Lives Lived Well

Partners in Recovery
Collaboration Project: The Navigator

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Dealing with addiction. Passionate about the possibilities.

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Abbreviations

ACT	Acute Care Team
ED	Emergency Department
GCHHS	Gold Coast Hospital and Health Service
GCUH	Gold Coast University Hospital
GP	General Practitioner
GPMHCP	General Practitioner Mental Health Care Plan
LGBTI	Lesbian, Gay, Bi-sexual, Transgender and Inter-sex
LLW	Lives Lived Well
NGO	Non-government organisation
PIR	Partners in Recovery

EXECUTIVE SUMMARY

The Navigator Project is a short-term, integrated response to feedback received from carers and consumers living in the Gold Coast region, who have experience of mental health concerns. Following the Partners in Recovery (PIR) Carers and Consumers Engagement Report, it was identified that carers and consumers with mental health concerns find it challenging to access, or be linked in with appropriate and available mental health community support services, particularly at the time of hospital discharge. This report highlights how the PIR Navigator role has been able to assist in identifying appropriate discharge linkages and planning for individuals and their carers exiting the Emergency Department (ED) at the Gold Coast Hospital and Health Service (GCHHS). PIR engagement with GCHHS aimed to build on opportunities to strengthen referral pathways to community services for people who may be at risk of pre-mature re-entry to hospital.

A Steering Committee was formed at the beginning of the project to ensure management of activities toward the agreed outcomes and project plan. Meetings were held monthly and committee members included relevant staff from the Gold Coast Hospital and Health Service Emergency Department; Partners in Recovery-Gold Coast Primary Health Network and Lives Lived Well.

The aim of the Navigator Project was to evaluate the acceptability, feasibility and impact of the placement of a non-clinical Navigator in the Emergency Department at the Gold Coast University Hospital (GCUH). The purpose of the Navigator role was to ensure a continuity of care to individuals with mental health concerns, through appropriate community-based discharge planning and supporting the individual's transition from 'ED to home' including mapping pathways from ED and the identification of any opportunities to assist GCHHS improve care pathways for discharge.

Between the 8th of September, 2015 and 4th of April, 2016 fifty-eight consumers, who presented to the GCUH ED with varied mental health concerns, including, those with symptoms of depression, anxiety and substance misuse, following mental health assessment and identification of defined community linkage needs (e.g. accommodation/employment/transport etc.). Consumers completed a baseline assessment with the Navigator in an initial consultation, either face-to-face or over the telephone.

All participating consumers experienced at least one short-term need that the Navigator was able to address, through referral and linking to a community-based service. The Navigator could assist with linking consumers in with an array of support and practical services on the Gold Coast. Almost 60% of services the Navigator referred to were support-based community services, including relationship and family counselling, mental health support groups and alcohol and other drug support services. The most utilised practical services referred to included wellness activities, location of a local General Practitioner (GP) and legal aid services.

Referrals to the Navigator were provided by clinicians in the GCHHS Mental Health Acute Care Team (ACT). While the scope of the project involved face-to-face consultation, more than half of the referrals were telephone referrals; that is, the referral was given to the Navigator after the individual had been discharged and left the ED, this was due to a number of factors, including rotating rosters of staff and availability of the Navigator. The Navigator service involved an initial consultation at the time of discharge, and 48-hour and one-week follow-up assessments. The average time the Navigator invested in each consumer case was just over two hours.

The Project faced a number of challenges that were unforseen when the project plan was developed, including a delay in sign off of the collaboration agreement by relevant delegates, which resulted in a slight

delay in the commencement of the collocation of project staff. Other challenges included time required to implement new changes, building relationships and mapping pathways with wider community non-government organisations (NGOs). There were also some challenges faced around NGOs limited access to Care Plans, GCHHS medical records/ data, and treating team handovers/ case reviews.

Overall, the consumers referred to and engaged with the Navigator service were satisfied with the service. Consumer feedback included reports that they felt supported during the "ED to home" transition, felt informed of primary and community care services available to them, such as the General Practitioner Mental Health Care Plan (GPMHCP) and other appropriate community-based services, felt listened to and included in their own discharge planning which made them feel empowered to start to take control of their own recovery.

The results of the Navigator Project suggests that the Navigator model of service, utilising PIR staff co-located in the ED, working alongside the GCHHS ACT, assists in addressing community linking needs of consumers upon discharge. This model may assist consumers to avoid future re-entry to the ED.

Based on project outcomes and feedback received from the consumers, a non-clinical Navigator with a strong background in community services is best suited to meet the needs of the consumer, as they have a vast knowledge of appropriate non-government organisations and community-based services, including referral pathways, wait lists and services offered.

The project identified a number of further opportunities for improvement in the care pathway between ED, primary care and community that were not able to be addressed in this pilot due to time frames and will be shared with the GCHHS /PIR /PHN via this report.

1.0 INTRODUCTION

The Gold Coast region has one of the highest rates of mental illness in Australia, with substance misuse and social isolation identified as two of the key triggers. Compared to Queensland and Australia, the Gold Coast has higher rates of psychological distress, mental, behavioural and mood problems, with 10.4% of males and 12.2% of females having mental and behavioural problems [2]. The GCHHS provides a comprehensive specialized and focused public mental health service. The Model of Care employed across the Gold Coast Mental Health & Specialist Services that flows from this is delivered via an integrated system of assessment, intervention and management across the acute to continuing care continuum, inpatient and outpatient settings and encompassing all age groups. Assessments and interventions reflect the contributions of a multi-disciplinary team approach and specialist input and advice. In addition there are age specific and specialist programs including: Child & Youth Mental Health, Adult Mental Health Older Persons Mental Health, Persistent Pain, Aboriginal and Torres Strait Islander Health, Alcohol & Other Drug Services and interpreter services.

The care approach in mental health is focussed on the paradigm of recovery, as identified in the National Mental Health Plan. This builds upon the treatment and care of our consumers in all settings. Recovery emphasises the need for a comprehensive community based service system in which all sectors take responsibility for the health of their community and provide appropriate Mental Health Service services and supporting mechanisms in a coordinated and collaborative manner. The specific MH programs provided fall under the three broad service functions of:

- Acute care
- Continuing care
- Specialist services.

GCHHS ED presentations with a mental health problem/concern is on average 700 presentations a month

Partners in Recovery (PR) conducted seven three-hour public consultations on the Gold Coast. The aim of these sessions was to better understand the experiences, issues and challenges faced by people with mental health concerns when accessing mental health services on the Gold Coast. The findings from these sessions are outlined in the 'PIR Carer and Consumer Engagement Report, 2014' [1], which identifies a number of key issues and emerging themes. Discharge planning that includes linkages to community services, to better support the transition from 'hospital to home' was highlighted as the priority issue in which they felt PIR needed to work collaboratively with GCHHS to address [1].

Additionally, annual reporting from Gold Coast Complex Needs Panels (CNAPY & CNAP – Youth at Risk Alliance Wesley Mission, CNAPS – LLW and CNAP – GCHHS), identified that service integration care pathways from GCHHS ED to community limited and reportedly resulted in some individuals reporting that they either did not access or were not aware of community support services that may have been of benefit to them.

A lack of continuity of care following ED discharge has been found to contribute to impaired health and excess mortality in individuals with severe mental illness [4]. A systematic review and meta-analysis of eleven studies looking at the efficacy of discharge planning interventions in mental health care from hospital to community, found discharge planning interventions to be effective in reducing re-hospitalisations and in improving

adherence to aftercare among people with mental disorders [5]. Thus, providing continuity of care through appropriate discharge planning is vital in supporting a person with mental illness in their recovery.

Further to this, evidence suggests that the transition from 'emergency department to home' is difficult for mental health consumers, with only 50% of consumers accessing aftercare in the community during the period immediately following discharge [7, 8]. Therefore, support for an individual with mental health concerns during this transitional period could improve access to services and support recovery.

A relatively new role in the public health system, the Navigator, or patient navigator, is suggested to have the flexibility and capability to provide a supportive service to patients, whereby they assist in navigating complex health services, provide links to primary health care and community services, assist in identifying and overcoming access barriers and supporting the transition from hospital to community. Based on evidence-based research, a project was undertaken to pilot a Navigator role model of service within the GCUH ED aimed to address issues identified around pathways for individual from the ED department to community specifically regarding improved discharge planning.

Partners in Recovery collaborated with Lives Lived Well (LLW) and GCHHS to initiate the Navigator Project, based on the abovementioned feedback received from extensive community consultation. The aim of this innovative project was to provide an evidence base for the effectiveness of a Navigator role working directly in the ED at the GCUH. The project involved the design, implementation and evaluation of the placement of a non-clinical patient navigator within the ED, working alongside the GCHHS Mental Health Acute Care Team (ACT) clinician's, to increase individuals knowledge of and access to community based support services upon discharge, to assist in pre-venting hospital re-entry.

The Navigator Project aimed to contribute to the following Partners in Recovery objectives:

- Facilitate better coordination of clinical and other support and services to deliver individually tailored 'wrap around' care
- Strengthen partnerships between various clinical and community support organisations responsible for delivering services to PIR group
- Improving referral pathways that facilitate access to the range of services and supports needed by PIR target group, and
- Promoting community recovery based practice to underpin all clinical and community support services delivered to people experiencing mental health concerns.

Implementation of the Navigator Project was originally intended to take place in the Emergency Department in July 2015, however due to a delay with the collaboration agreement, the project was operational on the 8th September 2015

The primary objectives of the project included:

- Placement of a Navigator to work alongside the Mental Health ACT clinician's in the GCUH ED, to support provision of comprehensive discharge planning for the individual from the ED to the community for individuals presenting to ED (over 18) with a mental health concern following a mental health assessment. This was to involve linking individuals to mental health support services in the community, such as GP, NGO's and other relevant service providers, identifying and addressing access barriers to care and provision of relevant resources for community supports.
- Develop a Navigator program that is evidence-based research, with the patient navigator acting as a resource person to the multidisciplinary Mental Health ACT.
- Develop the Navigator role within the GCUH's clinical governance framework, protocols, procedures, polices and professional guidelines.

- Identify gaps and barriers at a systems level to assist GCHHS improve care pathways for discharging consumers.
- Map care pathways between Emergency Departments, primary care and community-based services at the point of discharge to the community.
- Assist in knowledge development and linkages from Emergency Department to primary health and community services, encouraging integrated care and creating better care pathways.
- Identify capacity building opportunities for the Navigator role, between PIR and GCHHS and PIR and non-government organisations and community-based services.
- Reduce the number of potentially avoidable reoccurring mental health emergency department presentations. ED presentations for mental health concerns that are preventable, treatable or manageable with appropriate primary care, such as the GP, or community-based community services, unnecessarily utilize hospital resources, lower the efficiency of the public health system and potentially raise costs [9].

