phn MURRAY

An Australian Government Initiative

PART A
PROGRAM GUIDELINES

PRIMARY MENTAL HEALTH, PSYCHOSOCIAL RECOVERY AND ALCOHOL AND OTHER DRUG SERVICES

SEPTEMBER 2020

Leadership

Collaboration

Knowledge

Innovation

Accountability

About this document

This document provides guidance for health services commissioned by Murray PHN (Primary Health Network) to provide primary mental health, psychosocial recovery and alcohol and other drug services for people located across the Murray PHN catchment. The catchment of Murray PHN is significant in both size and diversity and covers an area of almost 100,000 square km, with a population of more than 644,000 people.

Outlined in this document are the scope, eligibility requirements, clinical governance obligations and workforce requirements specific to the provision of services within the three streams of Primary Mental Health, Psychosocial Recovery and Alcohol and Other Drug Services (AOD). This document as **Part A – Program Guidelines**, details general principles for a stepped care approach, service delivery, governance and workforce requirements of funded service providers applicable to all three service streams, outlined above. It must be read in conjunction with **Part B – Specific Program Information** relevant to each service stream. Funded programs within these service streams include:

1. **Primary Mental Health Services**
    a. Psychological Therapy Services (PTS), both generalist and specialist services for specific population groups
    b. Clinical Care Coordination (CCC)
    c. Youth Enhanced Services (Youth Severe)
    d. Mental Health Services For Older People Socially Isolated by the impact of COVID-19
2. **Psychosocial Recovery Services**
    a. Continuity of Supports (CoS)
    b. Extended Transition Arrangements (ETS)
    c. National Psychosocial Support Measure (NPSM)
3. **Alcohol and Other Drug Services**
    a. Drug and Alcohol Treatment Services - NIAS (National Ice Action Strategy) Operational and Mainstream Funding
    b. Drug and Alcohol Treatment Services - NIAS (National Ice Action Strategy) Aboriginal and Torres Strait Islander People Funding
    c. Drug and Alcohol Treatment Services - Core AOD and Operational Funding (Transitional services)
    d. Increasing Access to Drug and Alcohol Treatment Services in Regional, Rural and Remote Areas.

In addition, there is a separate guidance document on PMHC-MDS and other data capture and reporting specifications for all service providers and this forms **Part C** of the suite of Murray PHN Primary Mental Health, Psychosocial Recovery and Alcohol and Other Drug Services Guidelines documents.

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

Mental Health Hubs

A new mental health pandemic response service is available to all people in the Murray PHN region. The new service (part of the Federal Government's $31.9 million package for Victoria) includes a state-wide 1800 phone line providing intake and referral advice to anyone who feels they are not coping. In addition, the service is supported by 15 mental health hubs located at appropriate existing health services to provide a welcoming, low stigma entry point for people seeking help for their mental health and wellbeing.

Murray PHN has worked closely with primary care services, hospitals, the Victorian Mental Health Pandemic Response Taskforce and the State and Federal Governments in identifying suitable locations for the hubs, based on criteria provided by the Federal Department of Health. These criteria included:

- Local Government Area population size including distribution across age groups
- Local capacity and ability to rapidly establish services
- Accessibility and suitability of service locations (including whether they are rated as COVID-safe)
- Identified gaps in mental health service delivery.

Murray PHN hosts two of these hubs, at Bendigo Community Health Services (15 Helm Street, Kangaroo Flat, Bendigo) and Gateway Health (155 High Street, Wodonga). The mental health hubs are not designed to replace or duplicate other mental health services throughout the region, or fragment service support. In addition, Murray PHN will work collaboratively with service providers to integrate these services within the stepped care service system. Furthermore, the services are intended to complement existing and newly funded mental health services under the guidance of the Victorian Mental Health Pandemic Response Taskforce.

Like other PHNs, Murray PHN is taking a staged approach to establishing the mental health hub services, which will begin operating with foundational staffing. Work will occur to gradually scale up the service resourcing in consultation with key stakeholders including (but not limited to) primary care providers, existing mental health providers, Aboriginal Community Controlled Health Organisations, people with lived/living experience of mental ill-health, and emergency services.

