Victorian Mental Health Hubs

HUB Model of Care

We acknowledge the traditional owners of the land on which we work and live. We pay our respects to their Elders past, present and emerging, and extend that respect to all Aboriginal and Torres Strait Islander people.

HeadtoHealth centres are operated through the Victorian PHN Network, an Australian Government initiative.

Contents

1. Policy context

In 2013, the Australian Government requested the National Mental Health Commission (the Commission) to conduct a national review of mental health programs and services. The focus of the Review was on assessing the effectiveness of programs and services in supporting individuals living with mental illness, their families and other support people.

In November 2014, the Commission delivered its findings which highlighted existing complexity, inefficiency and fragmentation of the mental health system, and presented a compelling case for long-term sustainable reform.

The Commission argued that more efficient and sustainable approaches are needed to improve the system for individuals, across the life course and across illness severity, and to improve targeting of efforts.

The Commission recommended a major overhaul of the mental health system to shift the focus of the system from crisis and acute care to community-based services, primary health care, prevention and early intervention, and to better focus services on supporting individuals and families.

One of the transformational changes proposed by the Commission was the introduction of a 'stepped care' approach for mental health, in which a range of help options of varying intensity match levels of need.

In response to the Review findings, the Australian Government stated "The Commission has made a strong case to redesign, redirect, rebalance and repackage the approach to mental health, and has highlighted the risks of maintaining the status quo or further 'tinkering around the edges'".

In 2015, the Government committed to transforming the mental health system making stepped care a central component of its reform agenda.

Acknowledging that systems change and the implementation of stepped care in mental health will be challenging, the Australian Government set out the following key principles to guide funding and reform:

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

Underpinning this approach is person-centred practice with clearly defined pathways that relate to the person's acuity and functional impairment and which recognises the importance of non-health supports such as housing, justice, employment, and education, and emphasises cost-effective, community-based care; taking a 'whole-of-person care' perspective.

Many people living with mental illness interface with health care, social care, housing, and other services. If the needs of consumers and carers are truly at the centre of the way in which services are planned and delivered, there needs to be greater integration between mental health services and other services and better recognition of the broader determinants of mental health and issues that affect people living with mental illness. This means connecting health and areas such as disability, housing, education, and employment. It also means extending integration to prevention and early intervention.

The priority of a person-centred system is to enable individuals and their families to look after themselves. For most people, self-care, and support from those closest to them are the most important resources they must build and sustain to achieve good mental health and overall wellbeing, across the whole life span. Resilience

and wellbeing can also come from life within a local community through social contacts and participation in employment, education, clubs, and other activities.

The person-centred approach fits within a population-based model that aims to match available resources to identified need, placing emphasis on population groups which are at higher risk or have special needs. It is supported by a strong focus on prevention, early intervention and support for recovery that is not just measured in terms of the absence of symptoms, but in the ability to lead a 'meaningful and contributing' life.

At present, the Royal Commission into Victoria's Mental Health System has been tasked with reviewing the Victorian Government's current state of the mental health system and effectiveness to prevent and treat mental illness. Concurrently, the Productivity Commission inquiry into mental health seeks to examine the effects mental health and wellbeing have on people's ability to participate and prosper; and how prevention, early detection and treatment through the lens of participation and contribution effects the Australian economy and productivity. Interim findings from the Royal Commission and the Productivity Commission draft reports call for transformational reforms and investment.

The Australian Government recognises that the COVID-19 pandemic and its associated social and economic impacts have severely affected the mental health of individuals and communities in Victoria, requiring a systemic and localised response.

As such, PHNs have been tasked with ensuring 15 hubs are established across Victoria which form strong alliance in planning, implementation and delivery with existing or planned Victorian Government mental health services, including community services, triage and emergency services.

To ensure the consumers are receiving the right level of care, at the right time, a standardised Hybrid Intake and Referral structure has been designed which incorporates the richness of the regional service sector and provider knowledge to support consumer allocation.

2. Background

Eastern Melbourne PHN (EMPHN) developed a Mental Health Stepped Care Model (MHSCM) in line with mental health reform directions across Australia. The model seeks to respond to the National Mental Health Commission's recommendations for new models designed to deliver substantive reform (Australian Government Response, 2015). EMPHN's MHSCM was developed following extensive co-design and engagement with stakeholders over more than a year during 2016 and 2017. More than 450 stakeholders were engaged, including consumers, carers, mental health service providers and primary care providers. The MHSCM:

- Utilises the strengths of local service providers to meet the mental health needs of people in our catchment.
- Provides primary mental health services across the continuum of need, for people requiring low intensity support to higher levels of support.
- Is person-centred.
- Has an emphasis on recovery.
- Facilitates collaboration with the person's significant others and members of the person's care team to deliver the best possible care.
- Aims to reduce the stigma associated with having a mental health issue.

The HeadtoHelp Hub Model of Care has used EMPHN's core model as a starting place to develop the State-wide model, looking to scale up and spread, whilst enabling some iteration based on regional needs.

3. Definitions

"Care team" means the consumer, carer and all health workers involved in the collaborative shared-care plan developed to address the health and other support needs of the consumer. Health and other support workers include mental health professionals, other clinical staff such as peer workers and support facilitators, General Practitioners (GPs), other physical health professionals, Aboriginal Health workers, housing workers and other social and occupational support services, providing care to the consumer.

"Catchment" refers to the PHN hub region outlined in the Contract.