This report provides a background of the project including a discussion on the evidence base that exists in support patient navigation roles. The Navigator role and project overview, including project approach, outcomes and challenges, are outlined. This report will outline the value in a non-clinical navigator working with mental health consumers in a public health setting and highlight the notable achievements of the project. On a last note, the report discusses key learnings and provides recommendations for future Navigator projects or Navigator roles within a mental health ED setting.

2.0 HISTORY OF THE NAVIGATOR ROLE

A patient navigator is an individual whose primary responsibility is to provide personalized guidance to consumers as they interact with and move through health care systems. Dr. Harold P. Freeman, a surgeon in Harlem, created the first patient navigation program in the 1980s, focused on improving outcomes in breast cancer and reducing disparities through increased screening and complete follow up of abnormal mammograms [10]. Since then there has been over a decade of use in oncology, including multi-year large National Cancer Institute funded clinical trials which found a positive impact of patient navigation on cancer outcomes related to screening, follow-up, and treatment of various common cancers like breast, colorectal, and cervical [11,12,13].

There has been numerous studies conducted on the success of patient navigation among cancer patients and now early evidence suggesting it could be translated into similar success for chronic diseases such as cardiovascular disease [14, 15], palliative care [16] and kidney disease [17]. Patient navigation has also had significant success in increasing colonoscopy screenings [18], improving HIV care access [19], transitioning individuals with type 1 diabetes from paediatric to adult health care [20] and reducing health disparities [21].

While there is currently limited research on a Navigation role in mental health services, a study by Druss et al. (2010), found a patient navigator intervention program in a mental health care setting, which provided community linkages to health care providers and support and advocacy, to be associated with significant improvements in the quality and outcomes of primary care for individuals with mental health concerns.
Non-clinical navigators with strong ties to the community, have proven to be more successful in these roles compared to clinical navigators, as they have a unique opportunity to build patient trust by demonstrating their knowledge and respect for cultural and linguistic differences and to extend that trust to the larger health system [9, 22, 23, and 24].

Patient navigation has been shown to be potentially useful in linking vulnerable patients to appropriate medical and support services, reducing disruptions in care, and increasing patient satisfaction [26, 27], therefore, a patient navigation program may improve actual and perceived access to care and prevent or reduce emergency department presentations [28]. Thygesen et al (2011) found affectionate bonds were made to the navigator, and patients felt that they benefited from their presence and help, which they requested until one month after discharge.

This evidence-based research supports the implementation of a non-clinical Navigator with a community-services background, in the emergency department to provide a support and linking service to individuals with mental health concerns.

3. A SNAPSHOT: GOLD COAST MENTAL HEALTH

This section provides a snapshot of the current mental health system in the Gold Coast, looking at the hospital system, non-government organisations and the consumer experience.

2.1. GOLD COAST HOSPITAL AND HEALTH SERVICES

The Gold Coast Hospital and Health Services (GCHHS) provides all public mental health services on the Gold Coast, including the Gold Coast University Hospital (GCUH), Robina Hospital and a number of community clinics [30]. The GCHHS had almost 9000 new mental health referrals in the 2012/2013 financial year [3], providing the following services:

Gold Coast Hospital and Health Service: Public Mental Health Services	
Acute Care	Inpatient Beds in GCUH and Robina The Acute Care Team (ACT) based in community and providing in-reach into Emergency Departments at both GCUH and Robina Hospital Emergency Psychiatry Service (EPS) based in the Emergency Department (ED) The Acute Care Team (ACT) A Rehabilitation Service A Consultation Liaison Service
Continuing Care	Inpatient beds in Robina Hospital - includes extended treatment beds and extended rehabilitation beds Adult Community mental health clinics located in Ashmore and Palm Beach. - Continuing Care Teams –CCT provide specialised, multidisciplinary community mental health case management services, including assessment and treatment services, to people 18-65 years old who are affected by serious and/or persistent mental illness, their family/significant others and carers. Mobile Intensive Treatment Team-MIRT is a highly responsive, assertive treatment and recovery orientated multidisciplinary service, aimed at improving the quality of life for consumers with complex and enduring mental illness/mental health needs requiring intensive intervention in the community. MIRT assists with the development or re-engagement with meaningful life roles for consumers, with an explicit belief that people can, and do recover from mental illness. The two key functions of MIRT are assertive community treatment and intensive case management. This service is co-located with the Continuing Care teams at Ashmore and Palm Beach.
Child and Youth	Inpatient beds at the Robina Hospital Outpatient clinics located at Southport and Burleigh Infant Mental Health - a limited community based service for acute needs Consultation Liaison Service School Mental Health Programs - provides a service to local schools

	Child Safety Unit The Early Psychosis (EP) service is a specialised multidisciplinary service, which provides early phase treatment for young people aged 15 – 24 years (inclusive) who have, or have experienced, a first episode psychosis in the last 12 months. The service aims to provide intensive assertive outreach treatment, as well as to minimise the stigma associated with psychosis, including the impact of distress, trauma on both the young person and his/her family.
Older Persons	Inpatient Beds Robina hospital -Older Person Mental Health beds A community Older person mental health service. Older Persons Mental Health Community provides specialised, community based multidisciplinary services, including mental health assessment and treatment, for adults over the age of 65 years, who have a severe and complex mental health illness/disorder, which is complicated by problems/illnesses related to aging. Consumers are seen in various settings, including hospitals, aged care facilities and their own homes

2.2. GOLD COAST UNIVERSITY HOSPITAL

The GCUH is a 750 bed tertiary-level facility, which provides a comprehensive specialized and focused public mental health service., including a mental health acute care services in the emergency departments, a mental health inpatient units and outpatient services, including psychiatry [30].

2.3. GCUH EMERGENCY DEPARTMENT

The GCUH ED is one of the busiest ED's in the state with recent data indicating that on average there is approx. 400 mental health presentations per month listed as presenting problem by ED, with November 2015 the busiest month with 584 presentations [3]. Table 1.0 shows mental health presentations by departure status from July 2015 to February 2016.

Table 1.0 Mental Health ED Presentations by Departure Status: July 2015 – February 2016 [3]

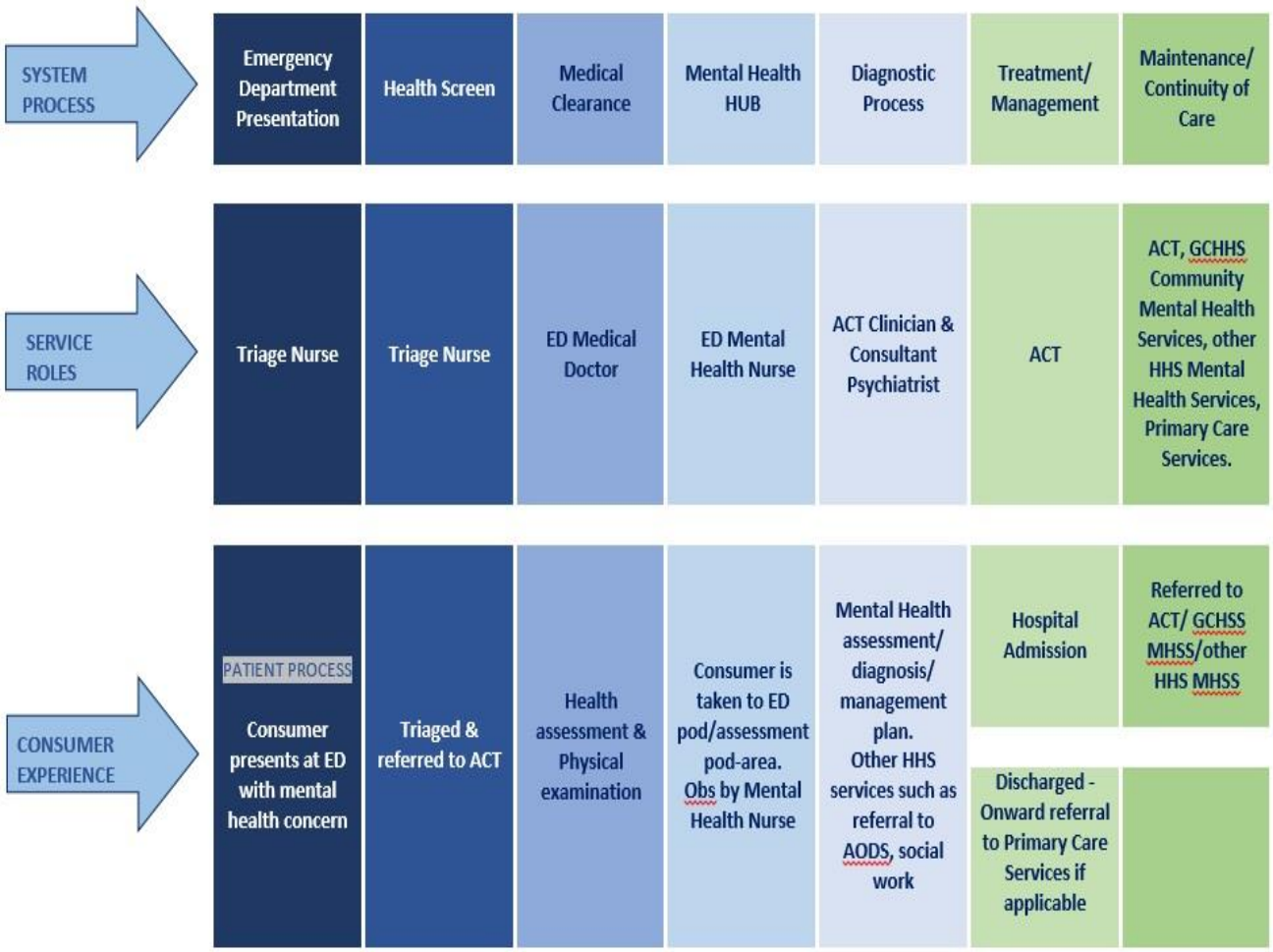
	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-15	Feb-15	Total
Admitted / Transferred	122	117	139	151	159	147	137	155	**1137**
Did not wait / Left after triage	43	23	44	48	55	37	40	34	**324**
Discharged / Home	171	174	185	216	370	209	193	187	**1706**

Total	336	341	369	415	584	393	370	386	3162

2.3.1. MENTAL HEALTH EMERGENCY DEPARTMENT CARE PATHWAY

In Figure 1, the current care pathway for an individual who presents at the GCUH Emergency Department with mental health concern or mental illness listed as presenting problem by ED is shown.

Figure 1. Care Pathway for Emergency Department: Mental Health Consumers



HEALTH SCREEN: TRIAGE

Upon presentation at the ED, triage is conducted by an ED Triage Nurse using the Australian Triage Scale (ATS). Triage represents the first clinical contact to determine urgency of care and general management within the ED in line with triage score. Triage is the process for facilitating access to treatment in the health system. It involves the coordination of resources to meet a person's nee. This includes an assessment of need, acuity, risk, complexity and referral for consults by other services such as mental health. On completion of triage the Triage Nurse will make a referral to e.g. mental health ACT for an individual who presenting, appears to have mental health illness/problem.