Once fully established, the service will offer multidisciplinary teams of mental health workers, including psychologists, mental health nurses, social workers, and alcohol and drug workers to provide extra support during the pandemic.

Service providers should be alert to the possibility of referrals from the new hubs – either from the central intake function, or from the hub service provider themselves. Such referrals should be treated as provisional referrals as is further detailed in section 5.1 Referral Pathways and requirements (page 14), of these guidelines. Of note is that a GP mental health treatment plan is not required for referral to this service, which is available to anyone of any age.

A manual outlining the operations of the Mental Health Hubs is available through Murray PHN.

PART A: Program guidelines

MURRAY PHN

Psychosocial Recovery Services, Primary Mental Health Services, Alcohol and Other Drug Services

PART B: Program specific information

PSYCHOSOCIAL RECOVERY SERVICES	PRIMARY MENTAL HEALTH SERVICES	ALCOHOL AND OTHER DRUG SERVICES
• Continuity of Support (CoS) • Extended Transition Arrangements (ETA) • National Psychosocial Support Measure (NPSM)	• Psychological Treatment Services (PTS) • Clinical Care Coordination (CCC) • Youth Enhanced Services (Youth Severe) • Services For Older People	• Drug and Alcohol Treatment Services – NIAS (National Ice Action Strategy) Operational and Mainstream Funding • Drug and Alcohol Treatment Services – NIAS (National Ice Action Strategy) Aboriginal and Torres Strait Islander People Funding • Drug and Alcohol Treatment Services – Core AOD and Operational Funding (Transitional Services) • Increasing Access to Drug and Alcohol Treatment Services in Regional, Rural and Remote Areas.

PART C: Data Reporting Specifications

Primary mental health, psychosocial recovery and alcohol and other drug services commissioned by Murray PHN represents part of the overall service system. As such, commissioned services are expected to ensure that service delivery and care are integrated and coordinated into the regional and/or local service system and supported by clear referral pathways and options necessary to provide consumers with the right care, in the right place, at the right time.

This is a newly structured version of the Murray PHN Mental Health, Psychosocial Recovery and Alcohol and Other Drug Program Guidelines (Guidelines). It builds on previous versions of the Murray PHN Primary Mental Health Guidelines. This document has been informed by feedback and ongoing collaboration with commissioned health services, consumers, other partners of Murray PHN and by priority areas and PHN funding guidance from the Commonwealth Government of Australia (2019). In addition, relevant state and national practice and accreditation standards, clinical governance, service frameworks and legislative requirements have been used to inform these program guidelines.

For further information or clarification about any information outlined in this document, please contact:

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Version	Document Title	Date released	Prepared by	Approved
1	Murray PHN Primary Mental Health Program Guidelines	February 2018	M Dineen	P Wilkinson
2	Murray PHN Primary Mental Health Program Guidelines	November 2018	S McConnachie	P Wilkinson
3	Murray PHN Primary Mental Health Program Guidelines	June 2019	S McConnachie	P Wilkinson
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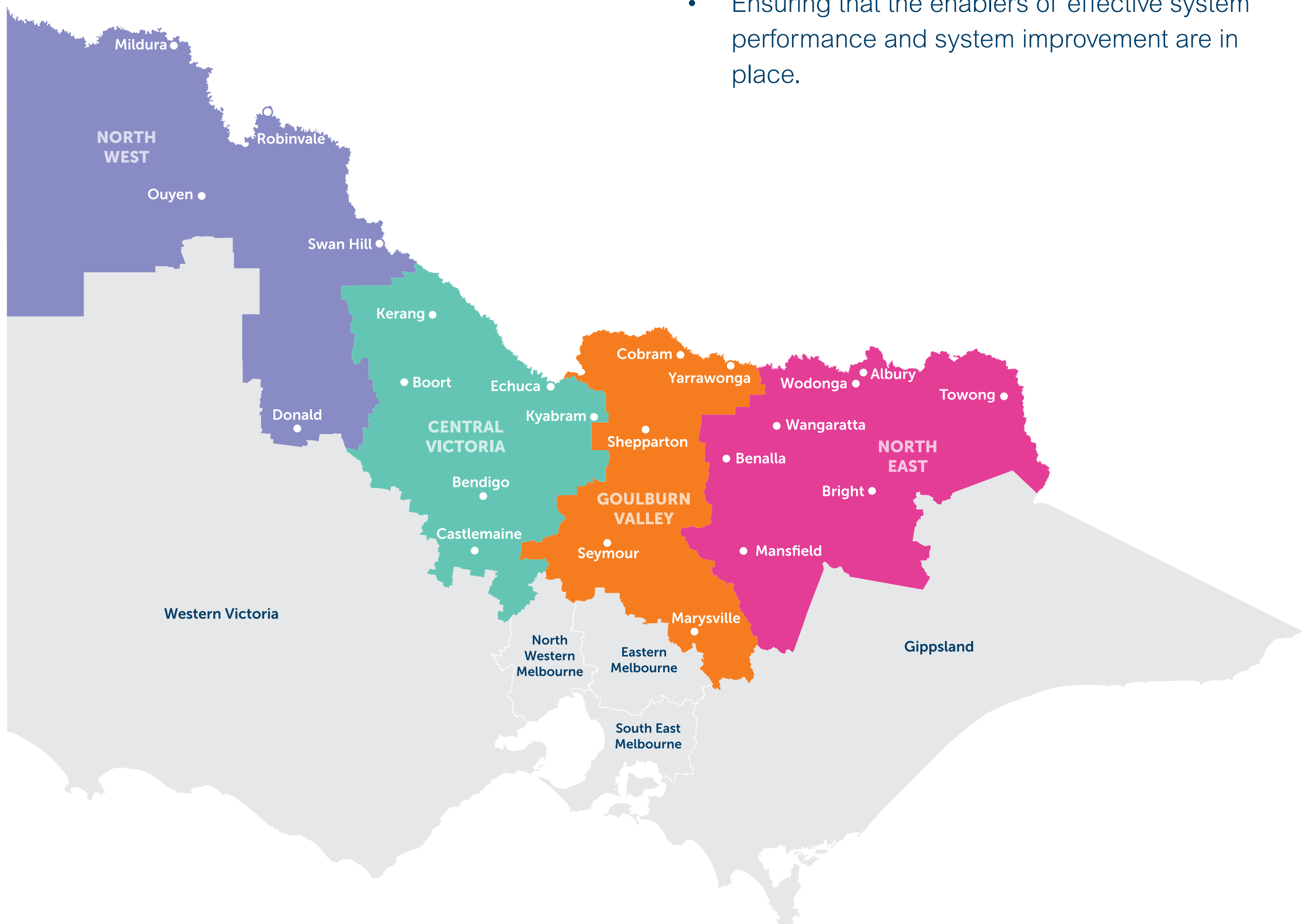
1. Introduction

Murray PHN is a part of the national network of 31 Primary Health Networks across Australia. We work closely with the primary health system to identify opportunities to improve health outcomes in our community, through better coordination and support of health services and by commissioning new services to address the health needs of our population.

The Mental Health Commission's Contributing Lives, Thriving Communities report in 2014 provided key recommendations for future mental health services in Australia. The Australian Government welcomed the findings and, in its document Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services (released 26 November 2015), it recommended a stepped care approach to mental health care, service planning and delivery. Consequently, the Commonwealth Government tasked PHNs with commissioning primary mental health services.

