HEAD TO HEALTH

# Service Model for Head to Health Adult Mental Health Centres and Satellites

Revised June 2021

What's on your mind today?

Get it out in the open.

1800 595 212

Australian Government
Department of Health

# Contents

# Key terms Glossary of key terms used in the paper

In general, the terms used in this paper should be understood to align with definitions provided in the Fifth National Mental Health and Suicide Prevention Plan. The following terms are highlighted.

Warm transfer – the site actively communicates with the service to which the individual is connected to provide essential information about their needs before transferring them. Support is maintained for the individual by the site until they are received by the service.

Clinical governance – Clinical governance is defined as the system by which the governing body (bodies), managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents. It includes workforce credentialling and scope of practice determinations.

Episode of care - the package of care and evidence-based treatment provided by a site, for individuals with a specific mental health need. An episode of care is delivered by members of a multidisciplinary team over a set time period.

Peer support worker – Workers who have a lived experience of mental illness and/or suicide and who provide valuable contributions by sharing their experience of mental illness and/or suicide and recovery with others. Peer workers may have lived experience as a consumer or as a carer.

Care navigator – a person who works collaboratively with consumers and carers to assist them in finding the most appropriate treatment, care or supports.

'Front of house' – the location where the public is received and may wait for services. Front of house services are provided in these public areas.

Local Hospital Networks (LHNs) – entities established by state and territory governments to manage single or small groups of public hospital services, including managing budgets and being responsible for performance in a defined geographical area. LHNs also commonly manage other health services such as community-based health services.

Some jurisdictions have their own local names for LHNs. For example, in New South Wales they are known as 'Local Health Districts', in Queensland they are known as 'Hospital and Health Services', in South Australia they are known as 'Local Health Networks', and in Tasmania they are known as 'Tasmanian Health Organisations'.

Co-morbidity – other conditions that occur at the same time as mental illness. This is often physical illness or poor health but also includes use of alcohol and other drugs. Both are very common in those with mental illness or mental disorders.

Alcohol and Other Drugs (AOD) – this term most often refers to excess use of alcohol and misuse of illicit or prescribed drugs.

## Introduction

As part of the 2019-20 Budget, the Australian Government announced it would invest $114.5 million over five years to undertake a trial of eight Adult Mental Health Centres, with one to be established in each state and territory. Through the 2019 Mid-Year Economic and Fiscal Outlook process, funding was brought forward to enable the South Australian Centre to be established in mid-2020, and to enable the remaining seven Centres to be established from 2020-21, with service delivery to commence in 2021-22.

In 2020-21 the Productivity Commission (PC) released its Inquiry into Mental Health. The Report noted the complexity of the mental health system and that many people who needed treatment and care were unable to access appropriate services that were well integrated with other parts of the system – both those funded through Commonwealth and State and Territory services. The impact of COVID-19 on the mental health and wellbeing of the community was also significant. The planning and development of adult mental health services has been further informed and refined in the context of the PC report and the response by all governments to COVID-19.

Through the 2021-22 Budget, the Australian Government invested $487.2 million to establish the Head to Health Centre and satellite network of community-based adult mental health services delivered by multidisciplinary teams who will provide holistic, collaborative care. This includes funding for eight new Head to Health Centres, 24 satellites embedded into

existing primary care settings and ongoing funding for the initial eight sites announced as part of the 2019-20 Budget. The announcement also included funding for a central intake and assessment phone service that promotes consistent triage and enables warm transfer and referral to the most appropriate services, including Head to Health centres and satellites.

This paper was first prepared in 2020 to support consistency in the establishment and implementation of the Centres, and has been updated to reflect expansion of the initiative and learnings from the establishment of the initial eight sites and the Victorian *HeadtoHelp* initiative. A Technical Advisory Group was established to advise the Department on the initiative and public consultation was undertaken to inform the original service model.

The paper outlines the key assumptions underpinning the model of service, explores how individuals with different needs might access services from the centres and satellites, and proposes services that would be needed in-house as well as on referral. It also considers workforce, flexibilities allowed in the model, and essential safety and quality issues. The paper also reflects the recommendations of the PC report to ensure there is greater integration of all parts of the mental health system.

Head to Health centres and satellites, collectively referred to as sites, are designed to provide a welcoming, low stigma, soft entry point to engagement, assessment and treatment for people who may be experiencing distress or crisis, including people with conditions too complex for many current primary care services but who are not eligible for or who need more timely care than that available from state or territory public community mental health. It is also intended to offer immediate, short and medium term episodes of care and service navigation to connect people to ongoing services. It will assist adults seeking help in times of crisis, or as needs emerge, to have access to on-the-spot care, advice and support provided by mental health professionals – without needing a prior appointment.

Head to Health sites are intended to complement, not replace or duplicate, mental health services already provided in the community. They are not designed to offer longer term ongoing care but will be based on an episode of care model, delivering packages of

evidence-based care and family support to cover the short to medium term, based on clinical judgement and individual need, including interventions to support those with associated alcohol and drug misuse.