"Episode of Care" means the period between formal entry to and exit from service, during which treatment for presenting concern(s) is provided. This includes treatment for the reason defined at the point of referral, and during the treatment period. Formal exit from the service includes formal discharge from the service's Client Information Management System (CIMS), as the person's episode of care is considered to be open until this process has been finalised.

"HeadtoHelp Hub MOC" means the HeadtoHelp State-wide Hub Model of Care document, as updated from time to time by the PHN. As at the date of this Agreement, the latest version of the MOC is Version 1 (Attachment a).

"HeadtoHelp IAR MOC" means HeadtoHelp State-wide Initial Assessment and Referral Model of Care document, as updated from time to time by the PHN. As at the date of this Agreement, the latest version of the MOC is Version 1 (Attachment b).

"IAR" refers to Initial Assessment and Referral Tool. An initial assessment is used to gather information from the referrer and consumer to guide decisions about the most appropriate next steps aligned to the required level of care. Level 1 (self-management); Level 2 (low intensity interventions); Level 3 (moderate intensity interventions); Level 4 (high intensity interventions); Level 5 (acute and specialist community mental health services).

"**Integrated Care"** means health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course.

"Occasion of Service" any service of clinical significance delivered by the Head to Help Hub workforce and as described in the Head to Help Hub model of care.

"Step down care" means the processes/procedures required to facilitate access and/or transition to other mental health services of lower intensity in consultation with a consumer, carer/s (as appropriate) and care team, as clinically appropriate.

"Step up care" means the processes/procedures required to facilitate access and/or transition to other mental health services of higher intensity in consultation with a consumer, carer/s (as appropriate) and care team, as clinically appropriate.

"Stepped Care Approach" is an evidence-based, staged system of care, comprising a range of help and support options of varying intensity, matched to the level of need and complexity of the conditions being experienced by any given consumer. Once an assessment is complete, the most appropriate, cost effective level of care will be provided, and then continually re-calibrated to the consumer's changing needs. This is based on the consumer knowing themselves, and working with their care team, including their general practitioner (GP), mental health clinician and other health supports to know when to 'step up' or 'step down' their support needs.

"Target group" means people who are suitable for and will benefit from the Services detailed in this Agreement, identified as Level 3 or Level 4 on the IAR.

"Warm transfer" means the HeadtoHelp Hub 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 Hub until they are received by the new service.

4. Principles of Care

- Person centred: The consumer is at the centre of their care, with an understanding of connection to family, friends, peers, and the community.
- No wrong door: The service must accommodate presentations at all stages of illness, and people with comorbidities.
- Flexible: The service provides information and navigation assistance to ensure consumers receive the right care, at the right time, in the right way, and is simple to access.
- Recovery focused: The supports are specific to the person and their needs, promoting recovery and self-care.
- Needs-based: A range of evidence-based, culturally appropriate interventions are available, matched to consumers' current needs.
- Collaborative, integrated and whole-of-person: The service works in partnership with other key services, health professionals, families, and individuals. This includes development of integrated care pathways between primary care practitioners, specialist services and hospitals, and with social and community services such as housing, justice, education, disability, and employment.
- Skilled staff: An appropriately qualified and skilled multidisciplinary workforce, inclusive of peers, is a hallmark of the service.
- Safety and quality: The service operates to the highest standards of safety and quality in the delivery of services and support to the consumer.

5. Purpose

- Complement not replace or duplicate, mental health services already provided in the community. HeadtoHelp Hubs are not designed to offer longer term 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. HeadtoHelp Hub's provide an accessible, responsive service that meets consumer's needs and provides expertise in assessment of needs, information, linkage and support, and treatment.
- Deliver evidence informed, person-centred, recovery-oriented and cost-effective mental health services in the community, aligned with a stepped care approach.
- Deliver 'whole of person' holistic care by developing clearly defined pathways that relate to the person's acuity, physical health, alcohol and other drug use, and social and community supports such as housing, justice, employment, education and family and social functioning.
- Work with the PHN to develop integrated care pathways within the mental health system, health system, social and community services in the Catchment.
- Ensure the most efficient use of resources to develop and implement timely service pathways.
- Actively promote the use of the digital technologies, existing and emerging, that facilitate improved consumer care integration as a core element of a stepped care approach.
- Support GPs and other health professionals, to make appropriate referrals into HeadtoHelp, ensuring people are referred to the right place, for the right care, at the right time.
- Ensure the most appropriate, cost-effective level of care is provided to consumers by staff working at top of scope of practice, and continually re-assessing to meet consumers' changing needs.