Much of the focus of primary mental health service planning and delivery has also been guided by The Fifth National Mental Health and Suicide Prevention Plan 2017. This plan was endorsed by the Council of Australian Government's Health Council on 4 August 2017, and seeks to establish a national approach for collaborative government effort from 2017 to 2022 across eight targeted priority areas:

- Achieving integrated regional planning and service delivery
- Effective suicide prevention
- Coordinated treatment and supports for people with severe and complex mental illness
- Improving Aboriginal and Torres Strait Islander mental health and suicide prevention
- Improving the physical health of people living with mental illness and reducing early mortality
- Reducing stigma and discrimination
- Making safety and quality central to mental health service delivery
- Ensuring that the enablers of effective system performance and system improvement are in place.



2. Scope

These guidelines are for use by commissioned primary mental health, psychosocial recovery and alcohol and other drug service providers and Murray PHN staff. They are to be read in conjunction with:

- Funding Agreements and Deeds of Variation between Murray PHN and the primary mental health, psychosocial recovery and alcohol and other drug commissioned service provider organisations
- Part B – Specific Program Information, relevant to each service stream
- Part C – Data Capture Specifications.

This document can be distributed to relevant stakeholders and others, in order to ensure there is community-wide understanding of the purpose and scope of services. This may include allied health providers, GPs and state government health departments and associated services. It is recommended that health care providers contact either Murray PHN or the local service provider of these services, for information specifically related to eligibility criteria and availability in the local area.

3. Principles for the Murray PHN stepped care approach

3.1 Stepped care and levels of need

Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, that can be matched to the individual's needs.

Stepped care recognises there is a spectrum of treatment needs, and therefore, also requires a spectrum of services across mental health, psychosocial recovery and alcohol and other drug services. Stepped care is a different concept from 'step up/step down' services. While there are multiple levels in a stepped care approach, they do not operate in silos or as one-directional steps, but rather offer a continuum of interventions matched to the spectrum of mental health, psychosocial recovery and alcohol and other drugs service needs. This spectrum, and the levels of care associated with it at a population level, is illustrated in Figure 1.

A stepped care approach promotes person-centered care that targets the needs of the individual consumer. Rather than offering a 'one size fits all' approach, individual consumers will be more likely to receive a service that optimally matches their needs, does not under or over service them, and makes the best use of workforce and technology. A stepped care approach provides the right care, in the right time, in the right place, with lower intensity steps available to support individuals before illness manifests.

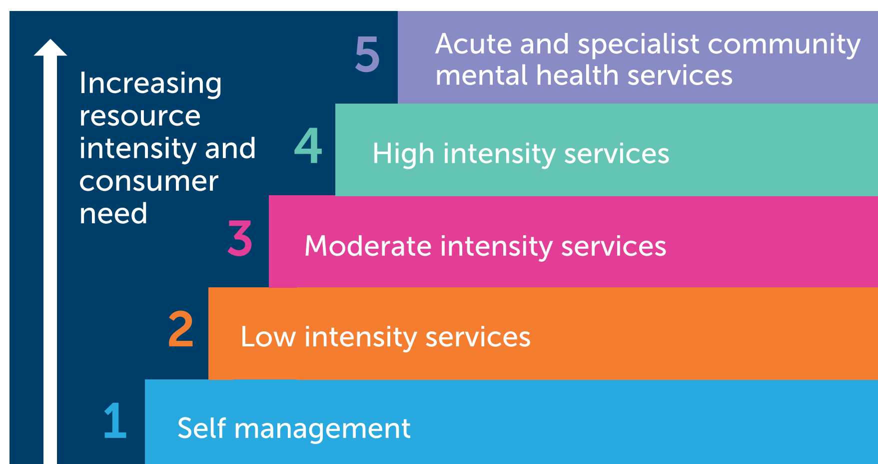


Figure 1 – Schematic representation of levels of care[2]

3.2 Initial assessment and referral (IAR) guidance

Applying the concept of stepped care to individual consumers begins at the initial assessment phase. Recognising this, the Department of Health released the National PHN Guidance on Initial Assessment and Referral for Mental Healthcare[3] (IAR Guidance). The IAR Guidance outlines a systematic and structured approach to assist PHNs in establishing assessment and referral systems founded on stepped care principles. The guidance identifies eight critical areas (referred to as 'domains') that need to be assessed when making decisions about the most appropriate level of care to meet the individual consumer's needs.