Through the initial eight sites, Centres were commissioned in all states and territories except South Australia through funding to the corresponding Primary Health Networks (PHNs). Under the Head to Health expansion, further sites will be commissioned by PHNs, with the expectation of seamless integration with services funded by states and territories, and other Commonwealth-funded services such as Better Access. As part of their commissioning processes, PHNs will undertake consultation, at a local level, with consumers, carers, Local Hospital Networks (LHNs) or their equivalent and other local stakeholders to co-design and shape services to meet the particular needs of the area, within the framework presented by this model. Avoiding further fragmentation and ensuring sustainability will be key priorities in the commissioning process as recommended by the PC report. Whilst, over time, sites may meet a range of special needs within their region, a key imperative will be ensuring the model of care offers a culturally safe response to the needs of Aboriginal and Torres Strait Islander people, in line with the principles of the Gayaa Dhuwi (Proud Spirit) Declaration.[1]

Centres and satellites, whilst both working within the principles of this service model, will differ in their service delivery due to their structure and resourcing, outlined below. Centres and satellites are expected to collaborate, particularly where they share catchment boundaries, to reduce transfer issues and share workforce, training and capability:

- Centres are stand-alone multidisciplinary, collaborative mental health services providing immediate, and short to medium term mental health treatment and support for people in distress and/or with moderate to severe mental illness. Centres will have a range of multidisciplinary clinical, peer support and administrative staff, as deemed most relevant to the local setting, within recruitment capability.

[1] Available from http//natsil.mh.org.au/sites/default/files/gayaa_dhuwi_declaration_A4.pdf

- Satellites are multidisciplinary, collaborative mental health services embedded within existing primary care settings. Satellites are expected to be closely connected with the nearest centre to support clinical governance, administration efficiency and expand the geographic reach of community based mental health services, particularly in areas where there may be workforce or infrastructure challenges.

## Summary of the key elements of the Head to Health model

The model of service will seek to address key gaps in the system by:

- Providing a highly visible and accessible entry point to services for people experiencing psychological distress, where all feel safe and welcomed
- Offering assessment to match people to the services they need
- Providing on the spot support, care and advice without needing referral, prior appointments or out of pocket cost. Every interaction should be with the intention of therapeutic benefit
- Offering an episode of care model based on short to medium term multidisciplinary collaborative care, aimed at improving psychological wellbeing for people with moderate to high levels of mental health need, whose needs are not being met through other services.

The service model for individual sites will need to address the following four service elements:

- Respond to people in significant distress, including people at heightened risk of suicide, providing support that may reduce the need for emergency department attendance
- Provide a central point to connect people to other services in the region, including through offering information and advice about mental health and AOD use, service navigation and warm referral pathways for individuals, and their carers and family
- Provide in-house assessment, including information and support to access services
- Provide evidence-based and evidence-informed immediate, and short to medium term episodes of care, including utilisation of digital mental health platforms.

## Assumptions underpinning the service model

- Sites will welcome adults experiencing emotional distress, crises, mental ill health, and/or addiction, and their families and carers through a 'no wrong door' approach that is consistent with the Mental Health Statement of Rights and Responsibilities.
- Sites should offer a holistic approach to care, addressing a broad range of social, physical and emotional needs, supported by best practice in evidence-based and evidence-informed care. This should include integrated care for people concerned about AOD use which coexists with mental ill health, other comorbidities or dual disabilities, and culturally appropriate best practice. Staffing profile and level will enable these needs to be met, and support ongoing workforce development and training.
- Sites should plan and deliver services that are co-designed to meet local needs in a way that is person-centred and prioritises self-determination, choice and agency.
- Sites should be required to provide or facilitate core functions within an agreed framework, in a way which complements and does not duplicate existing services, including acute or long term services, noting that satellites will have less capacity than centres due to their size.
- Sites must adhere to the principles of the Gayaa Dhuwi (Proud Spirit) Declaration in the development and delivery of services to ensure culturally safe services for Aboriginal and Torres Strait Islander people are included as part of the broader model.
- Sites must be safe and inclusive to all who present, including members of LGBTI communities and people from Culturally and Linguistically Diverse (CALD) backgrounds.
- Young people aged 12-25 years old should be given information about care and support available from youth specific services such as headspace and other services targeting the needs of young people, if this is the most appropriate way to meet the needs of the individual.

- Sites should have some flexibility for regional variation, over time, to address other cultural or local population needs and to make optimal use of already available services. This includes opportunity for the development of innovative approaches to complement core services provided through sites.
- Sites should be promoted as supporting people at times of crisis and distress, and not in terms of language of mental illness.
- Sites will connect people to services providing less urgent longer-term care where this is in the person's best interest. To maintain accessibility and manage demand, Head to Health sites are not expected to provide services of an ongoing nature, but will have capacity to provide short to medium term targeted care and support.
- Sites should promote optimal use of digital mental health and AOD services, including integrating digital forms of support into care plans and supporting their use.
- Sites should work collaboratively with the central intake and assessment phone service to develop strong working relationships. This should include shared or common information systems to allow smooth transfer of information and transition between providers.
- Sites should have formal relationships with other relevant services in their area, including State or Territory funded services and other services provided through PHN commissioning or Better Access.
- A quality framework should support the model of service, including by ensuring the risks of supporting individuals who may be experiencing high distress are managed, and attending to appropriate ongoing support, supervision and training for all staff, including peer support workers.
- Sites, particularly centres, will emphasise the importance of workforce development by supporting placements for students and trainees in relevant disciplines. Staffing models within centres will support inclusion of clinician time to provide support and supervision to junior staff. This is likely to require integration with training and support provided through State and Territory funded services.