MEDICAL CLEARANCE

Prior to referral to mental Health, a base line medical evaluation is completed as part of the triage process and further comprehensive medical evaluation also done if indicated.

DIAGNOSTIC: MENTAL HEALTH ASSESMENT

ACT clinician's work under the clinical governance of the GCHHS mental health service ACT and there are ACT clinician's based in ED. A comprehensive standardised mental health assessment/triage is conducted by an ACT clinician or psychiatric registrar in the ED pod, most often in the ED assessment area following referral to ACT from triage. The following documents are utilized in the assessment/intake process to support thorough mental health clinical assessment and development management plan being conducted. This includes:

- Mental Health Services Consumer Intake Form or Adult Mental Health Services Consumer Assessment Form (as applicable)

These forms document include documentation of presentation -episode of care from triage to discharge within the ED, while supporting and ensuring quality and safety in the clinical care. The forms are endorsed by QH state-wide evidenced based, and provide consistent and standardized approach/tool for clinician's in to document consumers assessment/clinical presentation and communication tool between treatment providers, emergency departments and mental health services across the care continuum. These mental health service documents have been designed to be completed by one mental health professional, at one point in time. Based on the information collated during the process, clinicians also complete relevant National outcome measures which are as well as assessments/triage completed, record the results in the consumers' electronic medical record CIMHA, any mental health documentation is also uploaded into the GCHHS electronic medical record eMR.

A mental health assessment/triage is aimed at determining the nature and urgency of care, most appropriate care for the individual within or outside the HHS MHS, this may include whether consumer requires admission to one of the mental health inpatient units.

All mental health assessments/intakes are discussed with ACT medical officer i.e. Consulting Psychiatrist or Psychiatric Registrar prior to consumer being discharged from ED and further discussed in the ACT multidisciplinary team case review. The ACT MDT provides a structured process to discuss a consumer's care and ensure that discharge to appropriate follow-up/care for the consumer.
Consumers presenting to ED maybe discharged directly from ED or admitted to one of the mental health inpatient units based on assessment/intake and management plan formulated.

TREATMENT / MANAGEMENT: CONSUMER END OF CARE / DISCHARGE

Once a decision is made to for discharge from the ED, the discharge plan is completed utilising the CIMHA Consumer Assessment or Intake form or Progress note utilising SBAR format
The discharge plans briefly include but not limited the following:

- Assessment

- Reasons for discharge
- Risk management plan
- Recommendation for ongoing care
- Referrals with private providers and appropriate community services

The discharge is a crucial transition point in consumers care and requires clinician's to utilise skills in collaboration, information sharing, planning and risk management

Under the National Emergency Access Target (NEAT), the Gold Coast University emergency department is striving to achieve the NEAT target in order to improve the patient journey and experience, reduce delays and increases access to services, and to ensure best practice. The target for the GCHHS ED NEAT is that length of stay in the ED is within four hours; from triage to admission or discharge. If consumers presenting with a mental health problem/concern length of stay in ED exceeds this 4 hour timeframe, ACT clinicians will provide information to the Team Leader –to assist in service identifying any trends or issues in meeting this target and opportunities for service to address these
[31].

2.3.2. ACUTE CARE TEAM

The Mental Health Acute Care Treatment Team (ACT) provides 24 hours, 7 day a week specialist mental health care services including intake, crisis intervention, assessment, screening admissions to public adult acute psychiatric inpatient services, referral and community based treatment. Following triage, ACT will facilitate the most appropriate type of care/service for the consumer.

ACT provides:

- 1300MH CALL (1300642255) service, that functions as a first point of contact for consumers accessing public mental health services.
- In-reach service, into Emergency Departments at both the Gold Coast University Hospital and Robina Hospital, that provides triage, consultation, assessment and referral of consumers presenting to the Emergency Department with mental health issues.

Short term, community based intensive care/mobile assertive outreach service, that offers a range of short to medium term options, tailored to meet individual needs in the community in the community, which may also include acute care in the immediate post discharge phase of an inpatient admission.

The ACT team is a multidisciplinary team consists of a team leader, consultant psychiatrists, psychiatric registrars, senior clinicians (OT/Social workers/Nursing/Psychologist) and clinicians, all of which have formal mental health qualifications. The ACT clinicians work on a three-month rotating roster between Gold Coast University Hospital, Robina Hospital and ACT Community.

Gold Coast Hospital and Health Service: Public Mental Health Services	
Consulting Psychiatrist	Consultant Psychiatrist Responsible for providing an advanced standard of clinical care through the provision of consultation, assessment and treatment services to individuals presenting with psychiatric, emotional and/or behavioural disturbances through a multidisciplinary team approach. This position also provides clinical leadership within the multidisciplinary team to deliver professional Psychiatric Medical interventions, direct clinical care and treatment to clients and their families with a mental illness. This includes but not limited to: • Conducting mental health assessments • Conducting physical examinations as applicable • Provide consultancy and advice; • Participates in MDT meetings;
Psychiatric Registrar	Psychiatric Registrar Registrar is a Doctor undertaking specialist training in psychiatry. This position ensures delivery of clinical care as planned by the multidisciplinary team to clients and families with mental illness This includes but not limited to • Conducting mental health assessments • Conducting physical examinations as applicable • Provide consultancy and advice; • Participates in MDT meetings
Clinicians	ACT clinicians come from an array of professional backgrounds, including Registered Nurses, Social Workers, Occupational Therapists and Psychologists. All clinicians are required to have a relevant qualification and registration with AHPRA or equivalent body, post-graduate qualification and experience within the area of ACT as applicable. Responsible for the provision of direct clinical work involving the assessment and treatment of people with a mental illness/disorder Clinicians report operationally to the team leader Acute Care Team and professionally to the relevant Allied Health Clinical lead /DON. This includes but not limited to • Conducting mental health assessments • Conducting physical examinations as applicable • Provide consultancy and advice; • Participates in MDT meetings

2.3.3. MULTIDISCIPLINARY TEAM MEETINGS (MDT)

The ACT ED MDT meeting is run once per day in the ACT open office space. In this meeting, a psychiatrist registrar or ACT clinician presents each of the cases seen by the ACT over the previous 24-hour period to the ACT MDT –which includes a consultant psychiatrist
The ACT MDT provides a structured process to discuss a consumer's care and ensure that discharge to appropriate follow-up/care for the consumer (e.g. discussion management plan formulation, medications, referrals and allocation)

These MDT meetings are sometimes held in person with the consultant, but generally conducted via telephone conference.

MDT meetings are beneficial, as the consumer's case is discussed amongst a number of different mental health professionals and specialists, to ensure the most optimal outcome.

2.3.4. CONSUMER INTEGRATED MENTAL HEALTH APPLICATION (CIMHA)

Consumer Integrated Mental Health Application (CIMHA), is a comprehensive tool utilised by Queensland Health Mental Health professionals, including the Mental Health ACT. The web-based database allows for mental health professionals within ACT to:

- Record demographic information of mental health consumers;
- Access mental health history of a consumer, including previous emergency department presentations, mental health assessments and hospital admissions;
- Enter new service episodes of care;
- Enter clinical notes, diagnosis, treatment and outcomes;
- Upload referrals, assessments and other relevant documents;
- Produce consumer reports.

There are stringent access guidelines around CIMHA, which specify that only mental health professionals and mental health teams within Queensland Health can access the application.

2.3.5. IDENTIFIED SYSTEMIC GAPS / ACCESS BARRIERS / OTHER ISSUES

The Navigator Project aimed to identify opportunities and make observations and recommendations to assist the Mental Health ACT and the GCUH ED improve referral pathways to community care via the Navigator role. The following observations have been identified in this process:

- When consumers who are assessed and public mental health service is not determined as the most appropriate follow-up i.e. ACT/ MHS community team –dependant on clinical decision at time assessment they may receive further follow-up phone contact by MH ACT/ MHS and referred on to an appropriate community/ primary care service. Continuity of care can be difficult between public and community/primary setting, as pathways from ED to community care –regarding changes in

service providers and as community services can be difficult to navigate and fragmented for consumers and clinician's.

- Targets such as the National Emergency target NEAT, which aims for patients presenting to the emergency department to be discharged home, admitted to hospital or transferred to another facility within four hours. [30]. During busy times in the ED, these time targets may potentially impact service delivered regarding clinician's, limiting their time collaborating with consumer/others in relation to care/management plan, making direct referrals/linkages regarding follow-up to community care/primary care.
- Consumers are not provided with a written copy of their management/discharge Plan at Triage.
- There are a finite number of beds in ED area and inpatient mental health units; which at times may impact on the management plan made by the ACT team in conjunction with the consumer/other. All management plans ultimately based on clinician's judgement of the team following assessment. An ED Mental Health Nurse is not a mental health nurse-rather a nurse who works in the area where mental health assessment conducted –similar to other areas e.g. ED acute nurse. The ED mental health nurse provides nursing care to consumers in this area.. The title of this role is deceiving causes confusion among emergency department staff about the role and capabilities of the ED Mental Health Nurse.
- MHS utilises CIMHA electronic medical record –whilst the HHS utilises eMR, some ED staff have access to CIMHA but two systems makes information exchange and integrated care challenging between ACT and other emergency departments and health services within the hospital. There are a number of mitigating strategies to lesson this challenge such as ACT CIMHA documentation is downloaded and uploaded into CIMHA, notification on eMR of a CIMHA record
- MDT meetings – While MDT meetings are traditionally formal confidential meetings, the ACT MDT meetings are held in an open office space, via the telephone loudspeaker. The ACT clinicians and psychiatrist registrars have indicated at times that they find it difficult to communicate effectively in this manner.
- ACT staff have limited knowledge of the wide range of services that fall under the "community" umbrella, as many primary care organisations change frequently due to funding, therefore this impacts the ability for staff to refer.

2.4. NON-GOVERNMENT ORGANISATIONS

There are an array of community-based services, social supports and wellness activities available and accessible to individuals with a mental illness in the Gold Coast region.

Support services include, but are not limited to: Aboriginal and Torres Strait Islander services, LGBTIQ services, relationship counselling, mental health support groups, disability supports, alcohol and other drug support, domestic violence and sexual assault supports and gambling support services.

Practical services include: Accommodation and homeless services, employment services, income/financial aid services, transport services, GP and other health professional services, wellness activities, alcohol and other drug detox and rehabilitation centres and legal services.