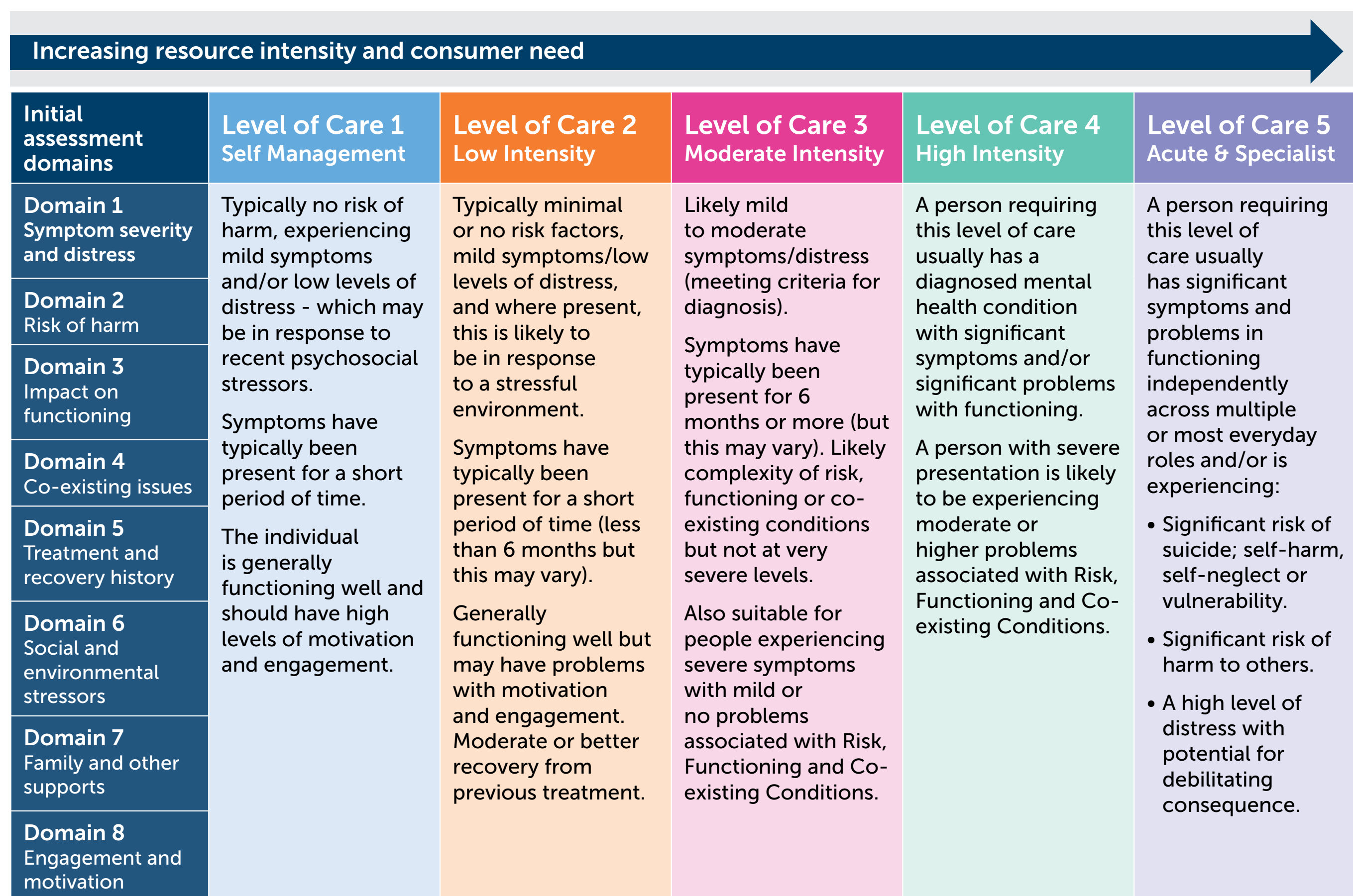
Five levels of care are described, based on the intensity of resources required and suggestions are given on how the initial assessment against the eight domains can be used to assign a level of care and inform a referral decision.