## A highly visible and accessible entry point for individuals and those providing support to them

The physical environment of the sites should be calm, safe, friendly and welcoming to individuals experiencing emotional or psychological distress and to family and carers who support them. Sites should feel welcoming and safe to all who present, including Aboriginal and Torres Strait Islander people, people from diverse cultural backgrounds and LGBTI people. In addition, it is important that the sites provide a safe entry point to integrated care for people who present concerned about their AOD use. Sites should be in a location easy to reach by public transport. They should be relatively close to a major hospital and/or to other health services, so a close relationship with crisis teams can be developed, and to facilitate their role of offering an alternative to emergency department attendance, where appropriate.

Sites, particularly centres, must be open extended hours in order to maximise availability to people when they are experiencing distress. Sites should enable access to support and advice seven days a week, and after hours, including through provision of a digitally based contact point for people experiencing distress at times the site itself is not physically open. Opening hours may be adjusted in response to demand and to complement availability of other regional services.

Sites will have a "front-of-house" function where people can seek information and assistance navigating services by visiting the site, and potentially also by digital means through telephone or internet, supported by the central intake and assessment phone service. A digital presence for the site may also include provision of computers on site and assistance accessing a range of digital information and mental health services. This could include low intensity on-line services through the Head to Health website, or other self-help or clinician supported digital interventions for mental health and/or problems related to AOD use.

Whilst people are waiting for services at the site, staff, including peer support workers, will be available to check in with them, and provide support if needed. People seeking

information or resources rather than services, including family members or carers, will be welcomed at the sites and supported to get the information they need. It is intended that support and interventions will be provided over a short timeframe for most people so that long wait times and waiting lists are avoided. It is recognised that for some people there will not be readily available services to which they can be referred, and in these circumstances targeted medium term care may be appropriate, particularly whilst waiting for longer term or specialist care.

Note: due to the nature of satellites being embedded within existing services, not all above requirements may be able to be met by satellites. These requirements should be considered during site selection, and upheld as best possible in satellite locations

## Assessment

Those requiring more than information or assistance navigating available services will be provided with a biopsychosocial assessment of their needs. Assessment of need will be undertaken using an agreed Initial Assessment and Referral (IAR) decisional support tool. The assessment process may be undertaken in-person at sites, or via the central intake and assessment phone service, and will be conducted by a mental health professional to match people with the services they need. Individuals may be referred into Head to Health for care, or connected by warm referral to other available local PHN-commissioned, jurisdictional, NGO or private services, including those offered on a fee-for-service basis, where this is most appropriate to meet individual needs.

An initial brief review of needs should be undertaken at the point of accessing sites to identify whether individuals need urgent support, and to determine what the main focus of support is likely to be. In particular, all staff involved in initial intake, or who play a role in supporting clients while waiting, should be trained to recognise an individual who may need urgent support and who should be 'fast-tracked' to a clinician. Clients of Head to Health should not be required to go through two stages of assessment, nor tell their story more than once. It is expected that the clinician who first sees the person will make clinical judgements on the most appropriate interventions and in many cases also be the

professional to deliver the episode of care. At times they will need to seek the particular expertise of other team members. It is expected that a number of clinicians at a site will have experience and/or expertise across mental health, AOD and physical health, given the prevalence of these problems amongst the population likely to present.

For those presenting with significant distress and acute needs which require urgent medical attention beyond the capacity of the site, protocols will be developed with the LHN for urgent review and referral. This may include immediate communication with, or warm transfer to, emergency or acute services where this is needed. Immediate support will be provided by staff at the site to help de-escalate symptoms and ensure people and their families feel safe. The site will form an agreement with the local acute mental health service for prompt in-reach support.

The assessment and referral process will determine the level of service a person requires, and care to be provided. It will inform development of a care plan where appropriate, and identify those individuals who would benefit from service navigation. Sites will ensure that the physical health needs of people with more severe mental illness are assessed, and that drug and alcohol comorbidities or risks of substance misuse are routinely assessed. Where substance use is a significant component of the presentation, professionals with competency in identifying and managing substance misuse issues, including addiction specialists, should be involved or consulted in assessment processes and subsequent treatment plans. Where physical health needs are prominent (e.g. people with co-occurring chronic illness), the site should assist in organising an early appointment with local primary health services. It is anticipated that some sites may develop local arrangements for medical services and other services able to be billed to Medicare to be provided in-house if clinicians are not salaried, within the clinical governance of the sites as outlined below. The assessment process will also consider non-health factors which would both impact and be impacted by distress levels including a lack of adequate, stable safe housing, domestic and family violence, low socio-economic status, a history of trauma, and past experience of high levels of discrimination and stigma.

## Core services to be provided by Head to Health sites

To provide the elements of the service model, there are a number of services which all Head to Health sites would be reasonably expected to provide 'in-house', using available funding and through the most efficient mechanism of service delivery that meets the local need. In addition there are a number of important services and supports upon which the effectiveness of the model depends, which sites are expected to either offer in-house, **or** offer through seamless referral pathways and partnerships with other agencies.