6. Intended outcomes

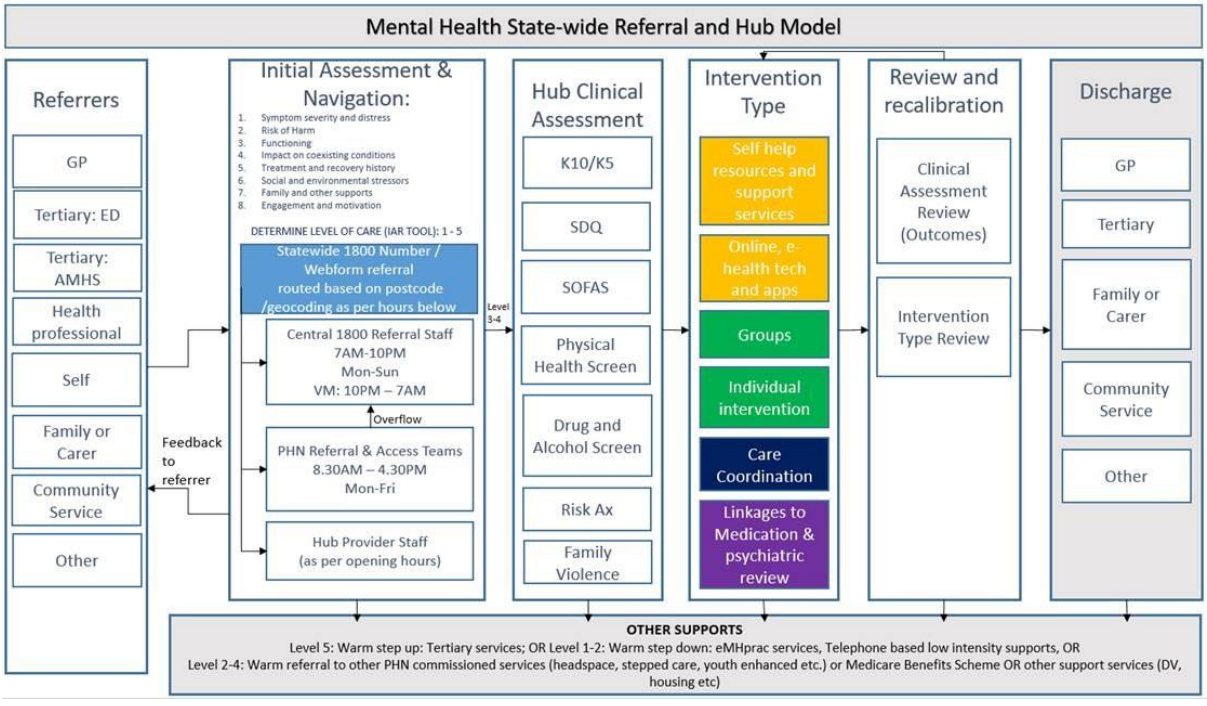
The key measures of success of the HeadtoHelp hub implementation, as defined by the Commonwealth Department of Health are:

1. Increased number of people accessing services.
2. Positive outcome as expressed by consumers/carers.
3. Reduced numbers of re-referral/readmission to Emergency Departments and Area Mental Health Services (AMHS).
4. Increased evidence of conjoint service and treatment planning.

7. Cohort

- Provide the Services to people of all ages who reside, work or study in the Catchment, who require support to manage their mental health. Prioritise support for consumers identified as requiring IAR Level 3 and Level 4 supports.
- Support consumers to navigate and access the right level of service within the community.
- Address service gaps in the provision of mental health support for people in rural areas and other underserviced and/or hard to reach populations.

8. Consumer journey overview



9. Initial Assessment and Referral

- Accept referrals into the HeadtoHelp Hub from any source, including but not limited to:
    - Self-referrals.
    - Carers, families and friends (with consumer consent).
    - General Practitioners, psychiatrists and paediatricians.
    - Specialist mental health clinicians and workers.

- Other support service staff (including telephone-based support services).
- Other health professionals, including Emergency Department clinicians.
- Schools.
- Community and social services.

- Accept referrals via phone, web-form or walk-in (e.g. on the spot).
- Provide a central process/point for initial assessment and referral, provision of information and advice, and navigation and warm referral pathways to support consumers and carers/family members to connect with appropriate care options available within the community.
- Follow agreed State-wide HeadtoHelp Initial Assessment and Referral processes, as outlined in "HeadtoHelp IAR MOC", including but not limited to:
    - Obtain and document informed consent to receive the agreed care and to support reporting, quality improvement and evaluation.
    - Maintain intake processes including screening, initial assessment and triage procedures which are consistent with HeadtoHelp IAR MOC.
    - Use the agreed State-wide 'HeadtoHelp Initial Assessment and Referral' referral form.
    - Ensure an IAR is completed for all consumers to help define the required 'level of care'.
    - Support consumers with care needs matching Level 1, Level 2 and Level 5 to navigate, via warm transfer, to appropriate care options outside of the 'HeadtoHelp Hub', which may include:
        - Step Down options: warm transfer to self-management (e.g. via Head to Health) and low intensity support options in the community (for example, but not limited to, beyond blue, PANDA, kids helpline); or
        - Step Up options: warm transfer to hospital mental health services (e.g. psychiatric triage services); or
        - Warm transfer to privately funded mental health services or Medicare Benefits Scheme services; or
        - Warm transfer to other appropriate PHN commissioned services (e.g. headspace, stepped care services, suicide prevention services, alcohol and other drug services); and/or
        - Warm transfer to other support services (e.g. physical health, family violence, housing services, financial, employment/vocational, other social and family services).
    - Support consumers with care needs matching Level 3 and Level 4 to navigate to appropriate care options, which may include:
        - Service intervention within the HeadtoHelp Hub; or
        - Warm transfer to other appropriate PHN commissioned services (e.g. stepped care services, youth enhanced services, psychosocial support services, suicide prevention services, alcohol and other drug services); or
        - Warm transfer to privately funded mental health services or Medicare Benefits Scheme services; and/or
        - Warm transfer to other support services (e.g. physical health, family violence, housing services, financial, employment/vocational, other social and family services).
    - The initial assessment and referral process must provide a 'no wrong door approach', ensuring all referrals are supported to engage with an appropriate service that meets their needs.

