 December 2020.

The **Participant Information Sheet and Consent Form** is attached for more information.

If you are interested in participating or have any questions, please contact me.

Appendix 5: Service provider participant information sheet and consent form

Participant information sheet

Please note: This Participant Information Sheet is to be read together with the Consent Form.

Queensland Alliance for Mental Health (QAMH) invites you to participate in an interview or online survey to understand the specific changes that have occurred across the mental health service system and how these decisions were made, through both the initial and longer-term impact of COVID-19.

Queensland Alliance for Mental Health

QAMH is the peak body for the community mental health and wellbeing sector in Queensland. The QAMH reforms, promotes and drives community mental wellbeing service delivery for all Queenslanders, through its influence and collaboration with its membership and its strategic partners.

About the Project

Funded by the Mental Health Alcohol and Other Drugs Branch, the *Mental Health Service System Changes: Experiences of COVID-19* Project seeks to understand and map the specific changes that have occurred across the service system and how these decisions were made, through both the initial and longer-term impact of COVID-19. It specifically seeks to understand the experiences of people who access mental health services and those who support them, as well as understanding the perceptions of care from the service providers viewpoint.

Purpose of the consultation

QAMH is conducting a retrospective mapping of service model changes that occurred from the imposed lock down (March 2020) period up until the present day through consultation with service providers and practitioners across the mental health service sector in the Metro South region. The views of service providers in relation to the effectiveness of these changes will be sought throughout this mapping process.

Consultation process

The Project Lead, Leanne Kelly, and the project team are conducting interviews via videoconference or face-to-face (if safe to do so). Alternatively, there is an opportunity to participate in this consultation by completing an online survey.

The interview/online survey is expected to take approximately **30 minutes**, depending on how much information you provide. Interviews will take place between 8am and 4pm on a weekday before **18 December 2020.** The online survey will close **31 December 2020.**

Personal information such as your name and contact information will be collected for the purposes of administering the consultation and will be handled in accordance with the privacy policy of QAMH, which is available on request.

Voice recordings of the interview will be made. The voice recording will be kept securely until information is analysed. All information about participants, health practitioners, staff, people who access mental health services and those who support them, will be de-identified in the final report. All recordings will be destroyed once the information has been analysed (July 2021).

All responses will be anonymous and confidential. All information you contribute will be analysed thematically with other responses and only prominent themes will be reported. In the case that a quote is reported, any identifying details will be altered to maintain confidentiality of participants. QAMH will invite you to be notified when the final report is available and receive a copy.

Your participation in this consultation is voluntary. You can withdraw consent at any time. Your relationship with QAMH or other organisations that sit on the Project Reference Group will not be affected by your decision. Sharing your experiences and knowledge may benefit others and lead to improvements to mental health services in the Metro South region and across Queensland.

Questions

If you have any questions about the information contained in the Participant Information Form, or the Consent Form, please contact:

Leanne Kelly
Project Lead
QAMH
Email: LKelly@qamh.org.au
Phone: 07 3394 8480

Sarah Childs
Director of Engagement
and Partnerships, QAMH
Email: schilds@qamh.org.au
Phone: 07 3394 8480

Consent form

This consent form tells Queensland Alliance for Mental Health that you:

- Have read or discussed information about taking part in an interview or survey; and
- Agree to take part in an interview or survey.

I agree that Queensland Alliance for Mental Health may audio-record the interview:

Yes ☐ No ☐ N/A (if completing survey online)

Signing below indicates you agree. Your name will not be made public. We ask for your name so that there is a record of your agreement to take part. This form will be filed separately to the record of your interview.

Name: _____

Signature: _____

Date: _____

If you would like to receive a copy of the final report (July 2021) please provide your contact details below.

Email: _____

Appendix 6: Consultation questions: people who access mental health services and those who support them

Below is an outline of the questions we may ask during your interview or focus group.

The questions are divided into three parts:

- Part 1: asks about your experience during the initial lockdown, March to June 2020.
- Part 2: asks about your experience of services and service delivery from July 2020 to the present, in the "new normal".
- Part 3: asks about the future.

We value your contribution to this project and your perspective on services and service delivery in the Brisbane South region according to your experience. Your input will help us to develop recommendations for improvements to the mental health system in the Brisbane South region and across Queensland.

PART 1: March – June 2020

1. **Thinking back to last year, between March to June, when everyone was in lockdown, what changes did you experience in the way services and supports were delivered?**
    a. How were you told about the changes to services and support programs during lockdown?
    b. Did you discuss with your service provider how these changes could work for you? **Y/N**
    c. Were you able to choose how you could access services and supports? **Y/N**
        - If yes, what choices did you have?