2.4.1. IDENTIFIED ISSUES AND ACCESS BARRIERS

There are a number of key issues and access barriers that have been identified by consumers, GCUH staff, NGO's themselves or the community in relation to these services, including:

- There are currently long waiting lists and wait times to access community-based mental health related services. This acts as a significant access barrier for individuals with mental health concerns.
- Feedback received from consumer's, hospital staff and the Navigator's experience, identified difficulties in getting through to the right person on the first phone call and calls are not returned and emails are not always replied to.
- NGO's have highlighted difficulties in supporting and caring for individuals with mental health concerns who access their services following an ED discharge, as they don't have access to information about the care plan or treatment paperwork, thus are unaware of the formal diagnosis, medications and treatment provided by the hospital.
- Partners in Recovery role is not clear among ACT clinicians. Clinicians have reported difficulty contacting the PIR Intake Team to refer or follow up on a referral and long wait times for consumers to be contacted by a PIR Intake Officer following a referral.
- NGO's don't have a clear understanding of the service delivery provided by the Mental Health Acute Care Team. This stems from a lack of understanding about the emergency department care pathway, service provision by ACT and hospital processes.

2.5. THE CONSUMER EXPERIENCE

In May 2014, Partners in Recovery held multiple community consultations to gain feedback on gaps and barriers that carers and consumers had experienced. The results of these sessions were outlined in the 2014 Partners in Recovery Engagement Report [1]. The findings in this report were the basis for the Navigator Project. The key messages and themes that emerged from this report include:

- For some individuals and their families, acute hospital admission was an experience characterised by their personal feelings of distress, powerlessness and loss of dignity.
- Upon acute hospital admission, there is a lack of information for, and understanding by consumers and carers on how to navigate the health system.
- Reports of not feeling listened to, remained a dominant experience for people.
- People appreciated information on alternatives to medication, the services of non-government organisations and on places in the community where they could go for ongoing social connection and assistance.
- Some people did not feel included in the development of their care plan in the emergency department and didn't feel they understood clearly their options or choices.
- Some people had concerns about not understanding other options to medication.
- People greatly appreciated the opportunity to participate in wellness focused activities and considered these as an important contributor to their recovery.
- Supports such as packages of psychologist visits were considered helpful.

- Leaving hospital felt abrupt and challenging in terms of loss of social connections and change to daily routine.
- Discharge planning process did not always seem to be a collaborative process for some consumers and some people did not feel confident in leaving the hospital.
- Where post-discharge follow up visits occurred, these were rarely with people they had met before.
- Some experiences with mental health professionals had been of staff that patients felt were not as helpful as they could have been and therefore felt dismissed on some occasions.

3.0 THE NAVIGATOR PROJECT: IMPLEMENTAITION AND EXECUTION

The Navigator Project was principally initiated to assist the GCUH identify opportunities to address the key issues raised in the PIR Carers and Consumers Engagement Report. Working directly in the Mental Health Emergency Department allowed the Project Team to gain a better understanding of the ED care pathway for individuals presenting with mental health concerns and to design a Navigator role that would work effectively within the current system. Here we discuss the Navigator role in depth, the project approach, outcomes, what was achieved, key learnings and recommendations for future Navigator projects or roles in an ED setting.

3.1. IMPLEMENTATION

On 8th September 2016, the Navigator Project became operational in the Emergency Department at the Gold Coast University Hospital. The Navigator Project involved the placement of a Project Officer (9 month role) and a Navigator (10-month role), employed by Lives Lived Well, to be based in the ED, working alongside the Mental Health ACT.

3.2. THE NAVIGATOR ROLE

Navigation is an important model of care delivery that has significantly evolved from care coordination. However, currently there is no standard, credentials, titles, formal training or specific job description of a navigator and therefore the role of a navigator can be varied to fit the criteria and requirements of the working environment and the type of patient involved [32].

The project team worked collaboratively with the Project Steering Committee to clearly define the role and responsibilities of the Navigator that would best address the needs of the consumers, which are outlined here.

3.2.1. THE NAVIGATOR POSITION DESCRIPTION

1. Assist in developing better care pathways from the emergency Department to primary care and community services;

2. Facilitate patient-centered care that is compassionate, appropriate and effective for the treatment of mental illness and the promotion of well-being;
3. Empower consumers to communicate their preferences and priorities for services and support needs and facilitate shared decision making;
4. Assist consumers to access services and navigate the mental health care system;
5. Link individuals to support services in the community such as GP's, NGO's and other relevant service providers;
6. Assist consumers to identify potential physical, psychological, social and spiritual barriers to accessing appropriate mental health services in the community and engage consumers and families in creating potential solutions. Where barriers cannot be addressed, provide feedback to Project Officer;
7. Assist with referral to Partners in Recovery Intake Team for eligible individuals;
8. Assist consumers and their carers to identify and access appropriate and credible resources and information that is responsive to consumer needs, while considering consumer's literacy, culture, language and the amount of information the consumer desires at the time;
9. Demonstrate empathy, integrity, honesty and compassion in difficult conversations with consumers;
10. Demonstrate sensitivity and responsiveness to a diverse consumer population, including but not limited to diversity in gender, age, culture, race, religion, sexual orientation and abilities;
11. Demonstrate a commitment to ethical principles pertaining to confidentiality, informed consent and GCHHS practices;
12. Communicate effectively with consumers, caregivers and ACT clinicians to build strong trusting relationships;
13. Provide information and details to consumers and carers on the GP Mental Health Care Plan, including eligibility, cost and availability;
14. Ensure consumers are already linked in with a GP, or link them in with a GP at the time of the consult, or provide contact details for a GP in their local area to discuss any physical needs or a Mental Health Care Plan;
15. Set clear boundaries that the Navigator role is non-clinical and refer consumers to clinical staff or their GP to answer question about clinical information, treatment, medications and potential outcomes;
16. Follow up with patients to support adherence to agreed-upon appointments, attendance to groups/wellbeing activities and to ensure all of their short term needs have been addressed to support recovery;
17. Encourage referrals to Navigator service through promotion and education among ACT clinicians, other emergency departments and service providers. Demonstrate value in the Navigator role;
18. Demonstrate basic understanding of mental illness, the care pathway for an individual presenting at the ED with mental illness and how consumers access mental health services and support in the community to support and assist consumers in their recovery;
19. Improve navigation process through continual self-evaluation and quality improvement;
20. Maintain comprehensive, timely and legible records capturing ongoing patient barriers, patient interactions, barrier resolution and other evaluation metrics and report data to show value to administrators and funders.

3.2.2. NAVIGATOR QUALIFICATIONS

The Navigator was recruited and employed by LLW, with the assistance of PIR. The Navigator has a strong community services background, with over 12+ years experience in disability and community services and is

from the Gold Coast community in which consumers of the project were living, giving the Navigator an intimate knowledge of relevant community services, and resources. The Navigator had no previous experience with formalised patient navigation.

3.3. WHO ELSE WAS INVOLVED?

3.3.1. PROJECT OFFICER

The Project Officer worked on-site to oversee the development, implementation, execution and evaluation of the Navigator Project. Core responsibilities of this role included:

- Map care pathways between the Emergency Department, primary care and community based services at the point of discharge to community. The findings and the recommendations from this process will be made to the project steering committee.
- Inform the project steering committee of further capacity building opportunities between PIR and GCHHS and PIR and community based services.
- Identify gaps and barriers to assist GCHHS improve care pathways for discharging patients.
- Assist in knowledge development and linkages to primary health and community services, creating better care pathways.
- Report findings to the Project Steering Committee.
- Improve navigator process through continual evaluation and quality improvement.
- Promote the navigation role, responsibilities and demonstrate its value to consumers, ACT clinicians and team leaders, service providers and stakeholders.
- Facilitate the development, implementation and evaluation of the project.
- Use evaluation data (barriers to care, patient encounters, resource provision, population health disparities data and quality indicators) to collaboratively improve navigation process and participate in quality improvement.
- Present progress to steering committee at monthly meetings and incorporate feedback on performance to improve or amend daily work.
- Use information technology to maximise efficiency of patient navigator's time.
- Continually identify, analyze and utilise new knowledge to mitigate barriers to care.
- Maintain comprehensive, timely and legible records capturing ongoing patient barriers, patient interactions and barrier resolution.

3.3.2. PROJECT STEERING COMMITTEE

The role of the steering committee will be to review the project against the agreed outcomes and continue to direct workflow depending on the findings from mapping the care pathways. The Project Steering Committee members include:

- GCHHS – Heidy van Engelen – Mental Health Clinical Lead
- GCHHS – Julie Evans – Team Leader - Acute Care Team
- GCHHS – April Boyd – Emergency Department Social Worker

- PIR – Lesley Maher – Program Manager – Partners in Recovery
- PIR - Phoebe Tucker – Partners in Recovery Project Officer
- PIR – Ash Simpson – Partners in Recovery Coordinator
- Lives Lived Well – Leah Tickner – Manager Operations & Performance, Community Services
- Lives Lived Well – Krystal Slapp – Project Officer
- Lives Lived Well – Vanessa Brown – Navigator

3.3.3. TARGET POPULATION GROUP

The target population of the Navigator Project included individuals with a mental health concern, who are being discharged from the emergency department following a full mental health assessment.

Eligible consumers were at least 18 years of age and had received a full mental health assessment by an ACT clinician and cleared to be discharged. Participants were ineligible for the Navigator service if they were unable to give informed consent, were being admitted to hospital or who had not had a mental health assessment.

3.4. THE APPROACH

3.4.1. REFERRALS TO THE NAVIGATOR

ACT clinicians provide referrals to the Navigator once a consumer has had a mental health assessment and is cleared to be discharged from ED. Referral to the Navigator depends on clinician's discretion, consumer consent and meets all of the referral criteria; (i) 18 years or older; (ii) received mental health assessment during current episode of care; and (iii) has been cleared for discharge from the emergency department (and identified as having a community linking need). The referral pathway can be seen in Appendix.1.0, which was provided to the ACT clinicians at the initial stage of the project.

REFERRAL PROCESS

- Business hours – Face to face referral: Verbal referral is provided by the clinician, where clinician provides the following details to Navigator:
    - Name, address, date of birth, presenting details, relevant history, clinician's recommendations of community needs.
- After-hours - Telephone referral: Clinician fills in after-hours referral form (Appendix 3.0), which collects the same data as listed above. Navigator contacts consumer via telephone on the following business day.

The simplicity of the referral process was designed to be time efficient for the clinicians, based on feedback received from the ACT Team Leader, who advised clinicians are extremely busy and have stringent time restraints to adhere to, thus would be more likely to refer to the Navigator if it was a simple, time efficient process. Additionally, the limited consumer information at the time of referral is attributed to restrictions on how much information ACT can share with the Navigator due to privacy and confidentiality of the consumer.

3.4.2. NAVIGATOR CONSULTATION

The Navigator meets the consumer in the ED assessment area at the GCHHS, or contacts the consumer via the telephone, to conduct the initial consultation which entails:

- Completion of client intake form to collect baseline and demographic data
- Assist in identifying the consumer's community-based needs, post discharge
- Navigating consumer through complex mental health services
- Make recommendations, linkages and referrals to available and appropriate community services and support groups
- Assists in identifying access barriers to community services post discharge
- Advise and educate consumers about GP Mental Health Care Plan
- Link consumer in with GP in local area or at least provide contact details for a GP
- Providing resources, information on where to/how to access mental health support from home.