- Accept referrals from other HeadtoHelp Initial Assessment and Referral teams for consumers with care needs matching Level 3 and Level 4.
- Participate in regular State-wide intake meetings with other HeadtoHelp Initial Assessment and Referral teams to refine the model and address issues regarding demand and access.
- Complete all required data capture requirements.

- Develop and maintain effective relationships with stakeholders (such as GPs, NGO's, Local Hospital Networks and community-based organisations) to increase identification and improve service response for consumers and promote the Program to potential referrers.
- Co-operate with other providers of similar and related programs (whether funded by the Victorian Government, Commonwealth Government or otherwise) to maintain linkages, referral pathways, connect services and provide for a consumer-centred focus.
- Develop strong connection, liaison, procedures and protocols, as appropriate, with other appropriate health service intake and access points.

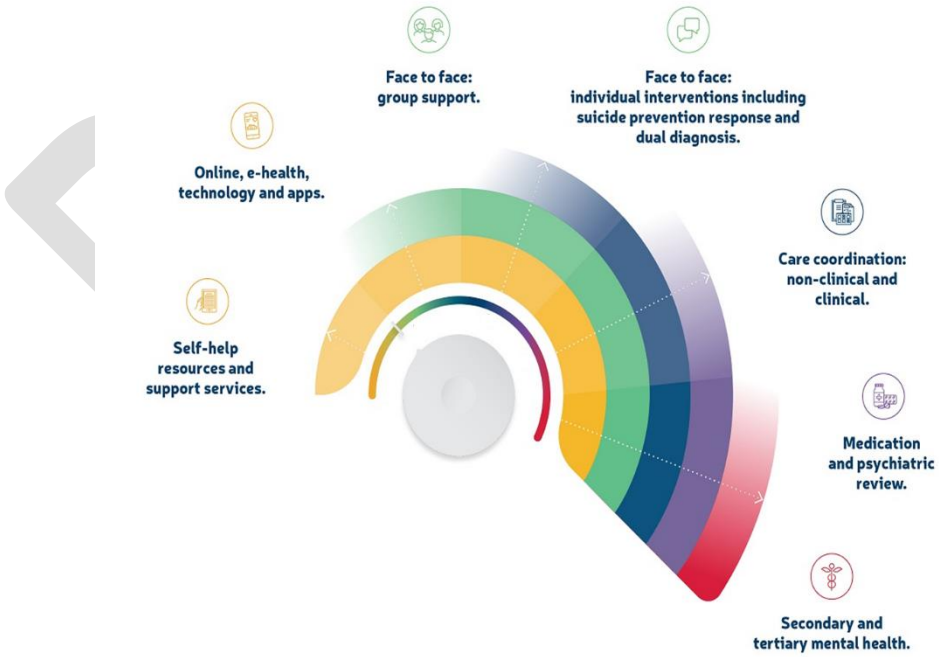
10. Comprehensive assessment

- Obtain and document informed consent to receive the agreed care and to support reporting, quality improvement and evaluation.
- The Contractor will hold the responsibility for developing a clinically robust assessment process to be completed in conjunction with the consumer and their carer(s) (as appropriate) to fully assess the consumer's presentation, impact of the mental health concerns on their functioning, co-occurring needs (e.g. physical health, housing education/vocation, financial), and the strength/viability of informal supports.
- The Contractor will demonstrate an evidence-informed and best practice assessment framework to ensure consumers are directed to the appropriate cost-effective support considering their level of need, thereby ensuring appropriate treatment type and intensity. A consumer may access one or more intervention types, but this should correlate with the intensity and need that the consumer is presenting with. Linkages to concurrent interventions can be made, targeting associated needs in relation to physical health, education and employment, alcohol and other drug harm reduction, family and social functioning, suicide and self-harm reduction, or any other areas of need.
- The Contractor will complete all required data capture and outcome measures as outlined below.
- Establish a robust Clinical Governance Framework and processes, including demand/waitlist management strategies, clinical escalation procedures and psychiatric consultation processes, to ensure consumers are followed-up and adequately supported in the event of waiting for service provision to commence, this includes, but is not limited to:
  - Implementing and coordinating an escalation policy to ensure timeliness, accurate risk assessment and triaging and a responsive service for consumers;
  - Consultation with psychiatrists via a case conferencing/coordination model using existing systems that are currently in operation by the Contractor or commissioned by the PHN.
  - Using an active waitlist management approach, including regular monitoring of consumers on the waitlist (fortnightly at a minimum), incidental counselling opportunities and referral to online and support groups or other services; and
  - Using group interventions to transition consumers out of the Program, and to assist consumers on the waitlist for one-on-one interventions, so that they remain engaged and supported.

11. Risk assessment, risk management and safety planning

- The Contractor will establish a Clinical Governance Framework and processes to ensure robust consumer risk assessments and safety planning processes are in place. This includes, but is not limited to:
    - Formal risk assessment, management and safety planning must occur as a part of thorough intake and assessment processes and as a routine part of safe ongoing clinical practice. Formal risk assessment should occur at a minimum on assessment and discharge, and as a part of standard care review processes (e.g. at 3-month intervals). This minimum expectation would only apply in instances where no risk or very low risk is indicated. In instances where risk is indicated to be higher, clinical judgment about frequency of risk assessment will be determined by the risk indicated and the circumstances that surround it. Clinical risk should also be reviewed at every clinical contact with the consumer, and safety plans adjusted as needed.
    - A thorough mental health assessment, including a mental state examination, relevant risk history, and factoring in other relevant diagnostic factors.
    - The Contractor must develop safety plans in collaboration with the consumer and their carers, when required.
    - All notes relating to assessment, risk and planning for a consumer's ongoing care need to be documented in the consumer's clinical notes, inclusive of any handover notes, and liaison with other services where a consumer has had to be referred to other/ additional services in order to be able to appropriately support the consumer.