2. **Describe your experience of the changes to services and supports during lockdown.**
    a. Did you continue to get the services and supports you needed during lockdown? **Y/N**
        - What were the reasons?
    b. Were you able to contact your service provider as required? **Y/N**
        - How did this make you feel?
    c. What other type of support did you have during this time?
        - Did you rely more on them/those supports during lockdown?
        - Were they/was that helpful?

3. **What (*other*) barriers (or problems) did you experience with accessing services?**
    a. Were you able to access mental health services at all during this time? Y/N

- If yes, was this a new service or continuing a service from before?

b. Were services and supports easy for you to access? Y/N
    - What were the reasons?

c. What assistance (if any) were you given to help you overcome any issues with accessing services and supports?

d. Was the assistance helpful? **Y/N**
    - What did you find most useful?
    - How could it have been improved?

4. **What *(other)* changes to services and supports worked well for you? Please explain.**

5. **What *(other)* changes to services and supports did not work well? Please explain.**

6. **Overall, is there anything else that you feel would have improved your experience of the changes to services and supports during lockdown?**

PART B: July 2020 – today

7. **Looking back on the changes to services and supports that occurred during lockdown, what changes are still in place today?**
    a. What changes to services and supports would you like to keep?
    b. Can you suggest any improvements, or anything that could be done better?
    c. Have you had an opportunity to provide feedback to inform improvements? **Y/N**
        - If yes, how did you give feedback?

8. **Looking back, what do you think could have been done differently to improve service delivery during the pandemic?**
    a. Can you think of anything such as a service or support program that would have been helpful but was not available?
    b. What would this service look like?

PART C: Future

9. **If restrictions are put in place again, do you feel confident that you will be able to access the services and supports you need?** Y/N

1. Why/why not?

10. Has there been a stand-out lesson from this experience that you would like to share?

11. What would you want to see prioritised to inform the mental health system going forward?

a. Are there any new services that you would like to have in the future?

12. Do you have any other feedback you would like to provide?

Appendix 7: Consultation promotion: people who access mental health services and those who support them

Mental Health Service System Changes: Experiences of COVID-19 Project

Expression of interest: Focus groups and interviews

Seeking input from people who access mental health services, and those who support them, on their experiences of the changes that have occurred across the mental health service system in the **Brisbane South region** due to COVID-19.

The Project is being delivered through a partnership between QAMH, Health Consumers Queensland (HCQ), Metro South Addictions and Mental Health Services (MSAMHS) and Brisbane South PHN.

Queensland Health has funded the Queensland Alliance for Mental Health (QAMH) to undertake the Mental Health Service System Changes: Experiences of COVID-19 Project.

Opportunities to be involved

To understand the experiences of people who access mental health services in the Brisbane South region, and those who support them, QAMH are conducting focus groups, individual interviews, and an online survey. Participants will **only be asked about their experiences of service delivery changes** and will **not** be asked any questions about their health.

Focus groups

Focus groups will be held during **February and March 2021**. Each focus group will have 6 – 10 people and go for **up to 2 hours.**

The focus groups will be facilitated by Leanne (Project Lead) and/or Tina (Lived Experience Advisor).

The focus groups will be online (e.g., via Zoom) or face-to-face.

Participants will be remunerated **$80** for their time and contribution to the Project.

Individual interviews

Individual interviews will also be **February and March 2021.**

The interviews will be conducted by Leanne (Project Lead) or Tina (Lived Experience Advisor). It is anticipated that each interview will take **30 – 60 minutes.**

The individual interviews will be conducted over the telephone, via videoconference, or face-to-face (if safe to do so).

Participants will be remunerated **$40** for their time.

Please note: There are limited opportunities to participate in the focus groups **or** individual interviews. People will be invited to attend based on the information provided in the expression of interest form. This is to ensure diversity in experiences across the Brisbane South region.

Online survey

Another option to participate in the Project and to share your views and experiences is to complete an online survey.

The survey will take approximately 30 – 60 minutes to complete, depending on how much information you choose to provide. You can access the online survey here. Completing the survey is voluntary. The survey will close on **31 March 2021.**

To express interest

If you are interested in participating in a **focus group or individual interview**, please click here to submit an expression of interest online, or complete the form and email to Leanne Kelly, LKelly@qamh.org.au, as soon as possible.