3.4.3. FOLLOW-UP

Follow up by the Navigator was essential in providing a continuity of care. The Navigator makes two follow-up calls to referred consumers:

(i) 48 hours after initial contact; and

(ii) 7 days after initial contact. Follow up calls were designed to ensure linkages had been established, the consumer felt supported, check if the consumer needed any further linkages or assistance or provision of information/contact details and to measure effectiveness of the Navigator service. The same person who conducted the initial consultation to provide familiarity and encourage a trusting relationship between Navigator and consumer always made follow up calls.

In the instance when the Navigator could not make contact with a consumer via telephone contact, a text message and/or email was sent.

3.4.4. INFORMATION EXCHANGE

The Navigator fills in a "Navigator Case Summary Form" (Appendix 4.0), which outlines the NGO's, health professionals and any other community-based services, which the Navigator linked or referred the consumer to. A PDF of this form is emailed to the referring clinician to upload and attach to the consumer's file in CIMHA.

3.4.5. RECORD KEEPING

The Navigator enters client details in to the LLW client database, Mimaso. Client intake forms, referral forms, case summary forms and any other relevant documentation is uploaded and attached to the client file in Mimaso. All paper documents are manually filed in a LLW filing system.

4.0 PROJECT CHALLENGES

A number of challenges, were identified during the project, which were able to be addressed via the continued collaboration of the Steering Committee. In Table 2.0, each challenge is outlined, with the suggested strategies that were discussed with the Project Steering Committee, and the outcome of each.

Table 2.0: Challenges

CHALLENGES	RECOMMENDATIONS	ACTION PLAN
8 week delay in the commencement of the co-location	Project Team utilised this time to network with NGO's, develop Navigator processes and procedures and Service Provider Database.	While the unexpected delay affected the overall number of referrals for the project, the Project Team utilised this time effectively to carefully plan and prepare for the implementation phase of the project.
Low referrals from clinicians due to a number of factors	Build on relationships with Senior Clinician and clinicians	Navigator found it difficult to establish relationships with some clinicians. However, those clinicians and psychiatry registrar that she was able to build strong relationships with, saw value in the service and referred consumers.
	Build on relationship with Psychiatric Registrar who was in a position to influence referrals.	Having an influential team member driving referrals and promoting the Navigator among clinicians saw an increase in referrals.
	Continue to have discussions with clinicians and inform them of Navigator role.	This was difficult with the busy environment the clinicians work in and additionally, the high number of clinicians in ACT, rotating over three sites every three months and working different day/night shifts each week.
	Open referral criteria to include patients who are referred to ACT community (patients who have been admitted to hospital following mental health assessment).	This process was approved by the steering committee and GCHHS, however did not have a significant impact on the referrals received from clinicians.
	Navigator to sit in on MDT meetings to provide input and community-based ideas in to the care plan of consumers.	Navigator is not a Queensland Health employee and therefore does not have authorisation to sit in on meetings or

		discussions about a consumer or access their hospital records.
	Include "Navigator" part of handover process and MDT meetings. (Navigator could not sit in on handover meetings due to confidentiality of the consumer, however it was suggested that the Navigator be discussed at the meetings to be included in consumer's care plans).	This was approved by steering committee. ACT Team Leader advised she would instruct the Senior Clinician to action this. However, this process was not implemented by the Senior Clinician and thus did not have an impact on referrals.
	Set target of 1 referral to the Navigator from each clinician per week.	The ACT Team Leader advised if we set this target, then it may deter clinicians from providing more referrals down the track and that it is therefore better not to set targets.
	Set target of 2 referrals to Navigator from the ACT team per day.	This was approved by GCHHS. Project Team met with Senior Clinician and Team Leader about this process that advised they would communicate this to the team. However, referrals were not impacted significantly.
	Access to triage nurses & mental health liaison nurse to educate them about the Navigator service, so they can flag it as a possible need when referring to the ACT.	The ACT Team Leader advised that triage nursing staff and the mental health liaison nurse are not mental health trained specifically, therefore this strategy, thus do not have the knowledge and understanding to flag individuals for referral to Navigator.
Concerns regarding ongoing sustainable support for consumers after leaving the ED	In this instance Navigator to have brief consultation with consumer at the ED and offer to call the consumer the following day/agreed time. Navigator to provide MI Networks (MIFQ) telephone service brochure and PIR Mental Health Services contact brochure for provision of ongoing sustainable services.	Project Team met with Mi-Networks to obtain brochures to provide consumers and collected PIR Contact Sheets to provide consumers. Navigator implemented this process when consulting with individuals who were not in the headspace to have a discussion. Consumers in this state responded well to this support service.
Low response rate to follow up calls	When follow up calls are not answered, Navigator to send email and text message.	Navigator implemented this process. There was a very low response rate to emails sent and not all consumers had an

		email address or access to a computer or internet. Text messaging had a good response rate and seemed to be the preferred means of contact for consumers. All but one of the consumers had a mobile phone.
ACT Clinicians are not aware of what services or what information the Navigator has provided to the consumers after referral.	Implement information exchange process, involving the Navigator filling in outcome of consultation on the Navigator Case Summary form and emailing a copy of this to the clinician to attach to the consumer's file in CIMHA.	This process was authorised by GCHHS. The Navigator implemented this process and received positive feedback from clinicians about the process and form.
Clinicians referring consumers to Navigator after they have been discharged and left the hospital, within business hours.	Navigator to continue to communicate to ACT senior clinician and clinicians the importance for face-to-face referrals.	The number of face to face referrals did increase in December (mid way through the project).
The Navigator does not have access to CIMHA. **Unable to do background check of patients, track history/previous presentations at ED and add notes about community service links that have been made.**	Navigator to be provided with Read-Only access to CIMHA.	As Navigator is not an employee of Queensland Health and not a mental health professional, she is not authorised to access CIMHA. Navigator obtained as much information from consumer at the time of the consultation. At the time of referral, Navigator to search Lives Lived Well Client Database to check if the consumer has been seen by Navigator previously. The Navigator Client Intake Form has been adjusted to include more space to write background history, diagnoses, meds etc., from information provided by clinician at time of referral.
The 4-hour-ED time restraint that clinicians are to adhere to, sometimes result in them not having the time to refer to Navigator.	Navigator to remind clinicians of Navigator service, continue to build strong working relationships with clinicians and promote time-efficient referral process.	Reiterating the easy referral process to clinicians did result in increased referrals from those clinicians the Navigator spoke to.

The need for a clearly defined pathway through ED to Navigator for a mental health patient.	Develop a clear map of the care pathway for consumers who present at the ED with mental health concerns. This will set a clear guideline for all ED departments and triage nurses to follow.	Members of the steering committee met with the ACT Team Leader to map clear ED pathway for mental health consumers. This map was in line with a care pathway map developed by Project Officer, provided in this report.
Clinicians and Navigator have experienced difficulties in getting through to PIR Intake Team for referrals or advice.	Project Officer provided this feedback to Project Manager, Partners in Recovery and the Steering Committee.	Partners in Recovery representatives advised they would take this feedback to the PIR intake team to address these issues.
PIR's role not clearly understood among clinicians' which may have been resulting in some clinicians not referring to Navigator, as the project is associated with PIR.	Project Team and Navigator removed "PIR" labels from client forms and case summary form and had discussions with clinicians and Registrar within ACT about this issue and making a clear distinction and separation between the Navigator Service and PIR Intake team.	This helped build stronger relationships with some clinicians who had previously advised they had not referred to Navigator because they thought we were PIR.
NGO's – Difficulty when calling NGO's and trying to source information or establish a link on behalf of a consumer. **This would be extremely difficult and overwhelming for consumers to do on their own and would act as a barrier for them accessing available services to them.**	Project Officer and Navigator to build stronger relationship with intake teams at NGO's. Project Officer provided details of specific troubles experienced with contacting NGO's to the steering committee, which PIR advised they would feed back to the NGO's to improve service delivery.	Project Team reconnected with NGO's that they had contacted in the initial phase of the project to build those relationships to better improve referral pathways.

5.0 PROJECT OUTCOMES

5.1. PROJECT POPULATION: THE CONSUMER

Consumers referred to the Navigator Project (N=55) provided verbal consent and completed a baseline assessment with the Navigator in an initial consultation. Forty-seven percent of consultations were face-to-face contact, while 51% were over the telephone.

The mean age of the project population was 36.2 years. The majority were under the age of 30 years (38.2%), Caucasian (94.5%) with an insignificant difference between males (54.5%) to females (45.5%). Suicidal thoughts and suicide attempts represented over 40% of the ED presentations, with depression (16%), anxiety (16%) and substance abuse (14.5%) following. The baseline characteristics of the project population are shown in **Table 3.0.**

Table 3.0: Background characteristics of Project Population (Consumers) (N=55)

		Number of Consumers (N=55)	Percentage of Consumers (N=55)
Age	18-29	21	38.2
	30-39	11	20.0
	40-49	14	25.5
	50-59	7	12.7
	60-69	2	3.6
	70-79	0	0.0
Gender	Male	30	54.5
	Female	25	45.5
Ethnic origin	Non-Indigenous	52	94.5
	Aboriginal or Torres Strait Islander	3	5.5
	Other	0	
Presenting Mental Health Issue/Illness (In some cases, there was more than one issue	Suicidal	24	43.7
	Depression	9	16.4
	Anxiety	9	16.4
	Borderline Personality Disorder	4	
	Self-Harm	4	
	Substance Misuse	8	14.5
Referrals	Face to Face	26	47.3
	Phone	29	52.7
	Phone referrals that did not answer (No contact made)	9	16.4

Follow Up Calls	48 Hour Follow up call – Answered	18	32.7
	1 Week Follow up call – Answered	12	21.8

5.2. COMMUNITY-BASED SERVICES

In consultation with consumers, the Navigator assisted in identifying short-term needs; community linking, referring and providing information/contact details about appropriate community-based services that would support their mental health recovery. On average, the Navigator provided linkages or information on 2-3 community-based services per consumer.

Mental health support services, including support groups, telephone counselling, online counselling and workshops, were the most common services referrals were made to. Other support services included relationship counselling, mental health support, domestic violence support, alcohol and other drugs support. Support services and groups represented nearly 60% of all recommendations, linkages and referrals by the Navigator.

Practical services such as legal aid, employment services, accommodation services, GP referrals, transport, income/Centrelink assistance and wellness activities accounted for 42% of referrals and linkages. The most common being wellness activities, recommendation of a local GP and legal aid services

Appendix 6.0 shows a list of the most commonly referred/linked services by the Navigator.

5.3. TIME ALLOCATION

The time required for consultation and sourcing appropriate information services and resources, varied from case to case and was dependent on:

- Complexity of case
- Consumers willingness to open up to Navigator about their situation and needs
- Number of short-term needs to address and access barriers
- Consumers state of mind at time of consultation

Table 4.0 outlines the tasks that the Navigator performed and the time required for each task. On average, the Navigator invested just over 2 hours total time on each case, including consultation, providing linkages and resources, data entry and follow up phone calls. The majority of time was spent in the initial consultation, on average 40 minutes in duration, however sourcing information and linking consumers in to services took up to 130 minutes. As there is such a low response rate to follow-up calls, the Navigator making these calls spent minimal time.