12. Intervention types



- As agreed with the PHN, Contractors will deliver the following evidence-based intervention types, including:
    - Use of evidence informed e-based technology (self-directed applications and clinician moderated). Funding for this service type is only for mental health workers to support this modality, and not for development of e-therapy systems. e-based clinician moderated services to be delivered by an appropriately trained mental health worker.

- Group programs (including psychoeducation groups) delivered by appropriately trained mental health workers, including peers.
- Evidence-based psychological interventions delivered in a group format, including family-based interventions. These services must be delivered by credentialed mental health clinicians.
- Evidence-based one-on-one psychological interventions delivered by credentialed mental health clinicians.
- Quick response suicide prevention support offering one-on-one psychological interventions delivered by credentialed mental health clinicians.
- Care coordination to support 'whole of person' care. Through social prescribing, workers will assist consumers to address their 'whole of person' needs by linking them with appropriate services such as physical health, alcohol and other drugs, education/employment, financial, and family and social needs supports. In particular, consumers are linked to primary health care, where GPs play a central role in managing the care and physical health of their consumers. Care coordination also focuses on enabling consumers to access and attend a range of services available to them. Care coordination may include providing supports to facilitate attendance at clinical appointments; providing follow-up support if consumers have failed to attend clinical appointments; or coordinating services for the consumer in relation to GPs, psychologists, psychiatrists, allied health workers, and other health professionals as required. Care coordination services are delivered by appropriately trained non-clinical mental health workers, or credentialed mental health clinicians, depending on individual consumer need.
- Dual diagnosis services delivered by appropriately trained mental health workers.
- Support linkages to psychiatric secondary and primary consultation using existing systems that are currently in operation by the Contractor or commissioned by the PHN.

- Contractors will deliver easily assessable services that can be offered in several delivery formats/modalities, including face-to-face (individual, group or family), outreach, telephone, telehealth/videoconferencing, e-based/internet-based services. When using telehealth/video conferencing, the provider will ensure that secure video conferencing systems that meet relevant Australian privacy and other legislation requirements are used.
- Service interventions/modalities are to be based on consumers' assessed needs and in consultation with the consumer, carer and referrer as appropriate. The higher the person's needs, the more intense the service interventions offered.
- Contractors will ensure that all intervention types delivered are culturally appropriate. This includes creating partnerships and co-location opportunities with local ACCHOs/ACCOs and other Culturally and Linguistically Diverse (CALD) services to meet the needs of the local community.
- Contractors will deliver service modalities or interventions that complement the current service system, and work with the PHN to ensure that duplication of services does not occur.
- Contractors will document, use and regularly review an individualised care plan/treatment plan for all consumers, outlining treatment and recovery goals. Where a consumer is identified as requiring the support of multiple services, the Contractor will facilitate the development and review of a Collaborative Shared Care Plan (see section 13 below).

13. Collaborative shared care planning and treatment

- When an individual requires the support of multiple services, the Contractor must come together with the consumer and family/carers (as appropriate) and other members of the care team, including involved health workers, such as GPs and other support services, to establish agreed working practices and develop a Collaborative Shared Care Plan.
- The Collaborative Shared Care Plan will promote a shared understanding of the consumer and their personal recovery goals, promote consistency in practice, avoid duplication of care, reduce stress, and ensure all care team parties are working towards the consumer's identified goals. Consent, confidentiality and appropriate information sharing are central tenets to a recovery-oriented collaborative shared care plan.
- The Contractor may use an existing Collaborative Shared Care Plan template, or the template developed for the Statewide HeadtoHelp Hubs (see Attachment c).
- The Contractor will ensure collaborative safety plans are developed with all care team members, when clinically indicated.
- The Contractor will work with consumers to facilitate links back to their GP, to ensure a whole of person approach with their physical health needs managed in concert with their mental health needs. Where the consumer does not have a regular GP, the Contractor will work with the consumer to establish a regular GP relationship.
- The Contractor will ensure clear communication with the referrer and the consumer's care team, including their GP. This includes the provision of regular feedback, treatment reports as necessary, and formal care team meetings with all members of the care team at a frequency matched to consumer need. Formal care team meetings may occur face-to-face or via telehealth/videoconferencing.

14. Review and recalibration

- The Contractor must ensure reviews of consumers are undertaken on a regular basis, at a minimum every three months, or as clinically indicated. This includes completion of required outcome measures.
- The level of care provided will be continually reassessed and re-calibrated based on the consumer's changing needs.
- In line with the principles of person-centred care, the Contractor must ensure that any handover to, or engagement with a new HeadtoHelp Hub worker or other service is done in consultation with the consumer and carer, as appropriate. These changes in care should be discussed with as much lead time as possible, considering the consumer's presentation and mental state. It is also a requirement for the Contractor to discuss handovers, transitions and additions to care with all members of the care team, including other relevant health professionals/services involved.
- Contractors must have in place:
    - Procedures and tools to initiate a review the consumers mental state, risk and safety.
    - Processes to review and re-calibrate care, including the need to step up, step down or transition out of care (discharge planning).
    - Procedures to involve the care team in any review and/or update of the consumer's Collaborative Shared Care Plan.
    - Processes to facilitate warm referrals to other services with consumer consent, as identified during the review.