Questions

If you have any questions or would like any more information about the above opportunities to be involved please contact Project Lead, **Leanne Kelly**, on **07 3394 8480** or email LKelly@qamh.org.au.

Appendix 8: Expression of interest form – focus groups and individual interviews

Contact Information

***Name:** _____

***Email:** _____

Preferred phone number: _____

Postcode: _____

Do you identify with any of the following groups? [Please tick all that apply]

- ☐ LGBTIQ+
- ☐ Culturally and linguistically diverse (CALD)
- ☐ From a non-English speaking background
- ☐ Living with a disability/chronic condition
- ☐ Living in a rural/remote area in the Brisbane South region
- ☐ Prefer not to answer
- ☐ Other (please specify)

_____

Do you identify as Aboriginal and/or Torres Strait Islander?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

Do you identify as:

- ☐ Someone who accesses mental health services
- ☐ Someone who supports a person who accesses mental health services
- ☐ Both
- ☐ Prefer not to answer

Age Range:

- ☐ 17 or under
- ☐ 18 to 24 years
- ☐ 25 to 34 years
- ☐ 35 to 44 years
- ☐ 45 to 54 years
- ☐ 55 to 64 years
- ☐ 65 years or older
- ☐ Prefer not to answer

Did you, or someone you support, access a mental health service in the Brisbane South region between March and June 2020?

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Prefer not to answer

Did you, or someone you support, access a mental health service in the Brisbane South region between July 2020 and now?

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Prefer not to answer

What type of mental health service/s did you access during this time? [Please tick all that apply]

- ☐ **Public mental health services** *(provided in a hospital ward or in the South Brisbane, Logan or Redlands community)*
- ☐ **Private mental health services** *(provided through private practice and inpatient care with private hospitals)*
- ☐ **Supports provided in the community** *(include individual and group-based community mental health support, peer-support, family and carer groups)*

- ☐ Not sure
- ☐ Prefer not to answer

Additional Comments:

Which consultation opportunity are you interested in?

- ☐ Individual Interview
- ☐ Focus Group
- ☐ Both (please indicate your preference)

How would you like to participate? [Please tick all that apply]

- ☐ Telephone
- ☐ Videoconference (e.g., Zoom)
- ☐ Face-to-face (if safe to do so with COVID-19 restrictions)

What weekdays/times are you generally available between now and March 2021? [Please tick all that apply]

Please note: Focus groups and interviews will take place between 8am and 4pm on a weekday.

- ☐ Monday (morning)
- ☐ Tuesday (morning)
- ☐ Wednesday (morning
- ☐ Thursday (morning)
- ☐ Friday (morning)
- ☐ Monday (afternoon)
- ☐ Tuesday (afternoon)
- ☐ Wednesday (afternoon)
- ☐ Thursday (afternoon)
- ☐ Friday (afternoon)

Do you require an interpreter?

- ☐ No
- ☐ Yes (please specify type of interpreter)

Is there anything else you would like to add?

Thank you for your interest in this Project!

Please send this form to Project Lead, Leanne Kelly:

1. **Email:** LKelly@qamh.org.au, or
2. **Postal Address:**

   Leanne Kelly

   Queensland Alliance for Mental Health

   433 Logan Road

   Stones Corner QLD 4120

We will be in contact with you shortly. In the meantime, please contact Leanne Kelly on 07 3394 8480 or LKelly@qamh.org.au.

Appendix 9: Participant information sheet and consent form: *[individual interviews/focus groups]* with people who access mental health services and those who support them

Participant information sheet

Please note: This Participant Information Sheet is to be read together with the Consent Form.

Queensland Alliance for Mental Health (QAMH) invites you to participate in *[an individual interview/ a focus group]* to share your experience of service changes that have occurred across the mental health service system due to COVID-19.

This document provides some information about QAMH and tells you about the Project and explains what taking part involves.

Please read this information carefully and please contact Project Lead, Leanne Kelly on 07 3394 8480 if you have any questions or want to know more.

Queensland Alliance for Mental Health

QAMH is the peak body for the community mental health and wellbeing sector in Queensland. Through its influence and collaboration with its membership and strategic partners, the QAMH reforms, promotes and drives community mental wellbeing service delivery for all Queenslanders.

About the Project

Queensland Health has funded the QAMH to undertake the *Mental Health Service System Changes: Experiences of COVID-19* Project.

The Project is being delivered through a partnership between QAMH, Health Consumers Queensland (HCQ), Metro South Addictions and Mental Health Services (MSAMHS) and the Brisbane South PHN.