Core services to be provided **'in-house', using funds available to the sites**, to address the key four elements of the service model, must include the following:

**1. Responding to people experiencing a crisis or in significant distress:**

- Immediate support to reduce distress for people experiencing crisis or at risk of suicide presenting to the site in person or connecting with the site digitally, to help them feel safe before ongoing management within the site, or arranging warm transfers to other services where appropriate (see also flexibilities)
- Support for communities and individuals experiencing significant distress associated with times of natural or other disasters.

**2. Providing a central point to connect people to other services in the region and seamless experience (in collaboration with the central intake and assessment phone service):**

- Information for individuals, families, friends and carers on locally available mental health, AOD and suicide prevention services, and related social support services
- Support and advice for families, friends and carers to assist them in their role, and acknowledge their social and emotional support needs
- Service navigation, supporting clear and seamless pathways, including access to digital self-help services, and providing a point of contact and follow-up.

**3. Provide in-house assessment, including information and support to access services (in collaboration with the central intake and assessment phone service):**

- Biopsychosocial assessment and further reviews as required to ensure people are matched to the services they need, including assessment of physical health needs, problems related to AOD use, and other social factors or adversity which might impact on their mental wellbeing.

**4. Evidence-based and evidence-informed immediate, and short to medium episodes of care:**

- Initial information provision, comfort and, if necessary, management of symptoms, including, where possible, those related to alcohol and drug use
- Short to medium term support and care, based on an episode of care model, whilst individuals are recovering or are waiting to be connected to longer term or more appropriate services and support, including regular contact and follow-up with individuals at heightened risk of suicide and their families and carers
- Digital mental health services and information, including promoting access to on-line therapies (such as those offered through the Head to Health website) and clinician-supported digital interventions for mental health and problems related to AOD use.

Head to Health sites will also ensure that the following services, which are essential to the integrity of this model, are available to people who present to the site, either on an **'in-house', 'in-reach' or referral basis**. These services may be funded by the site, or may be provided through referrals to existing services to best meet local needs. Most of these services would be provided under the clinical governance of the Centre, particularly where funded on an in-reach or in-house basis:

- Medical assessment, including initiation or continuation of medication management where appropriate; and assistance with physical health needs from GPs, or psychiatrists/psychiatry trainees
- Appropriate psychological assessment and treatment to those presenting with complex issues, including problems related to previous trauma
- Structured psychological therapies such as cognitive behaviour therapies, including services provided through Medicare Benefits Schedule (MBS) arrangements
- Assistance with accessing care coordination services

- Local outreach, either physically or via digital services, to meet the needs of vulnerable groups and the needs of people who are unable to easily access services delivered through the sites
- Specialised suicide prevention follow-up services, such as the Way Back Support Service
- Family therapies and family peer support and education services
- Assistance identifying and managing comorbid substance misuse from addiction specialists
- Integrated vocational support services Connection to services that assist with referral to the NDIS and related information
- Assistance managing stressors associated with high levels of distress, including financial problems, civil and criminal legal issues, family support, accommodation instability and social isolation
- Connection to specialised domestic violence supports
- Culturally safe services for Aboriginal and Torres Strait Islander people
- Connection to peer-led services such as peer networks, support groups, or phone lines
- Connection to group programs as a means of building social supports
- Other services which are essential to the integrity of the model, depending on the particular geographic, cultural and service needs of the region (see flexibilities below).

The mix of additional services which the sites provide in-house may vary from location to location, and will depend on arrangements negotiated with LHNs and other local services to ensure complementarity and to focus available site funding on addressing gaps. Some sites may focus on providing a platform for in-reach services to be offered, including services from GPs, psychiatrists or other MBS or privately funded providers.

## What services are out of scope for Head to Health sites?

To ensure demand management, and ensure capacity for new people to present, sites will not generally provide longer term or ongoing mental health care or support services.

Head to Health sites are not funded to provide:

- Services for people who cannot be managed safely within the Head to Health site

- Acute reception of police or ambulance referrals
- Pathology, radiology or pharmacy services
- Ongoing, long term psychosocial support services
- Recreational services
- Direct financial support
- Residential or bed-based services, including short-stay services
- Services targeting children and young people which could be provided more appropriately by headspace or other specialised children or youth mental health services
- Disability support services provided through the NDIS
- Other services which are provided by other agencies in the area (see referrals below).

## The role of the Head to Health sites in providing care to people with moderate to high levels of mental health need

The role of sites in relation to supporting people with moderate to severe levels of mental illness should focus on providing an episode of care which aims to support the individual and their family/carers and to assist them to navigate the health, mental health, and broader social services which they need. This will require sites to develop strong levels of integration with and referral pathways to and from state and territory community mental health services.

Sites may include a short to medium term service offering for people with moderate to high levels of need, where there are no available services appropriate to their needs to which they can be referred, or whilst they are waiting to be connected to longer term care. However, if sites are to continue to be accessible, and have capacity to deliver immediate support without access being unduly limited by the establishment of wait lists, they will need internal protocols to assist in demand management, including through strong established relationships with jurisdictional services. The sites are expected to have a limited role for those with enduring, long term needs.