Grouping the complex system of mental health services available in Australia into five levels is used as a framework to think about stepped care, rather than implying that there is a natural division of service types into tiered categories. While some services are associated with a single level of care, most contribute to multiple levels. For example, GP mental health care can be associated with lower levels of care when it is provided in isolation, or higher levels when delivered in combination with other services or interventions e.g. psychiatrist or involvement of a multidisciplinary team.

The levels, therefore, are best thought of as combinations of interventions that form potential 'packages' for consumers requiring that level of care, with the levels differentiated by the amount and scope of resources available. An individual consumer may use some or all interventions described at that level and move between levels of care as their needs change.

While higher levels of care are associated with increasing severity of symptoms and distress, the guidance highlights that multiple factors need to be considered when matching a consumer's needs to a particular level of care. The IAR Guidance includes a decision support tool (DST) to guide referrer decision-making. Figure 2 outlines the IAR Domains alongside the levels of stepped care and the elements of consumer presentation and need at each level of care.

Figure 2 – IAR domains and levels of care



Increasing resource intensity and consumer need →

Initial assessment domains	Level of Care 1 Self Management	Level of Care 2 Low Intensity	Level of Care 3 Moderate Intensity	Level of Care 4 High Intensity	Level of Care 5 Acute & Specialist
Domain 1 Symptom severity and distress **Domain 2** Risk of harm **Domain 3** Impact on functioning **Domain 4** Co-existing issues **Domain 5** Treatment and recovery history **Domain 6** Social and environmental stressors **Domain 7** Family and other supports **Domain 8** Engagement and motivation	Typically no risk of harm, experiencing mild symptoms and/or low levels of distress - which may be in response to recent psychosocial stressors. Symptoms have typically been present for a short period of time. The individual is generally functioning well and should have high levels of motivation and engagement.	Typically minimal or no risk factors, mild symptoms/low levels of distress, and where present, this is likely to be in response to a stressful environment. Symptoms have typically been present for a short period of time (less than 6 months but this may vary). Generally functioning well but may have problems with motivation and engagement. Moderate or better recovery from previous treatment.	Likely mild to moderate symptoms/distress (meeting criteria for diagnosis). Symptoms have typically been present for 6 months or more (but this may vary). Likely complexity of risk, functioning or co-existing conditions but not at very severe levels. Also suitable for people experiencing severe symptoms with mild or no problems associated with Risk, Functioning and Co-existing Conditions.	A person requiring this level of care usually has a diagnosed mental health condition with significant symptoms and/or significant problems with functioning. A person with severe presentation is likely to be experiencing moderate or higher problems associated with Risk, Functioning and Co-existing Conditions.	A person requiring this level of care usually has significant symptoms and problems in functioning independently across multiple or most everyday roles and/or is experiencing: • Significant risk of suicide; self-harm, self-neglect or vulnerability. • Significant risk of harm to others. • A high level of distress with potential for debilitating consequence.

Adapted from the Australian Department of Health, National Initial Assessment and Referral for Mental Healthcare Guidance, 2019

3.3 Consumer and carer participation and co-design

Engagement of consumers, family, carers and those with lived experience of mental health issues/ illness as partners in development, delivery and evaluation of stepped care services is vital to ensure it genuinely promotes person-centred care. Consumer and carer engagement and participation should span service planning, procurement, monitoring, review and evaluation. Furthermore, a spectrum of engaging consumers - from information provision to guest speakers at forums, through to employment of people with lived experience as peer support workers - needs to be considered in implementing stepped care.