15. Service exit/discharge

- The Contractor must establish care transition and discharge processes, this includes promoting and ensuring that there are processes and strategies for step up and step down care for those who require more or less intensive support.
- Collaborative shared care planning and supportive exit/discharge is expected for all consumers. When the consumer comes to the end of their care and exit is being considered, plans should be put in place in consultation with the consumer, their family/carers as appropriate, and their care team.
- The Contractor must collaborate and communicate with the consumer, their family/carers, the care team and other stakeholders in the planning and actioning of individual consumer's transition and exit.
- Upon service exit, all members of the care team are to be involved in, or informed of, the completion of care, and a summary regarding rationale and ongoing care arrangements to appropriate parties is to be circulated.
- The Contractor will have in place procedures that support consumers to re-enter the hub or access alternative supports if they require additional support in the future.
- Transition Out: The Contractor will ensure smooth care transitions and discharge pathways; this includes promoting and ensuring there are processes and strategies for Program End Date. The Contractor must assess whether an episode of care is likely to be completed by the Program End Date. If a consumer does not complete the episode of care by the Program End Date, the Contractor must either:
    - Continue at its own cost to provide appropriate clinical care and/or support to such consumers after the Program End Date.
    - In consultation with the PHN, transition the consumer to another program or service provider, which is clinically appropriate before the Program End Date. This process must be completed in consultation with all relevant health providers (including GPs), care team members and consumers and carers, as appropriate.

16. Integrated care pathways

- In partnership with the PHN, the Contractor is required to establish integrated care pathways and partnerships to support the delivery of the HeadtoHelp Hub, this includes with:
    - Referral agencies, including the HeadtoHelp Statewide Initial Assessment and Referral Teams and PHN Referral and Access Teams to facilitate referrals;
    - General practice, to facilitate referrals, support care coordination and manage transition support;
    - Local primary care agencies, to support the provision of outreach access points and service provision for consumers that are geographically spread across the Catchment;
    - Mental health services and practitioners to enable step up and step down care, including but not limited to beyond blue, hospitals including Emergency Department and area mental health services, and other service providers – private and public;
    - ACCHOs/ACCOs, and other Culturally and Linguistically Diverse (CALD) services to meet the needs of the local community;
    - Local services, to ensure the appropriate mix of health, education, disability, family support and other services can be matched with individual consumer (and carer/s) needs; and
    - Other programs and funding bodies that fund psychological services, such as Better Access Providers and the NDIS.

17. Access, service locations and times

- Services will be delivered from, at a minimum, the Contractor's or partners premises, or via colocation, in locations agreed with the PHN and outlined in the Agreement, and in the person's home or elsewhere.
- The Contractor will make available Program services at a minimum Monday to Friday between 8.30 am and 5.00 pm. In addition, a further 10 hours per week must be delivered after business hours, preferably at least one weekday evening, and either a Saturday/Sunday. The Contractor must seek approval from the PHN to make changes to service delivery times, in order to work flexibly to deliver services at times required by consumers.
- e-based technology services should be available seven days per week, these may not necessarily be services that are provided or owned by the Provider and should be consulted with the PHN.
- Outreach services must be delivered as required and be clinically appropriate.
- To support consumer access, the Contractor must:
    - Obtain the services of suitable Practitioners who speak languages other than English or ensure ready access to interpreters
    - Provide disability access and facilities at physical hub sites
    - Develop and implement strategies to increase access to services for identified hard to reach/underserviced target groups.

18. Workforce

- The Contractor must include an appropriate mix of qualified staff to competently deliver the Program, with consideration of both formal qualifications, lived and professional experience, who can deliver an appropriate service response across the continuum of acuity. The model is based on a multidisciplinary approach requiring a mix of clinical and non-clinical workforce.
- The Contractor should build in flexibility to the recruited workforce to ensure the Program can meet service demand and clinical requirements across the spectrum of acuity and across service intervention types in a timely way.
- All staff must have the appropriate skills and knowledge to competently deliver evidence-based interventions (including the knowledge of evidence-based interventions theory, and knowledge of research into their effectiveness). Staff must have the necessary experience required to assess and treat consumers with a range of mental health problems.
- The Contractor should give key consideration to employment of workforce with qualifications and experience that will meet consumer needs across the life span, as required to deliver the Head2Health Hub. For example, employment of clinicians with expertise in child, youth and family therapy, adults and older people.
- There must be one or more clinical workers involved in the delivery of this treatment service. The clinical workforce will comprise credentialed mental health clinicians including:
    - Division 1 Nurses*
    - Psychologists (Provisional Psychologists under supervision)*
    - Clinical Psychologists*
    - Social Workers*
    - Occupational Therapists*

  *Credentialing requirements outlined in the Table 1 below.

- Mental health support workers and peer workers can be involved in the delivery of this treatment service as required, if they meet the requirements outlined below. To be eligible to provide interventions, mental health support workers must have a minimum of two years' experience in the mental health sector; have daily practice overseen; and have the ability to contact a clinically trained supervisor. Mental Health support workers must be formally supervised by a clinically trained staff member on a fortnightly basis.
- Refer to Section 12, Intervention Types for details about workforce required to deliver respective intervention types.