An appropriate role for sites in supporting people with moderate to high levels of mental health need should include:

- Provision of immediate care for people with moderate to severe mental illness who present in distress or suicidal crisis
- A full biopsychosocial assessment of their mental health and other needs including co-occurring substance use or physical health issues which may influence their needs to enable appropriate referral and connection to more appropriate services
- Provision of short to medium term care according to an episode of care model, for people for whom there is no other service available. This should deliver a limited package of services through a multidisciplinary collaborative care team arrangement designed to address their mental health and related needs
- Warm referral to more specialised services and longer term psychosocial support where individuals require ongoing, long term care
- The provision of continuing assistance with care navigation to individuals who are experiencing moderate to severe levels of psychological distress, to ensure they are not left without services
- Connecting family and/or other carers with services that can support them in their roles.

Sites should not provide ongoing long term care, nor replace the role of state/territory community mental health services in providing services to people with acute needs related to exacerbations or relapses of pre-existing illness. In some circumstances, individuals may present who are the clients of existing services, including state/territory community mental health services. Whilst immediate care should be provided, sites should support these individuals to reconnect with their regular services.

The evaluation and ongoing monitoring of Head to Health will be useful to inform adjustment of the model of service to appropriately meet the needs of this group in a way which does not duplicate the role of other services, yet which helps to address the gap in services for people with more complex needs.

## The role of the Head to Health sites in providing care to people who present with significant levels of distress or suicidal crisis

Head to Health sites are intended to help address the service gaps which currently exist for people experiencing high levels of distress or suicidal crisis. In addition to providing a safe place to present, sites will also offer continued contact and follow-up support through an episode of care model until these individuals are either in recovery, or connected through warm transfer to services to meet their ongoing needs.

Precedents through initiatives such as the Safe Haven services, have shown this can successfully divert people from less appropriate emergency department attendance, and promote better outcomes, where urgent emergency department care is not required. These services rely on good cooperation with emergency departments and community-based front line services and acute mental health services to support throughput and ensure safety for clients and staff.

Protocols for this function at each site will need to be refined in partnership with the LHN and emergency departments to:

- Ensure swift identification of those individuals who are experiencing a crisis, and provision of immediate support and comfort to them and their family or carers
- Identify and refer individuals whose needs cannot be met appropriately in the site. This may include the care of individuals who are at risk of harm to themselves or others
- Identify individuals experiencing heightened distress who are intoxicated or under the influence of licit or illicit drugs, and swiftly decide whether their needs can be appropriately and safely met at the site
- Have in place clear arrangements for crisis support and transport to emergency departments when urgent referral is needed
- Have capacity to discretely provide care for individuals in heightened distress, in a way which protects their privacy and does not impact on other clients of the service.

In some locations there may already be services in place nearby which offer a safe and person-centred, friendly alternative to presenting to hospital. In these circumstances, sites may wish to partner with these services, rather than duplicating the service, and focus available funds on other aspects of the service model to better address service needs in consultation with LHNs and other key stakeholders.

## Referrals

Smooth referral pathways, which are seamless for people requiring support, will be essential to the effective operation of the service model. This must include capacity for warm transfers, particularly for people experiencing high levels of distress who require long term care, to enable new entries to the service. Through warm transfers, the site actively communicates with the service to which the individual is referred to provide essential information about their needs before transferring them. Support is maintained for the individual by the site whilst they are waiting for an appointment with the agency to which they have been referred. This function will require strong collaboration with the central intake and assessment phone service which also performs this function.

Services to be provided on referral, where it is not possible to provide these services in-house or through using the site as a platform, may include:

- GP management of ongoing physical health issues
- Private MBS funded psychiatry or psychological services
- headspace services or child mental health services
- Other services commissioned by PHNs, including psychological services, Aboriginal mental health services, or services targeting the needs of hard to reach groups
- Services providing mental health or broader support services for Veterans
- State or territory government funded acute and emergency care, and public and private hospitals
- Public and private specialist mental health services
- Services meeting particular needs such as perinatal depression, eating disorders, or early psychosis

- Specialised support networks and or physical health support services
- Social support services, including housing, employment, child and family support and income support
- Community legal assistance services or forensic mental health support services
- Specialised Alcohol and Other Drug services (where ongoing support is needed as opposed to integrated support for co-occurring mental health and substance use conditions at the site)
- Disability support services, including support through the National Disability Insurance Scheme and Information, Linkages and Capacity Building (ILC) programs
- Peer support groups, and peer led safe spaces.

## Partnerships and protocols

Close partnerships will be formed with the services described above as appropriate to enable an integrated approach to individuals who may require transfer from one service to the other. In particular, clear protocols will be developed for the interface between the sites, the PHN and the LHN and its emergency departments to enable a seamless transfer of patients when needed, and ensure best use of existing services. It is anticipated that some people who present in crisis at the site may have existing care arrangements with LHN mental health services.

As part of this it is expected that protocols developed with local services will provide clarity on what sort of presentations are likely to require emergency department attendance, and which individuals experiencing distress can be appropriately supported within the sites.

As many individuals presenting to the sites may already be clients of other services, including public and private specialist mental health services, protocols for communicating with and if appropriate providing shared care with these services will also be important. It will be important that services are not duplicated and that information is shared among providers (with consent) to minimise the need for repeated explanation by consumers and carers. The use of My Health Record, in addition to shared information systems, should be used to facilitate communication and coordination. In general,

wherever possible, efforts to co-locate services should be pursued to support a 'one stop shop' approach. This is most likely to avoid fragmentation and retelling of stories.