Table 4.0 Time allocation for each task performed by the Navigator

Navigator Tasks	Shortest Time (minutes)	Longest Time (mins)	Average Time (mins)
Referral discussion with clinician	5	15	8
Consultation with consumer	10	65	40
Sourcing information, gathering resources, phone calls for referrals and linkages	10	130	30
Taking information to consumer/calling consumer back to provide information	5	20	10
Data entry	20	45	30
Follow up call – 48 hour	2	20	10
Follow up call – 1 week	2	15	5
TOTAL	**54**	**310**	**133**

5.4. PATIENT SATISFACTION

The Navigator reported on consumer feedback received during consultation or at the time of follow-up. The following anecdotal feedback was recorded:

- Consumers reported feeling “grateful”, “relieved” and “refreshed” to have access to the Navigator role and found the Navigator supportive at the Emergency Department. Consumers found it positive to have the offer of alternative options of assistance for their mental health, in their local community, to assist in their recovery.
- Consumers reported that they found the Navigator helpful in identifying and recommending services that they did not know were available to them, or even existed.
- Consumers reported they felt more empowered, willing and able to take control of their mental health recovery and access community services that they need.
- Consumers noted the value of having someone to take the time to sit with them and explain the GP Mental Health Care Plan and others appreciated the Navigator calling a local GP in their area and making an appointment to discuss.

5.5. FINDINGS

Listed below are the key findings that were highlighted through the life of the project by the project team and steering committee:

- Systematic qualitative enquiry with community service providers indicated that Navigation appeared to result in more appropriate and effective referrals to existing services, and resulted in fewer clients experiencing gaps in service availability.
- Consumers who met the criteria for the navigator –identified community linkage need -with the Navigator were more likely to access available services than if they were discharged without the service.

- A high number of consumers reported not being aware of a GP Mental Health Care Plan, or if they had heard of it, they did not know if they were eligible or how to access the service.
- Consumers responded well to the non-clinical background of the Navigator.
- In some cases, individuals, while they consented to be seen by the Navigator, consumer reported that they did not feel ready to engage at that time and were happy to have a brief discussion about available options for supports when they were ready.

6.0 WHAT WE ACHIEVED

Regardless of the short duration of the project, there are a number of notable achievements by the project team.

6.1. PLANNING PHASE

The project team effectively utilized the initial 8 weeks, while not based at the ED, as the Planning Phase of the project, completing the following activities:

- Worked collaboratively with Senior Staff within the ACT department to develop Navigator processes, procedures and forms and had all approved by the steering committee.
- Met with ACT Team Leader to determine a working space for the Navigator.
- Determined resource requirements in hospital space provided. As the project staff were employed under Lives Lived Well and not Queensland Health, all resources were to be provided by LLW.
- Networking with NGO's on the Gold Coast who offer mental health services, to introduce the project, establish a relationship with intake officers and key contacts for referral purposes of the project.
- Collected resources, including flyers, posters, and brochures, to provide to consumers at the hospital.
- Project Officer developed a Service Provider database, to provide a user-friendly reference resource for the Navigator to quickly search for available services and contact details at the hospital.

In the planning phase, project staff also met with the ACT Team Leader and a small number of ACT clinicians to present the project and proposed procedures and referral process. The clinicians were asked for their feedback, buy-in and ideas to ensure the project was going to be effectively utilized to its full potential by the staff. Small changes to the referral process were made based on clinician feedback.

In August, the project team implemented a temporary process where the clinicians could refer to the Navigator via telephone. The Navigator would then contact the consumers via telephone. This process was in place for two weeks before commencing work in ED and two referrals were received in this time, it was a way to promote the Navigator service to the clinicians without actually being on site.

6.2. THE NAVIGATOR MODEL WORKS

While the number of referrals to the Navigator were limited during the life of the Project, of the consumers that the Navigator provided a service to, there were successful links and referrals made to appropriate community services for consumers. A case study included in Appendix 7.0 demonstrates the extent of the services that can be provided to assist an individual with mental health concerns. In the provided case study, the particular individual was not able to make the necessary community links to address his short-term needs. The Navigator successfully linked the consumer in with a number of services and crisis financial services. The Navigator was also able to assist the consumer in identifying access barriers that existed for him and was able to collaborate on developing effective strategies to overcome these. This demonstrates the value, the effectiveness and the need for a Navigator to support the needs of people with mental health concerns in the ED.

6.3. BUILT STRONG RELATIONSHIPS

In the early implementation stage, the Navigator focused on establishing relationships with ACT clinicians, while promoting the service and encouraging referrals from clinicians. The project was new to both the Navigator and the GCHHS Clinicians and it took some time to understand each other's respective roles and a way of working together. The Navigator focused on building relationships with the clinicians who were open to the Navigator service. Over the life of the project, relationships with clinicians increased, which resulted in increased referral numbers.

The Navigator established a strong relationship with one of the Psychiatric Registrar in ACT who saw value in the Navigator service and was a main driver in referring consumers herself or encouraging clinicians to refer to the Navigator. This relationship highlighted the value and effectiveness in having a key senior role within the ACT team driving referrals.

Visiting and contacting NGO's and community based support services in the initial phase of the project was key in networking and establishing strong relationships and improved communication with these organisations. This resulted in more fluent referral pathways for consumers, improved integrated care and worked towards closing the gap between the public and private sectors within the mental health system on the Gold Coast.

Strong relationships were formed between the Navigator and other Emergency Departments including:

- Homeless Health Outreach Team
    - The HHOT staff flagged a number of potential consumers for the Navigator services.
    - The Team was able to provide guidance and feedback for the Navigator Project regarding working within a busy ED environment.
- Alcohol and Other Drugs Team
    - The Navigator worked alongside the AODS team and formed strong relationships with these team members. AODS senior clinicians provided feedback that a Navigator within their team would be extensively used, highlighting potential growth of a Navigator role within the ED.

- Social Work Team
    - Social Workers approached the Navigator on several occasions about the potential of the Navigator consulting with some of there consumers through the ED. This was outside of the Project scope. However, again this highlights the potential and the need for a Navigator role in the ED over different ED departments.
    - Social Workers consulted with the Navigator on a number of occasions about advice and suggestions for community-based services for their consumers.

6.4. ENCOURAGED INTEGRATED CARE

This project highlighted an evident health system gap between the mental health public hospital service and non-government organisations, hindering an integrated service delivery of care for individuals with mental health concerns. The Navigator and Project Officer contacted and met a number of key NGO's and community stakeholders across the Gold Coast region at the beginning of the project to educate them about the PIR Project. The Project Team continued to network with NGO's and other community-based groups through the life of the project through meetings, attending community events and workshops. Building these relationships formed the basis for "closing the gap" between the ED mental health staff and the NGO's and educating both parties about the key roles and responsibilities that they each play and how they can complement each other.

6.5. FORMS FOR NAVIGATOR PROJECT

The Project Officer worked closely with the Navigator and Project Steering Committee in developing the following documents for the project, in order to collect baseline data and assist processes, including:

- Client intake form (Appendix 3.0)
- After hours referral form (Appendix 2.0)
- Case Summary Form (Appendix 4.0)

A list of services, designed to address most short term needs for mental health consumers, was developed and included on the Client Intake Form (Appendix 3.0). The project team and steering committee considered a number of factors when determining this list including (i) access barriers that prevent individuals with a mental illness from accessing appropriate services; (ii) evidence-based literature; and (iii) identified common community and support needs of individuals living with severe mental illness. The identified services include:

- Aboriginal or Torres Strait Islander services
- LGBTIQA services
- Accommodation
- Employment
- Income/financial aid/Centrelink,
- Transport
- Relationship counselling
- Oral/dental
- GP recommendation
- Mental health support group
- Wellness activities

- Disability service
- Alcohol and other drug service,
- Mental health service
- Domestic violence support and services
- Sexual assault support
- Gambling support
- Legal support.

6.6. DEMONSTRATED VALUE IN COMMUNITY-BASED SERVICES FOR MENTAL HEALTH RECOVERY

The Navigator Project in the ACT department demonstrated the value of including community-based services in the care plan of a person with mental health concerns. After each consultation with a consumer, the Navigator provided a Case Summary Form, outlining the linked services and the outcome of each, to the clinician to upload to CIMHA. Clinician feedback was very positive around this information sharing process, as it allowed them to see the extent of the services offered by the Navigator and the positive outcomes that linking services has on consumer experience and continuity of care.

In December, the addition of a “Navigator” column added to the Mental Health ED whiteboard to prompt clinicians to refer to Navigator was well received. This helped to demonstrate an integration of care between the clinical care provided by ACT and the non-clinical support provided by the Navigator. It was a step in the right direction.

6.7. REPORTING

The Project Officer and Navigator kept the Steering Committee well informed of project progress, challenges, barriers and outcomes, presented at each monthly meeting. Progressive reporting included monthly status reports, monthly barriers report and quarterly service delivery reports which were compiled by the Project Officer and provided to PIR and the steering committee.

7.0 PROMOTION

As part of the project, the Project Officer and Navigator promoted the project at a number of events including:

- World Suicide Prevention Day (hosted by Wesley Mission)
- Lives Lived Well Winter Schools
- Dual Diagnosis workshops
- Mental Health First Aid Training
- Partners In Recovery Networking Breakfast – Project Officer designed Navigator Project poster for this event (Appendix 5.0)

8.0 LEARNINGS

There are a number of lessons learned from the Navigator Project. Table 5.0 outlines these lessons, with provision of recommendations that can be used to improve the delivery of future patient navigation projects within an emergency department setting.