The aim of the Project is to understand the experiences of people who access mental health services, and those who support them, of the changes that have occurred across the mental health service system due to COVID-19.

What does participation in the Project entail?

If you choose to participate and provide consent, you'll take part in *[an individual interview/a focus group]*, online, by telephone or face-to-face.

You'll talk with the Project Lead, Leanne Kelly and/or Lived Experience Advisor, Tina Pentland. You will be provided with a list of questions ahead of time. You don't have to read this list, but it may help you to prepare for the *[focus group/interview].*

Voluntary participation and withdrawal

Your participation in this Project is voluntary, and you may decline to take part of to withdraw at any time until the end of the Project (June 2021). During the *[interview/focus group],* you may also decline to answer any question. If you withdraw, the data you have provided prior to withdrawal will be destroyed and not used.

QAMH will invite you to be notified when the final report is available and receive a copy.

Duration and location

It is anticipated that *the [interview will take approximately 30-60 minutes/focus group will take up to 2 hours]*. This will take place between the hours of **8am and 4pm during a weekday between February and March 2021.**

Remuneration

In recognition of your time, QAMH will pay you *[$40 (interview)/$80 (focus group)]* for your contribution to this Project.

Benefits

QAMH recognises the importance of having the views of people with lived experience of mental illness and values your input. Sharing your experiences may benefit others and lead to improvements to mental health services in the Brisbane South region and across Queensland.

Risks

You will only be asked about your experience of service delivery changes and will **not** be asked any questions about your health. We understand that talking about your experiences could be upsetting. To help, please only talk about things you feel comfortable talking about. It is also OK if you would rather not answer a question or questions. You can choose to stop the interview at any time.

What if talking about my experience is difficult?

Before you decide to take part, you may like to talk about it with someone you trust (e.g., friend or family member).

If reflecting on your experiences is upsetting, it could help to:

- Talk to a health professional; or

- Use a phone counselling service, such as beyondblue (1300 22 4636) or Lifeline (13 11 14).

Confidentiality

Personal information such as your name and contact information will be collected for administrative purposes only and will be handled in accordance with the Privacy Policy of QAMH, available upon request.

Your name will not be made public at any time and your privacy will be protected at all times. Outside the *[interview/focus group],* all responses will be anonymous and confidential. The information you contribute will be analysed thematically, along with the responses of other participants, and only prominent themes (e.g., access to mental health services) will be described in the final report. In the case that a quote is reported, any identifying details will be altered to maintain confidentiality of participants.

Voice recordings of the *[interviews/focus group]* will be made. The voice recordings will be kept securely until the information is analysed and then they will be destroyed. All information about participants (i.e., health practitioners, staff, people who access mental health services and those who support them) will be de-identified in the final report.

Questions

If you have any questions about the information contained in the Participant Information Form, or the Consent Form, please contact:

Leanne Kelly
Project Lead
QAMH
Email: LKelly@qamh.org.au
Phone: 07 3394 8480

Sarah Childs
Director of Engagement
and Partnerships, QAMH
Email: schilds@qamh.org.au
Phone: 07 3394 8480

Tina Pentland
Lived Experience Advisor
QAMH
Email: tpentland@qamh.org.au
Phone: 07 3394 8480

Consent form

This consent form tells Queensland Alliance for Mental Health that you:

- have read the Participant Information Sheet (or someone has read it to you in a way that you understand).
- have had the opportunity to ask questions and are satisfied with the answers you have received.
- understand that participation is voluntary, and you are free to withdraw from participation in the *[interview/focus group]* at any time or to decline to answer any question/s.
- understand you will be given a signed copy of this document to keep, and
- Agree to take part in *[an individual interview/focus group].*

I agree to take part in *[an individual interview/focus group].*

Yes ☐ No ☐

I agree that QAMH may audio-record the *[interview/focus group].*

Yes ☐ No ☐

Signing below indicates you agree. Your name will not be made public. We ask for your name so that there is a record of your agreement to take part. This form will be filed separately to the record of your *[interview/focus group].*

Name: _____

Signature: _____

Date: _____

If you would like to receive a copy of the final report (July 2021) please provide your contact details below:

Email: _____

Appendix 10: Smaller consultation themes

Service provider experiences of service delivery changes	
Theme	**Notes**
Other	The workload during the pandemic was challenging, particularly while working remotely. One service provider highlighted some clinicians were working from home during the pandemic while others worked from within the space at the office. It was challenging to maintain connection and support for clinicians who were providing mental health support to people who access mental health services over the phone. It was also challenging to manage teams and morale during this time; however, experiences improved when all staff could come back to the office. The decrease in face-to-face contact was initially challenging for some service providers with staff concerned for people who access mental health services and those who support them. Lack of access to PPE while still needing to provide some level of direct care caused staff anxiety.
Effective changes	
Theme	**Notes**
Other	A psychoeducation workbook, developed by one of the services, was a good option as it meant the service was still being made available for people in prison. From the service provider's point of view, the psychoeducation workbook is not ideal, but it is a useful option when the need arises. One person identified bulk billing for telehealth appointments with their GP as a helpful innovation, while another person reported the change in having prescriptions sent direct to pharmacies as very helpful. A person living in a community care unit during the pandemic highlighted nursing staff were very caring and supportive, ensuring people had access to PPE when required and helping residents' access COVID-19 tests.

Unsuitable changes	
Theme	**Notes**
Other	There were many frustrations, large and small. Prescriptions were being faxed to pharmacies, which was confusing for some, and many people were afraid of being a burden to the health system and put off seeking help. Service providers had to deal with the challenge of maintaining services and transitioning staff to new work conditions, many of whom did not like working from home. One service provider spent time and resources setting up for telehealth which was never used because restrictions eased in that time. Wait times for services increased. Some outreach was cancelled. People living on the fringes of society were further isolated by the lockdown. Some people commented that governments and services were very unprepared despite knowing about threats to public health from viruses for decades.
Enablers to care	
Theme	**Notes**
Access to PPE	Some service providers handed out PPE (masks and sanitiser) to people accessing their services. This assistance was very helpful as otherwise they would have been unable to go out. Organisations provided their teams with PPE, and this gave staff confidence to continue their work in safety.
Financial Assistance	Financial assistance to people accessing services and those supporting them occurred directly through Centrelink co-payments for services and indirectly through the Government increasing the number of bulk-billed mental health sessions from 10 to 20 annually. Both these initiatives gave people better access to services. Individual service providers also gave financial help in the form of data credit to help cover the costs of increased data usage incurred by telehealth, and some have provided financial assistance towards the cost of getting an NDIS plan. In general, GPs offered phone consultations, which could be bulk billed, but no alternative.

Other	Telehealth made access to services easier for people who did not have to rely on any public transport to get to the service. Some people continued mental health services as before, but found it was much harder to get appointments with their GP. The changes meant that some services were able ironically to reduce their wait lists because they were not getting referrals and could take on more people directly. In some instances, the pandemic caused people to be more resourceful. In a sort of role-reversal, it was no longer possible for people to rely solely on their service provider, and they had to take control of their own health and wellbeing. At the same time, the success of some organisations to transition to online services helped create a welcome sense of achievement among staff. Perhaps surprisingly, some organisations were also able to retain volunteers and students throughout the pandemic, moving them to different roles, which enabled them to maintain services.
Partnerships and Relationships	COVID-19 has highlighted the importance of relationships among organisations within and across the community. Organisations with existing partnerships, strong networks and links to providers and practitioners were better placed to provide continuity of services during lockdown. Within the organisations, having a strong relationship between people accessing the service and individual staff members was also invaluable as it enabled them to easily follow up on people if they had not been in touch. Community organisations and charities were an important conduit of information, and individuals found they were able to support each other in new ways.
Barriers to Care	
Theme	**Notes**
Organisational Response	Organisations had to quickly adapt to the lockdown and working from home. In some cases, managers were slow to accept working from home or to make the necessary changes to support this, and the organisational culture of some teams was not conducive to change. Community mental health services, delivered by non-government organisations, generally were able to respond and implement

	change more quickly than government. People were challenged to think differently and adapt to new ways of working.
Financial Barriers	Financial limitations meant that some people could not get counselling during the lockdown period. This barrier was partly offset by the Federal Government changes to psychosocial support from 10 to 20 sessions per year, together with a co-payment through Centrelink towards fees for services. Government support to organisations was initially only given for people supported through the NDIS, but this gap was subsequently made up with additional funding.
Other	The lack of integration in a mental health system that is divided across state, federal, public, private and community services and providers was identified as a major barrier to providing optimal care and support to people when it is needed. These problems are exacerbated when people are linguistically or culturally isolated, such as members of CALD communities, or are socially isolated and not linked to any services. Some people were displaced from their communities at this time because they were moved to emergency housing in the city centre.