## Workforce – a multidisciplinary collaborative team approach

To deliver the core functions of the Head to Health model, it is expected that sites will establish multidisciplinary collaborative holistic teams, supported by appropriate clinical governance – both within the site and where there are shared care arrangements. Services provided will need to be recovery focused, trauma informed and person-centred. The core workforce may be supplemented by practitioners providing services funded through MBS items, and may include salaried practitioners to best meet local site needs and support training placements.

A multidisciplinary team approach allows the opportunity for clinicians and peer support workers, and/or staff with dual expertise across mental health and AOD, or with expertise in delivering digital mental health services or particular cultural expertise, to utilise their particular skill sets while also functioning as an integrated team with shared clinical review and team support, reducing fragmentation and improving consumer experience.

However, not everyone presenting to the sites will require multidisciplinary care. Individuals with high levels of distress, or complex needs will most benefit from having access to a small team whilst they are in the care of the site (e.g. mental health nurse, psychologist and peer worker). On the other hand, many individuals with lower levels of distress will prefer to receive, and may only need support from one professional. Similarly, it would not be efficient to expect sites to establish an extended multidisciplinary care team in-house, including specialists, to meet the needs of all clients.

Sites should seek to establish partnerships with GPs, emergency department staff and other external professionals, including private service providers, to enhance a multidisciplinary team approach to meeting needs, without duplicating available services, to make best use of funding, and to best meet the needs within the catchment area which may vary from place to place. There may also be shared employment arrangements with

LHNs, including possible secondments, and potential for sessional in-reach services to enhance the spread of skill and expertise within the team.

Table 1 – Possible Multidisciplinary Team Members

| Core function | Skills or competencies | Possible multidisciplinary team members |
|---|---|---|
| Providing a central point for connection<br>Service navigation | • Knowledge of local services<br>• Knowledge of digital services<br>• Capacity to identify and provide reassurance to individuals in distress<br>• Skills in care navigation | • Peer Support Workers<br>• Mental Health Nurses<br>• Occupational Therapists<br>• Allied Health Professionals<br>• Care Navigators |
| Providing immediate intervention and support to reduce the need for emergency department attendance | • Ability to de-escalate high levels of distress<br>• Capacity to complete assessment, including identifying individuals requiring acute emergency department care<br>• Medical skills, including knowledge of medication<br>• | • Psychologists (esp Registered)<br>• Social Workers, Occupational Therapists or other Allied Health Professionals with mental health competency<br>• Mental Health Nurses<br>• Medical Staff (GPs and/or Specialist Psychiatrists and Registrars)<br>• Peer Support Workers<br>• AOD Professionals or staff with dual competency<br>• Aboriginal Health Workers |
| Assessment (noting a single professional would be likely to undertake an individual | • Skills in using the Initial Assessment and Referral (IAR) tool or similar model | • Mental Health Nurses |

| Core function | Skills or competencies | Possible multidisciplinary team members |
|---|---|---|
| assessment, but may seek support and advice from other team members) | • Competency as a mental health professional<br>• Ability to assess physical health needs and or AOD support needs<br>• Ability to assess suitability for digital support and treatment options | • Psychologists (esp clinical psychologists in those presenting with complex current or pre-existing issues<br>• Social workers, Occupational Therapists or other Allied Health Professionals with mental health competency<br>• Aboriginal Health Workers<br>• AOD Professionals and GPs |
| Providing care and support for individuals, families and carers (noting a single professional may meet the needs of some individuals, whilst a team approach to care could be required for people with complex needs) | • Skills and training in providing interventions or psychosocial support<br>• Competency as a mental health professional<br>• Competency in providing AOD support<br>• Competency in providing or supporting digital treatment options | • Psychiatrists and Registrars<br>• Addiction specialists<br>• GPs<br>• Social Workers, Occupational Therapists or other Allied Health Professionals with mental health competency<br>• Psychologists (both Registered and Clinical)<br>• Mental Health Nurses (scope for Nurse Practitioners)<br>• AOD Professionals<br>• Peer Support Workers<br>• Aboriginal Health Workers<br>• Transcultural Health Workers<br>• Vocational Support Workers |

Given the role of sites in offering an option for intervention and support to reduce the need for emergency department attendance, staff will need to be available who have received specialised training and who are experienced in supporting people at risk of suicide or who are experiencing significant levels of distress. In addition, all staff who provide "front of house" functions and support initial intake of people should be trained in ways to help support individuals experiencing distress, and to identify people requiring urgent care.

It is anticipated that Centre managers will have both clinical and operational expertise. Additional training or supports may be required for practice managers at satellite sites. Staff should have appropriate support or supervision arrangements in place.

## Flexibilities

In general, sites will be required to provide a reliable model of service consistent with the national framework and branding, and offer a minimum central suite of services as outlined earlier in this document. However flexibilities will be allowed to address regional variation and service size (Centre or satellite), including the following:

- Adjusting any service offering to ensure that the site is complementing and not duplicating existing services in the region
- Addressing particular cultural needs of the region, such as the needs of Aboriginal and Torres Strait Islander people, and the needs of people from diverse communities within the region including LGBTI people, with some sites having a strong level of expertise in delivering services for particular vulnerable groups
- Potential to adapt or share workforce in areas of reduced availability, for example sharing scarce professionals such as psychiatrists and mental health nurses with hospitals or other state or territory government services
- Some Centres may wish to offer opportunity for external entities to provide services using the Centres as a service platform, to offer more of an in-house service offering and make best use of resources

- Flexible approaches to providing access over extended opening hours may be utilised to make the best use of limited workforce, and complement other services in the region. Site opening hours may vary in this respect
- Making arrangements with professional training programs to utilise and where required, offer supervision to students and junior professionals in training, including those at Probationary and Registrar levels, and those preparing for peer support worker roles.