Consumer participation strategies should recognise the difference and uniqueness of consumers/ carers and their needs and target input accordingly. For example:

- Design of low intensity services aimed at groups such as young people with mild illness or men with early signs of depression would need to engage with these groups in the design process
- Design of suicide prevention activities must engage with people with lived experience of suicide
- The views and needs of carers, supporters and family members should always be considered
- Engagement of people with lived experience as peer support workers in providing services under a stepped care framework is a vital way of embedding a consumer perspective.

Effective consumer and carer participation need to be appropriately resourced in a way that recognises the opportunities for consumers and carers in providing input and enables them to engage in an informed and effective way. Murray PHN expects service providers to demonstrate commitment to active consumer and carer engagement and participation in all elements of service delivery.

A note on language: *throughout this guide, terms have been used such as engagement, participation, lived experience, co-design and co-production. Not all of these terms have commonly agreed definitions, and not all readers will identify with the use of these terms in the same way as they are presented here.*

For clarity, Murray PHN uses the following definitions that are drawn from the Australian Government National Mental Health Commission[4]:

Carers are people, often family members, who provide, or have provided in the past, ongoing personal care, support, advocacy and/or assistance to a person with mental illness.

Co-design is a process of identifying and creating an entirely new plan, initiative or service, that is successful, sustainable and cost-effective, and reflects the needs, expectations and requirements of all those who participated in, and will be affected by the plan, initiative or service. Co-design processes should include people who are directly affected by an issue but can also include other stakeholders and the general community.

Consumers are people who identify as having a living or lived experience of mental illness, irrespective of whether they have a formal diagnosis, have accessed services and/or received treatment. This includes people who describe themselves as a 'peer', 'survivor' and 'expert by experience'.

Co-production is a process of implementing, delivering and evaluating supports, systems and services, where consumers, carers and professionals work in an equal and reciprocal relationship, with shared power and responsibilities, to achieve positive change and improved outcomes.

Engagement refers to methods and actions taken by organisations to involve the public, consumers and carers generally but also allows for decision-making and co-design and co-production processes to be undertaken.

Mental health is a state of wellbeing in which the individual realises their own abilities and potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community.

Further information on consumer and carer engagement is available on the [Mental Health Commission website].

3.4 An integrated and coordinated system of care

An integrated and coordinated primary health approach to the delivery of mental health, psychosocial recovery and alcohol and other drug services, moves from the solitary provider model, to a health care system that involves partnerships across the health and wellbeing service sectors, to provide a unified system of care. This approach aims to enhance care, improve quality and avoid service duplication. The goal being that service providers working together in developing localised pathways will use innovative thinking to close systems gaps, reduce inefficiencies and provide holistic practice in a stepped care model of service delivery.

Murray PHN expects there to be integration and coordination between primary mental health, alcohol and other drug service providers, psychosocial recovery, GPs and allied health providers in the planning of integrated and coordinated care as necessary, to ensure individual consumers receive the right care, in the right place, at the right time.

Murray PHN primary mental health, alcohol and other drug and psychosocial recovery service providers are expected to:

- Design and implement models of care that are person-centred, recovery-oriented and integrated with the local health system, particularly general practice
- Strengthen the overall primary care service system to provide a broader service coordination and system integration for individual consumers presenting with mental health, alcohol and other drug and psychosocial recovery related presentations
- Support GPs in their role to ensure individual consumers are referred to, and receive the right care, in the right place, at the right time.

In addition, an individual, receiving primary mental health, psychosocial recovery and alcohol and other drug service interventions, should expect to have access to a range of services as required, according to their specific needs and recovery goals, within a stepped care approach. This should include access to a range of professional disciplines including GPs, psychiatrists, mental health nurses, psychologists, counsellors, social workers, occupational therapists, educators, employers, youth workers, vocational support workers, housing support workers, other allied health and/or community support workers, peer support workers, carers and family and/or friends (where nominated).

3.5 Cultural safety

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 is an important part of ongoing reform to the mental health system and interconnected with many strategic responses to Aboriginal and Torres Strait Islander peoples' health[5]. Service providers must work under this framework and ensure they have a clearly articulated strategy for providing cultural safety in the delivery of mental health, psychosocial recovery and alcohol and other drug services for Aboriginal and Torres Strait Islander people.