Table 1: Workforce Requirements

Workforce	Credentialing requirement
Division 1 Nurses (specialising in mental health)	Current registration with Australian Health Practitioner Regulatory Agency. Level equivalency requirement, RPN3 and above. *Desirable:* a minimum of two years' experience in mental health. *Desirable:* credentialed with or working towards credentialing with the Australian College of Mental Health Nurses.
Psychologists	Current general registration in the health profession of psychology with Australian Health Practitioner Regulatory Agency. Equivalency P2 and above. *Desirable:* a minimum of two years' experience in mental health.
Clinical Psychologists	Current registration in the health profession of psychology with Australian Health Practitioner Regulatory Agency and endorsed by the Psychology Board of Australia to practice in clinical psychology. Equivalency P2 and above. *Desirable:* a minimum of two years' experience in mental health.
Social Workers	Current members of, or eligible for, membership with the Australian Association of Social Workers (AASW). Equivalency SW 2 and above. *Desirable:* a minimum of two years' experience in mental health. *Desirable:* credentialed with or working towards credentialing with the AASW.
Occupational Therapists	Current registration in the health profession of occupational therapy with Australian Health Practitioner Regulatory Agency. Equivalency OT2 and above. *Desirable:* a minimum of two years' experience in mental health. *Desirable:* Accredited by Occupational Therapy Australia as having a minimum of two years' experience in mental health; and having undertaken to observe the standards set out in the document published by Occupational Therapy Australia 'Australian Competency Standards for Occupational Therapists in Mental Health' as in force on 1 November 2006.
Mental Health Support Workers	Tertiary qualification in health and related fields Completed further study in mental health such as a certificate or diploma level qualification in mental health or undergraduate or postgraduate study focusing on mental health. For Division 2 (Enrolled) Nurses: Current registration with Australian Health Practitioner Regulatory Agency. Advanced Diploma of Nursing (Mental Health); *Desirable:* a minimum of two years' experience in mental health.
Aboriginal and Torres Strait Islander Health	Current national registration with the Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHPBA).

Practitioners	
Youth Workers	Tertiary Diploma or Bachelor degree in Youth Work or Certificate III, Certificate IV in Youth Work, Advanced Diploma or a Diploma qualification in youth work, counselling or community services.
Peer workforce	Qualifications for direct service delivery: Cert IV in AOD, Mental Health or Peer Work, or Diploma of Community Services

- The Contractor must ensure that its practitioners comply with continuing professional development requirements of their respective professional bodies.
- The Contractor must ensure that all clinical staff, including peer workers receive appropriate clinical supervision to ensure safe and high-quality evidence-based clinical care.

19. Community engagement

- The Contractor must ensure consumers and carers are involved in any design, implementation, delivery and evaluation of the Program.

20. Capacity building

- The Contractor must:
    - Work with the PHN to build the capacity and confidence of GPs and other health professionals and practitioners in identifying and treating mental health consumers within a mental health stepped care approach.
    - Work with the PHN to build the capacity of stakeholders with regards to appropriate referral pathways for consumers.

21. Communications, promotions and marketing

- The PHN will produce a range of consumer-facing digital and print collateral to HeadtoHelp brand specifications, in simple, easily accessible language. Communication packs will be made available to Contractors as required.
- Any proposed alterations to this material or the production of additional promotional material should be discussed with the Communications Team at the PHN.
- Any material produced by the Contractor using the HeadtoHelp brand or the PHN logo must be approved by the PHN Communications Team before print or publication.
- The Contractor must follow any required Communication Protocols for Commissioned Services developed by PHNs.

22. Equipment and environment

- The Contractor must:
    - Provide safe and appropriate premises to deliver the Services for all age ranges, including therapeutic spaces for children, as well as outreach services for all age groups.
    - Provide all equipment, consumables, materials and technology required for the Services and all other components of the Agreement.

23. Quality, safety and risk

- The Contractor must establish a comprehensive Clinical Governance (quality and safety) framework that is aligned to the PHN's Clinical Governance Framework, including:
    - Compliance with relevant safety and quality standards.
    - Implementing appropriate confidentiality and privacy arrangements in accordance with relevant legislation, that allows for information sharing between practitioners.
    - Ensuring that staff are appropriately credentialed, well supported and trained to provide high quality, evidence-based care.
    - Protocols to ensure the safety of staff and clients in the event that an individual presents a risk to themselves or others, including consideration of after-hours arrangements
    - Diversity and cultural safety considerations to ensure that Aboriginal and Torres Strait Islander people, other people from CALD backgrounds, LGBTIQA+ communities and other vulnerable groups receive safe and quality care.
- The Contractor must:
    - Manage risks relating to the Program Services and Agreement, in accordance with the Contactor's risk management framework and as approved by the PHN.
    - Establish and maintain oversight of Clinical Governance and Risk Management arrangements, including with any partners or sub-contractors, which are aligned to the PHN's Clinical Governance Framework.
    - Participate in occupational health and safety risk assessments, which the PHN may conduct for premises from which Program Services are delivered and hold documented procedures for outreach and home visits.
    - Have, follow and maintain documented policies and procedures on the following matters, which must be adhered to and provided to the PHN on request:
        - Consent to treatment
        - Privacy and confidentiality (including the use of telehealth)
        - Mandatory reporting
        - Statement of consumer rights and expected behaviours towards health workers
        - Consumer feedback and complaints mechanism
        - Clinical pathways diagrams/charts
        - Clinical notetaking
        - Credentialing (for all relevant staff)
        - Records management policy
        - Clinical Governance Framework including incident management and follow up procedure
        - Risk Management Framework
        - Risk assessment and management
        - Outreach and home visit risk procedure
        - Referral, Access and Triage
        - Clinical supervision and continuing professional development.
    - The PHN may request the Contractor, or the Contractor's partners, to participate in an audit of program services and adhere to the Agreement. This includes audit of consumer files.