Flexibilities in focusing investment would be determined through a process of mapping existing services, negotiations with local state or territory government service providers and other stakeholders to focus on gaps and avoid duplication. This should build on and utilise mapping exercises, and knowledge acquired for joint regional mental health planning purposes. For example, if the LHN already funds an alternative mental health service or safe space for people experiencing crisis who otherwise would present at hospital, the site may instead focus on enhancing other complementary aspects of the service model, and partner with the LHN service in offering seamless referral pathways for consumers.

Sites are encouraged to explore partnerships with other agencies for the development of innovative service options to complement the site's core functions.

## Integration and planning

Each individual site will be established within a service landscape, which is likely to be unique. The mix of state and territory government, non-government and PHN funded mental health and social support services, which may be available, will vary. This makes it very important that sites should be carefully planned, mapping available services to ensure core functions are provided in a way which makes the best use of available resources.

In general to achieve appropriate integration and planning, sites will need to:

- Map available services
- Consult with other agencies, services, and consumers and carers about service gaps and needs

- Ensure appropriate information is shared between the site and other agencies about roles and relationships, facilitated by shared information systems
- Share experience and learning across sites in different jurisdictions
- Negotiate pathways and protocols for integrating services
- Identify risk of service duplication, or confusion to consumers about overlapping service intent
- Consider opportunities for co-design and co-commissioning.

## Safety and quality

A comprehensive safety and quality framework will be required as part of the implementation of the sites. This should include the following:

- Compliance with relevant safety and quality standards, including the National Standards for Mental Health Services 2010
- Implementing appropriate confidentiality and privacy arrangements in accordance with relevant legislation, whilst ensuring appropriate information sharing is in place between services involved in a care pathway to support quality care
- Clinical governance to ensure that staff are appropriately credentialled, well supported and trained to provide high quality care. Protocols must be in place to guide review of the care provided and for responding to critical incidents and complaints. There should be clear lines of accountability and processes for escalation within the site
- Protocols to ensure the safety of staff and clients in the event that an individual presents a risk to themselves or others
- Protocols with other relevant organisations, for example LHNs and their services, to ensure that offering alternative services to those offered in acute settings does not result in a delay in providing urgent services or otherwise risk the safety and wellbeing of individuals

- After hours arrangements that include provisions to ensure staff (including staff of other co-located services) and clients are not at risk and are equipped to discretely manage the care of individuals who are intoxicated or exhibiting anti-social behaviour associated with drug use (e.g. arrangements in place with police, minimum after hours staffing levels)
- Consideration in general of safety and quality priorities outlined in the Fifth National Mental Health and Suicide Prevention Plan
- Cultural safety considerations to ensure that Aboriginal and Torres Strait Islander people receive quality responses and equality of care
- Support for carers which is timely, responsive, appropriate and accessible, in line with the *Carer Recognition Act 2010*
- Support for the appropriate use of the *Privacy Act 1988* and the Australian Privacy Principles, so information can be shared by practitioners as part of effective collaboration with consumers and carers.

## Pathways to care

Pathways to care and support within the site will be different, depending on whether individuals seek information or connection to other services, in-house assessment and treatment services, or are experiencing significant distress or crisis. Pathways should also be in place to ensure family and carers seeking information, and potentially emotional support, are appropriately supported. A possible, broad pathway to care is outlined in Attachment A.

This pathway presumes the following broad elements:

- Initial contact – by phone, on-line, walk-in or referral from other services
- Initial brief assessment of needs to identify whether need is for information for self or others, for mental health services or for crisis support
- Provision of immediate support and assessment if appropriate
- Provision of short to medium term care targeted to need to enable support until the individual is connected to longer term care

- Liaison and referral with agencies to whom the individual is referred
- Review and, if required, follow-up.

## Phased implementation

The sites will be a new addition to the existing regional service landscape, and will face a number of local implementation challenges in addressing service gaps including:

- Planning services to complement, and not duplicate available services in the region
- Managing demand in a way which enables access to immediate support and advice for all who present, whilst also providing short to medium term episodes of care for those for whom services are not available
- Building a skilled multidisciplinary team in the context of likely workforce shortages
- Identifying and where possible meeting unmet special local or cultural needs whilst also having a standard suite of services
- Offering after hours services, including a level of crisis support, in a way which is sustainable from a duty of care, workforce and budget perspective
- Developing partnerships needed to offer a range of services and referral pathways.

To allow time to address these challenges, a phased approach to implementation of sites is proposed. These phases are likely to include:

- An establishment phase, which will be informed by consultation, needs assessment, local service mapping and existing joint regional mental health planning processes before opening for service delivery. This should include establishing a mission and culture, agreeing principles underlying the model of care, and providing initial inter-disciplinary training and supervision.
- An embedding phase, where a basic core suite of information, services and referral pathways is established and delivered, and partnerships are developed. This may, for example, involve focusing on provision of core in-house services such as the capacity to provide immediate information, advice and support and service navigation.
- A full implementation phase, through which additional partnerships to support in-reach services or more specialised support to address local need is offered.