Table 5.0 Key learning's and recommendations for the future

Learning	Recommendation
It is extremely challenging for a non-clinical Navigator from an NGO, to work within the clinical environment in the ED, experiencing difficulties with building referrals.	A non-clinical Navigator needs to be understanding and appreciative of the clinical environment they are working in and be willing to work in-line with the clinical approach and processes of the ACT, adopting a collaborative working attitude.
Many consumers referred to the Navigator were not always interested in, and/or able to have a discussion about their community-based needs, at the time of discharge.	It is important for the Navigator to still meet with the consumer, even if it is a brief interaction, to introduce themselves and provide resources/contact details of appropriate community-based services that can provide ongoing and sustainable mental health support after discharge.
Evaluation measures should have been identified in the initial plan, this knowledge will increase data collection and analysis effectiveness, and evaluation of outcomes in future projects.	Clear evaluation measures should be put in place before the implementation of a Navigator role. They should be e.g. included in the Collaboration Agreement to allow for the collection of baseline and evaluation data for referred consumers and also project manager/service system collection data identified. Additionally, consent process needed to be included with regard to obtaining data such as asking participating consumers to sign a Consent Form that allows project team to access their hospital records for data collection and reporting purposes etc. A consumer-satisfaction questionnaire to be given to consumers to fill in after the Navigator has consulted with them to measure satisfaction with Navigator service, such as the linkages provided, recommended

	services and adequate provision of information at the initial consultation.
Anecdotal feedback from clinicians in the final phase of the project indicated that some clinicians did not have a thorough understanding of the Navigator role and services provided and were unsure of referral criteria and process, which prevented them from referring consumers.	At the implementation phase, run a number of workshops/presentations, possibly tacked on to the monthly ACT staff meetings, to reach all clinicians outside of the busy ED environment, to provide a clear and concise explanation of the Navigator Project and processes.
A person of seniority within the ACT has the influential power to drive referrals for the Navigator role. This was demonstrated in the current project when a senior clinician -the Psychiatric Registrar actively encourage clinicians to refer to the Navigator when there was a need, positively influencing referrals.	Ensure the nomination of a senior member of the Acute Care Team to be engaged and who has influence over staff, to work collaboratively with the Navigator to educate clinicians about the service and drive the number of referrals for the Navigator.
Over 60% of referred consumers had dual diagnosis/problems or comorbidity of psychological conditions/problems and/or substance abuse.	The Navigator role working in this environment has a thorough understanding of mental illness and dual diagnosis to provide referrals and linkages of appropriate services that offer dual diagnosis services.
A predominant part of this role is educating and advising consumers about available and accessible community-based services that are appropriate for their circumstances. A high proportion of consumers seen by the Navigator reported not having knowledge of available services on the Gold Coast. Further to this, a high number of consumers reported that they were not aware of what a GP Mental Health Care Plan was, or if they had heard of it, they were not aware of their eligibility or how to access this.	The Navigator should have a community services background, or be familiar with community services in the region, to be able to provide consumers with comprehensive information about available and appropriate services. Additionally, the Navigator should have a thorough understanding of the GP Mental Health Care Plan process in order to advise/inform the consumer.
Low response rate to telephone follow-up calls at 48 hours and particularly at 1 week. Text messages were the preferred means of contact for consumers, with a much higher response rate at follow up.	The Navigator should use/identify alternate options also re contact i.e. Text messages to contact consumers for follow up, as a process for those who do not respond.

9.0 CONCLUSION

Partners in Recovery, Gold Coast Hospital and Health Service and stakeholders involved in this project, had invested interests in improving the current care pathway for individuals presenting at the ED with people discharged from ED who have mental health concerns and took innovative action in establishing the Navigator Project.

The Project experienced a number of challenges during the life of the project, with the most significant revolving around the number of referrals. This was attributed to the introduction of a new role in ED, change process, establishing engagement with stakeholders, building relationships, communication strategy, understanding each other's roles to optimise working together within the busy hospital environment. Low referral numbers were also attributed to not having a communication strategy place to assist in an increased knowledge and understanding of the scope of the navigator service and referral procedures among clinicians. Other opportunities were identified as there being a benefit in the Navigator being involved in the ACT MDT meetings or handover meetings, which ideally would have been a perfect platform for the Navigator to provide feedback and community-based suggestions to cases and also demonstrate to ACT clinicians the extent to which the Navigator could provide assistance in consumer cases.

In light of the many challenges, there were some notable achievements made by the project team. The Navigator established key relationships with community-based services, other Emergency Departments and a number of ACT clinicians, which worked towards closing the gap between community and hospital services and promoted an integrated care approach. The Navigator project raised awareness among ACT clinicians about the full extent of available community-services, which many clinicians were not aware of prior to this project, which could prompt community services suggestions and referrals from clinicians in the absence of a Navigator in the future. The Project Officer and Navigator identified a number of opportunities during the project and provided this feedback to the steering committee to work towards improved care pathways for mental health consumers.

The project has laid the foundations for a Navigator role within the ED, working alongside a mental health acute care team. It has provided a valuable resource to ACT clinicians and mental health consumers. Based on the findings and outcomes of the Navigator Project, a number of recommendations have been made in order for a Navigator role to become sustainable in the ED ACT environment and have the full potential of the position utilised. These recommendations include:

Primary recommendation

- The Navigator in this environment is essentially a "community linker", therefore it is recommended that this role be filled by a non-clinical, community services professional, with local knowledge of NGO's, community-based mental health services and social supports, support groups and wellness activities.

Other recommendations

- A Navigator may be better received by clinicians if they are directly employed by Queensland Health, rather than an NGO. A Navigator formally employed under the hospital umbrella may find it easier to establish relationships and generate more referrals.
- Despite the challenges posed in the trial service gains were made and these should be built on. The advantages of the Navigator role being managed within the NGO sector reinforces that the specialist services should focus on the specialist service provision and the NGO on the complimentary provision of service.

- Ongoing discussion needs to occur with regard to whether a Navigator working in ACT should be provided "Read only" access to CIMHA. This would allow the Navigator to gather information about a consumer, such as previous ED presentations, mental health history and family history. This would also eliminate the need for the consumer to have to repeat details to the Navigator following a mental health assessment with a clinician. There are many valid points for and against this type of access and therefore, though logically it would be advantageous for Navigators to have CIMHA, there are many considerations that need to be discussed further before that decision is made for future projects.
- Reinforced the need that wherever possible discharge plans, collaboratively compiled by clinicians, in conjunction with the consumer/family have input from the Navigator also.
- Prior to the commencement of any future Navigator or similar models of service in ACT, a communication plan is developed which may include a workshop or training session be developed for all clinicians to ensure clarity around services provided and referral procedures.

Our findings support the ongoing benefit for patients in the implementation of a Navigator role to provide community-based discharge interventions for individuals with mental health concerns at the GCUH ED. A Navigator role in this setting can improve the integration of services between hospital and the community, supporting the "ED to home" transition, provide referrals, recommendations and linkages to appropriate community services for individuals who would benefit from the service. A non-clinical Navigator with a community services background has proven to be particularly beneficial in this process, due to their familiarity with Gold Coast community services, referral processes and accessibility.

The project overall was viewed as successful as per LLW/PIR/MHS in implementing a non-clinical Navigator in the Emergency Department at the GCUH, working alongside the Mental Health Acute Care Team. Consumers that the Navigator consulted with, there were positive results, including successful linkages to community-based services and positive feedback from the consumers about the support and empathy they received at the difficult transition of "ED to home".

For a better understanding, hospital statistical data, project service statistical data, a consumer satisfaction questionnaire and cost-effectiveness analyses over a longer period of time, are needed in order to examine the full impact of a Navigator role within the ED ACT.

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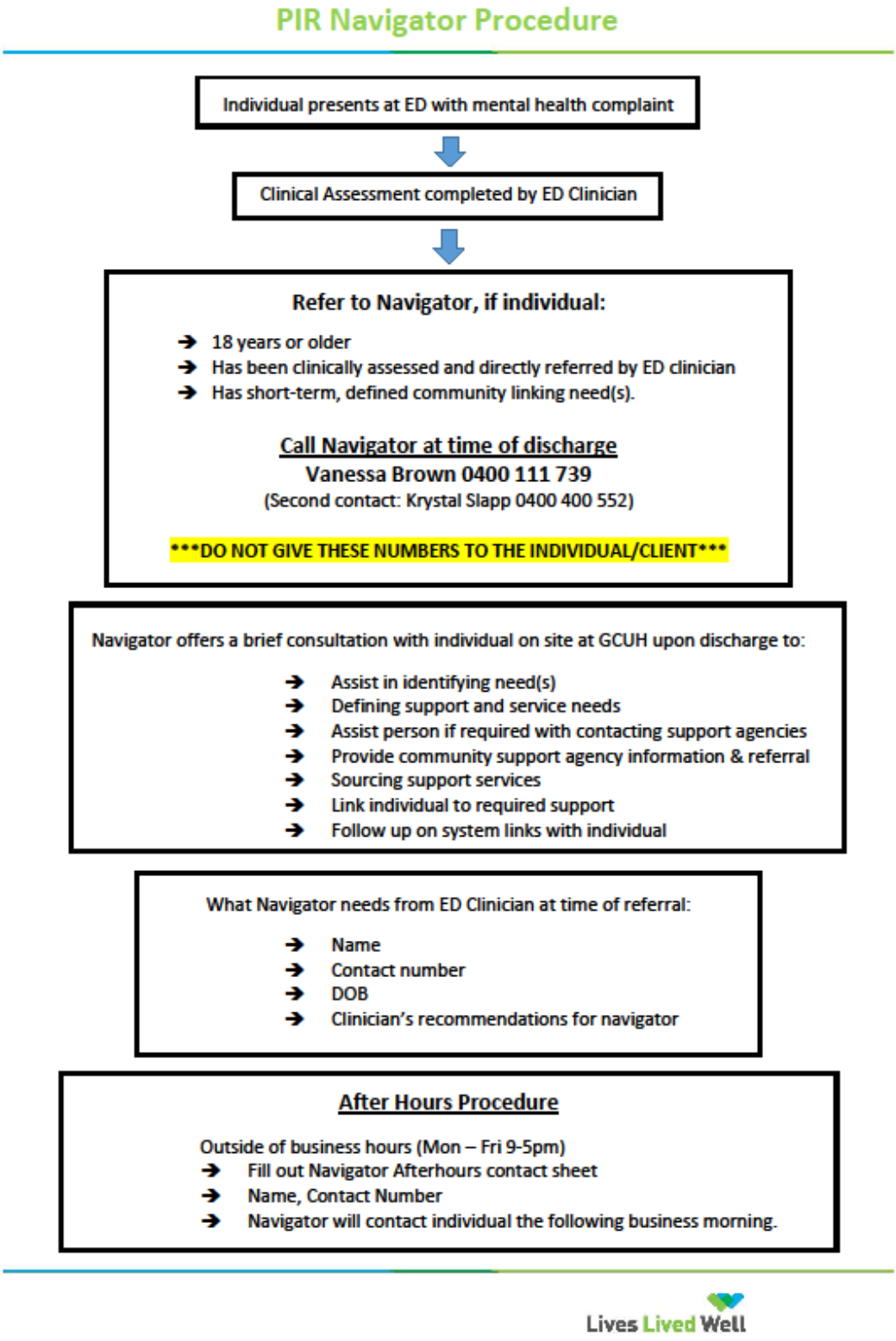
APPENDICES

Appendix 1.0: Navigator Referral Pathway



Appendix 2.0: Navigator: After-Hours Referral Form

PIR Navigator – AFTER HOURS

1. If individual meets criteria for Navigator consultation and the Navigator is unavailable/out of business hours, ED clinician to fill in the individuals discharge date, name and contact number.
2. Leave this after hours sheet in "Navigator Tray".
3. Navigator will call individual on the following business day for a telephone consultation.

Discharge Date	Name	Contact Number	Clinician's Recommendations for Navigator	Has consumer consented to be contacted by Navigator?