24. Incident reporting

- The Contractor, including with any partners or sub-contractors, must follow incident management procedures outlined in the Agreement by the PHN.

25. Feedback and complaints

- The Contractor, including with any partners or sub-contractors, must allow consumers and other stakeholders, the opportunity to provide feedback to the Contractor regarding the Contractor and its partners and sub-contractors.
- Upon request, the Contractor must provide a consumer feedback and complaints management process acceptable to the PHN.
- Upon request, the Contractor must participate in any complaint's management processes operated by the PHN.

26. Mandatory data and outcome measures

- The Contractor must:
    - Use the required state-wide data capture system specified by the PHN for the HeadtoHelp Initial Assessment and Referral process, as outlined in "HeadtoHelp IAR MOC".
    - Maintain a client information management system and/or other data capture processes, as approved and/or required by the PHN, which collects:
        - Commonwealth Department of Health's Primary Mental Health Care Minimum Data Set (PMHC MDS);
        - Other data and outcome measures required by the PHN; and
        - All relevant clinical information in accordance with legislation, and relevant data to measure and evaluate the service model.
    - Provide data extracts, KPI reporting and any other outcome measure data at regular intervals, as required by the PHN.
    - Produce any reports specified from time to time by the PHN, submitted in a manner determined by the PHN.
- Evaluation: The Contractor, including with any partners or sub-contractors, must fully participate in and contribute to any review, evaluation, survey, interview or audit activity by the Department or the PHN (or their nominees).

27. Specific laws, policies, guidelines and standards

The Contractor must meet and maintain compliance with relevant legislation, policies, guidelines and standards including, but not limited to the below, at all times throughout the duration of the Agreement:

a. National Standards for Mental Health Services 2010
b. All standards outlined in the Practitioner's profession's relevant practice standards or competency standards documents (e.g. Australian Competency Standards for Occupational Therapists in Mental Health for occupational therapists)
c. Privacy Act 1988 (Cth) and the Australian Privacy Principles (APPs) established under that Act
d. Personally Controlled Electronic Health Records Act 2012 (Cth)
e. Health Records Act 2001 (Vic)
f. Freedom of Information Act 1982 (Vic)

g. Any other applicable law relating to privacy and the PHNs reasonable directions in relation to the protection of personal information and delivery of clinical services
h. National framework for recovery orientated mental health services 2013
i. Child Youth and Families Act 2005 (Vic)
j. Child Safe Standards issued by the Victorian Government
k. Allied health: credentialing, competency and capability framework 2014
l. Dangerous Goods Act 1985 (Vic)
m. Environment Protection Act 1970 (Vic)
n. Occupational Health and Safety Act 2004 (Vic)
o. Workplace Injury Rehabilitation and Compensation Act 2013 (Vic)
p. Industrial relations legislation and obligations as it relates to its employees and workers
q. Any rules and guidelines issued by WorkSafe Victoria
r. All relevant Australian Council on Healthcare Standards
s. Mandatory reporting legislation
t. Mental Health Act 2014 (Vic)
u. Working with Vulnerable People Act 2011 (Cth)
v. Working with Children Check
w. Disability Workers Exclusion Scheme
x. Other PHN policies and procedures relevant to the Program Services and as advised
y. Any other requirements imposed on the PHN by the Department which may impact the Program Services.

28. Licensing and credentialing

- Matters to be verified before appointment: identity, professional registration with AHPRA, qualifications/certifications required for the role, previous employment/ experience/ performance, criminal history checks, suitability to work with children (Working with Children Check), suitability to work with vulnerable people including those with a disability (DWES) and driver's licence (where relevant).
- Matters to be verified at least annually and when roles change: professional registration with AHPRA, qualifications/certifications required for the role, suitability to work with children and driver's licence (where relevant).
- The Contractor must provide the PHN with a statutory declaration at the time of entering into this Agreement, annually and on PHN request, stating that all mental health workers and program staff delivering the services meet the credentialing standards outlined in the Agreement, have a criminal history check that details no history of offences and have a current Working with Children Check. In the case of subcontracting providers, this statutory declaration must also attest to appropriate insurance for those subcontracted providers.
- The Contractor must ensure that its practitioners comply with continuing professional development requirements of their respective professional bodies.
- Training for the provision of services to people experiencing family, domestic or intimate partner violence
- Any mandatory training requirements, which may be organised by the Department or the PHN.

29. Clinical requirements

- The Contractor must ensure that all clinical staff, including peer workers, receive adequate clinical supervision to ensure safe and high-quality evidence-informed clinical care. Where available, this should be in line with the Practitioner's profession's relevant practice standards or competency standards documents.
- The Contractor must ensure adequate case file management and audits.
- Implementation: Establish an Implementation Committee to support the establishment of the program with representation from key partners, including PHN representatives and a consumer/carer representative, meeting monthly.