A process of iterative review between phases, including continuing consultation with key stakeholders, will help to shape the role of sites to deliver a basic suite of services and locally appropriate additional services to optimally complement existing regional services.

## Evaluating the service model

In broad terms, the following outcomes for consumers and carers are expected from each site:

- People requiring support in the area, or those attending the site, will recognise Head to Health as an accessible entry point to the mental health care system for the services and information they need
- People will be able to access, or be connected to, the particular mental health and related services they are assessed as needing
- People will receive immediate advice and care which will reduce their level of mental and emotional distress.

Individuals experiencing high levels of psychological distress or in crisis will receive the care they need from the site, resulting in a reduction in the number of non-urgent presentations to local hospital emergency departments.

Refinement of the evaluation framework is underway. The framework was developed with the assistance of the Technical Advisory Group, to support monitoring and review of the effectiveness of the model of service in achieving these outcomes, and to inform future expansion of the initiative.

Head to Health sites should collect outcomes data to inform an iterative, ongoing evaluation of service effectiveness to ensure the needs of the local community are being met.

Attachment A

# Patient pathways within the Head to Health sites

| | | | |
|---|---|---|---|
| **Initial contact and intake** | By central intake phone service, on-line, walk-in, or referral from other service (e.g. GP, hospital, state/territory service) | | |
| **Initial brief assessment of needs** | **Information for self or others** | **Mental health service needs (non-crisis)** | **Crisis services (alternative to emergency department)** |
| **Immediate support and assessment if appropriate** | Connect with information and services<br>Support and advice for families, friends and carers | Assessment undertaken to identify level of need and/or referrals required, using Initial Assessment and Referral decision tool, or similar. Initial support provided.<br>AOD use and physical health assessed. GP advised patient is receiving services. | Immediate support to de-escalate and;<br>• Support in-house<br>• Supported transfer to home/carers<br>• Warm transfer to acute OR<br>• Full assessment following stabilisation as per non-crisis. |
| **Short to medium term care and episode of care according to need** | Support to access digital information and treatment services | Support and short to medium term therapeutic care, based on an episode of care model, whilst individuals are waiting to be connected to longer | Support and short term targeted therapeutic care, based on an episode of care model, including while waiting connection to longer term support. |

| | | | |
|---|---|---|---|
| **Initial contact and intake** | By central intake phone service, on-line, walk-in, or referral from other service (e.g. GP, hospital, state/territory service) | | |
| **Initial brief assessment of needs** | **Information for self or others** | **Mental health service needs (non-crisis)** | **Crisis services (alternative to emergency department)** |
| | relating to mental health and/or AOD needs | term services and support if needed.<br>For some individuals this short term support may be enough to resolve distress, supplemented with digital treatment services or family support. | Regular contact and time limited follow-up with individuals at heightened risk of suicide and their families and carers, including by digital means. |
| **Service navigation and referral** | | Service navigation to assist them to connect to services and supports.<br>Warm referral to relevant services. | Service navigation and option of review<br>Warm referral to relevant services<br>Referral to Way Back or other follow-up services if risk of suicide |
| **Review** | | Follow-up and review. | Follow-up and review. |
| **Enablers** | Partnerships, clear protocols with state/territory services, multi-agency care planning, skilled workforce, clear roles, supported pathways. | | |

Attachment B

# Head to Health adult mental health centre and satellite - Principles

The Australian Government is funding Head to Health adult mental health centres and satellites across Australia. Head to Health sites will be developed and operate at the local level under the following operational principles. The sites will:

1. Offer a highly visible and accessible 'no wrong door' entry point for adults and their families to access information and services which are designed to empower, support and improve their psychological and physical health, and social and emotional wellbeing.
2. Provide information and services which can assist those providing support to people in need.
3. Provide a welcoming, compassionate, culturally appropriate and safe environment that is inclusive for all people accessing services or supports that are trauma-informed, person-centred and recovery-focused.
4. Provide access across extended hours to best practice on the spot advice, support and care for immediate, short term, and where appropriate, medium term needs delivered by a multidisciplinary collaborative professional health care team providing discipline specific and interdisciplinary care including a suitably trained peer support workforce, nursing and allied health and specialist medical care, without prior appointments or a fee.
5. Assist people in need to find, access and effectively utilise digital forms of help including information, support and therapies.
6. Support people to connect to pathways of care through integration with longer term existing community mental health services where these are accessible and appropriate, local Primary Health Network commissioned services, or GPs and state and territory funded services, as required.

7. Provide an option for intervention and support that may reduce the need for emergency department attendance.
8. Explore opportunities for the development and utilisation of innovation to complement defined core functions, and to meet gaps in the provision of mental health services in the region.
9. Implement appropriate confidentiality and privacy arrangements in accordance with relevant legislation.
10. Operate under robust effective governance frameworks that support connectivity to other supports and services, and conduct local evaluation activities, to ensure transparency and accountability and maximising service quality.

The establishment and implementation of Head to Health centres and satellites will be nationally evaluated to generate new evidence and to guide any future expansion of this initiative or amendment to the service model.