Lives Lived Well

Appendix 3.0: Navigator Client Intake Form

NAVIGATOR – Client Form

Client #: _____

PERSONAL DETAILS			
Name			
Date of Birth		Male	Female
Contact Number			
Address			

CLIENT BACKGROUND
ED Presentation
Current Medications
Background Client Information
Identified Recommendations

Is client eligible for a PIR Referral? If yes – Email PIR Intake Referral to: pir@mentalhealth.org.au	Yes	No
Does the client use alcohol or other drugs? If yes, what is primary substance of use? _____	Yes	No

CURRENT STATUS WITH NGO's / COMMUNITY SERVICES		
Is client currently linked with any NGO's/Community services? If yes – which ones?	Yes	No
Are there any NGO's/Services they have not been able to be linked with? If yes, why?	Yes	No
Is the client on any wait lists for NGO/Community Services?	Yes	No
What are/were barriers the client has experienced with NGO/Community Services previously?	Yes	No

Lives Lived Well

CONSUMER'S SHORT-TERM NEEDS (Does consumer need assistance/support with any of the following?)			
Do you identify as Aboriginal or TSI? Is specialised support required?	Yes	No	
Do you identify as LGBTIQA? Is specialised support required?	Yes	No	
Accommodation	Yes	No	
Employment	Yes	No	
Income/ Money/ Benefits	Yes	No	
Transport	Yes	No	
Relationship Counselling	Yes	No	
Oral / Dental Complaints	Yes	No	
Recommendation of GP	Yes	No	
Support Service, ie. Support Group If yes, what for?	Yes	No	
Wellness Activities in community If yes, what are the areas of interest? _____	Yes	No	
Disability Services If yes, specify support required	Yes	No	
Alcohol and Other Drugs Services	Yes	No	
Mental Health Services	Yes	No	
Domestic Violence Services	Yes	No	If yes, refer to GCUH Social Worker
Gambling Services	Yes	No	
Legal Support Services	Yes	No	
Other	Yes	No	

Lives Lived Well

CONSUMER FOLLOW-UP

INITIAL CONTACT:					
Date		Time		Face to Face	Telephone
What happened:					
What links were made:					

48 Hour Follow-Up					
Project Caller		Date		Time	
Did consumer answer?	Yes	No			
Outcome of call:					

1 Week Follow-Up					
Project Caller		Date		Time	
Did consumer answer?	Yes	No			
Outcome of call:					
Has consumer been in contact with GP since ED discharge? Yes No					

PIR Navigator (Name): _____ **Signature:** _____

Consumer details entered in to Mimaso Client Database by: _____ **Date:** _____

Appendix 4.0: Navigator Case Summary Form

Navigator File Note – Community Links

Lives Lived Well

NAVIGATOR'S NAME: _____

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

CONTACT NUMBER: _____

_____

CASE NOTES:

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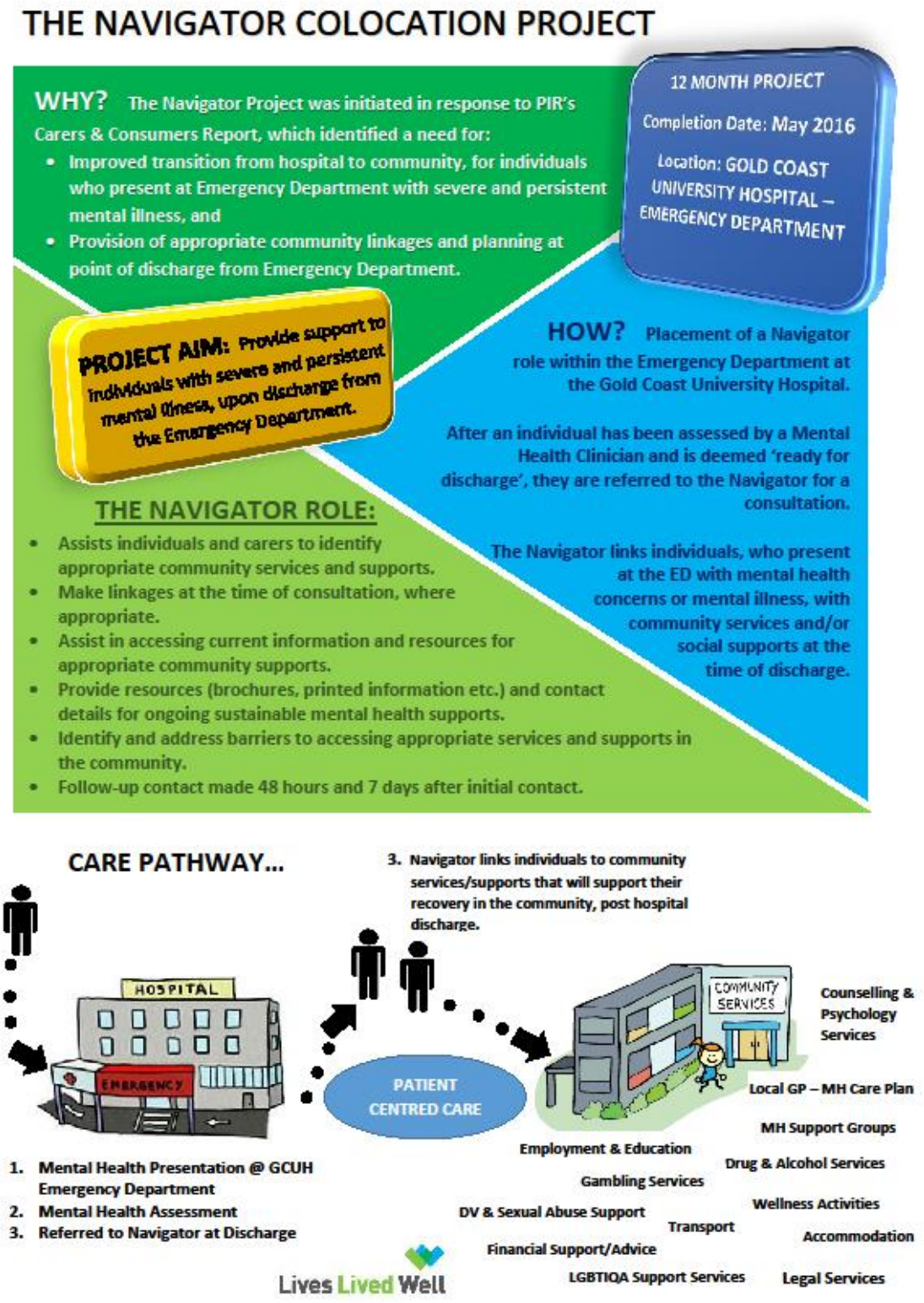
P: 07 3834 0200
F: 07 3832 2527
E: contactus@liveslivedwell.org.au

Level 1, Boundary Court, 55 Little Edward Street
(PO Box 332) Spring Hill QLD 4004
www.liveslivedwell.org.au

Appendix 5.0: Navigator Poster for PIR Networking Event



Appendix 6.0: Community Services

LIST OF COMMUNITY LINKS

Community linkages were established for consumers with the following services:

- Relationships Australia
- Mi Networks
- MIFQ
- Lives Lived Well – Free Alcohol and Drug Telephone Counselling Service
- Lifeline 131 114
- Better Outcomes – Social Worker – Outreach Service 0416 181 828
- Partners in Recovery Intake Team
- MensLink 1300 789 978
- AOD 24-hour Crisis Line 1800 177 833
- The Butterfly Foundation
- Local wellness activity groups such as Yoga, Walking
- Men's & Family Counselling Service
- Domestic Violence Gold Coast – Women's Group
- Poppy Play Group – Aftercare
- 13HEALTH
- Pregnancy, Birth and Baby Hotline
- Perinatal Anxiety and Depression Australia (PANDA)
- SANE
- BeyondBlue 1300 224 636
- AODS Central Gold Coast
- Recruitment services: Kelly Recruitment Services, Bluestone Recruitment, Online Labour Hire
- Nerang Neighbourhood Centre
- Men's Shed
- Coomera Community Centre
- Dad's in Distress
- Autism Queensland
- Carer's and Consumer's Line

Appendix 7.0: Case Study

CASE STUDY: 25 YEAR OLD / MALE

ED PRESENTATION:

- Brought to GCUH Emergency Department by police, after having a fight with his partner and threatening to light himself and his house on fire. (Living in rental property with partner + 2 children).
- Trigger: Partner revealed she has been cheating on him with another man.
- Previously diagnosis: PTSD, Depression, Anxiety
- No family supports in Queensland – brother and father live in Hobart.
- Receives DSP for mental illness – had been suspended.

TELEPHONE REFERRAL FROM ACT CLINICIAN - CYNTHIA : INITIAL TELEPHONE CALL

Navigator spoke with Anthony on the phone.

- Anthony reported feeling extremely depressed after his relationship breakdown, his ex-partner not letting him see his children and financial stress.
- Identified needs:
  - Crisis financial support - $75 for GP appointment for medical report
  - Free mental health counselling service
  - Advice re: rights to see children

NAVIGATOR ACTIONS:

- Called PIR to enquire about crisis financial support.
- Called the following organisations to attempt to source crisis financial support to pay for GP appointment:
  - YHES – No answer – Msg bank advised closed.
  - Uniting Care – Do not offer crisis financial support.
  - Wesley Mission – Only offer emergency welfare support in the form of food vouchers and clothing only.
  - St Vincents – Offer crisis financial support, but not for doctor's appointments.
  - Anglicare Crisis Care – The 'financial lady' was not in the office that day to help.
  - Salvation Army – Could assist with payment of doctor's appointment, but needed Anthony to call himself with his Centrelink Reference Number.
- Called Anthony to advise of Salvation Army outcome. Anthony advised he had no phone credit and no money for phone credit in order to call Salvation Army. I advised Anthony that he could come and meet me at the hospital to use my work phone to make the call. Anthony agreed to meet with me.

FACE TO FACE CONTACT @ HOSPITAL:

- Met with Anthony – sat with him while he called Salvation Army to arrange payment for his doctor's appointment.
- Salvation Army also offered Anthony a $50 food voucher that he could pick up from Surfers.
- Provided Anthony with $5 phone card, provided by HEDLO team member, so he had a means to call his doctor to make appointment.
- Provided Anthony with brochures/contact details for: PIR Mental Health Contacts on GC, MIFQ Mi Networks brochure, Relationships Australia, Dad's in Distress.
- I suggested negotiating a visit with his children with ex-partner at a police station.

48 HOUR FOLLOW UP

- Spoke with Anthony on telephone – very engaging and thankful for support and help.
- Anthony had been to Salvation Army office to sort out payment for doctor's appointment and collect food voucher.
- Anthony had made appointment with GP and advised Centrelink of his plan.

1 WEEK FOLLOW UP

- Anthony had been to his doctor for medical report and provided this to Centrelink.
- DSP suspension has been lifted.
- His brother has arranged a flight for him to fly to Hobart to live with him for support.