Culturally appropriate health services and providers will facilitate more effective mental health service delivery and improved mental health, psychosocial recovery and alcohol and other drug service outcomes for Aboriginal and Torres Strait Islander people. This requires cultural awareness, cultural respect, cultural safety and an understanding of the importance of cultural healing and the cultural determinants of health[6].

Services for culturally and linguistically diverse (CALD) communities must be delivered in keeping with the Commonwealth Department of Health CALD Appropriate Communication.

Service providers must ensure that programs are safe and responsive to the needs of lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA+) people, their families of choice and communities, and are delivered in keeping with the National Framework for Recovery-oriented Mental Health Services Capability Domain 2E.

3.6 Reducing stigma

Stigma towards people living with mental illness is prevalent in Australia, with almost three out of four people with mental illness experiencing stigma[7]. People living with mental illness may be perceived or represented as violent, unpredictable, prone to criminality, incompetent, undeserving or weak in character. Discriminatory behaviours may include avoidance, or withholding opportunities or support. The impact of stigma and discrimination against people living with mental illness is far-reaching and is compounded for groups who are already marginalised and who experience other forms of discrimination, such as Aboriginal and Torres Strait Islander peoples and people who identify as LGBTQIA+.

People living with mental illness may also experience stigma and discrimination by the health workforce. This may include being advised by a health professional to lower their expectations for accomplishments in life, being shunned or avoided by a health professional, or a health professional behaving differently after discovering that a person has a mental illness. A particular issue of concern is diagnostic overshadowing, where a health professional misattributes physical symptoms to a person's mental illness and subsequently provides inadequate diagnosis or treatment[8].

Murray PHN is committed (and expects this of all its funded service providers and their workforce) to reducing the stigma and discrimination experienced by people with mental illness. In line with the fifth National Mental Health and Suicide Plan (2017), service approaches are expected to:

- Involve consumers, carers, supporters and their families, in all aspects of service planning, design, delivery and evaluation
- Build on existing evidence-based initiatives that involve reducing mental health stigma and discrimination
- Account for the specific experience needs of groups already at high-risk of stigma
- Implement workforce training programs that build awareness of and knowledge about the impact of stigma and discrimination
- Respond proactively and provide leadership when stigma or discrimination is seen.

3.7 The role of the general practitioner

Within a stepped care approach, the role of the GP is critical. GPs are often the first point of clinical contact for individuals seeking help for mental health issues and related problems. They are gatekeepers to other services and therefore, central to an integrated service system approach and key to stepped care.

Though it is anticipated that access to most primary mental health, psychosocial recovery and alcohol and other drug services commissioned by Murray PHN will continue to require a referral from a GP, psychiatrist or paediatrician (with the exception of low intensity services), in the form of a treatment plan, ***the absence of this should not prevent the individual consumer accessing a service in the first instance***.

While GPs will generally be required to undertake the initial assessment with the consumer to determine the most appropriate level of care, the GP is central to the consumer's recovery journey and must be communicated with by the service provider at critical stages of care. It is also acknowledged that while at times communication with the GP may be difficult, at a minimum, GPs should expect communication and correspondence from the service provider regarding:

- Receipt of referral
- Completion of the comprehensive assessment
- Participation in and outcomes of the clinical case review
- Step up/ step down and discharge from the relevant program.

3.8 Local service delivery

Services need to be delivered from settings that are both accessible and appropriate to the needs of the individual. The designated mental health service geographic regions should inform service planning and delivery, but not restrict an individual from receiving services in their preferred location due to their postcode.

4. Service delivery approaches

4.1 Recovery

The concept of recovery was conceived by, and for, people with mental health issues to describe their own experiences and journeys and to affirm personal identity beyond the constraints of diagnosis. The recovery movement began in the 1970s primarily as a civil rights movement aimed at restoring the human rights and full community inclusion of people with mental health issues. Recovery approaches are viewed by the consumer movement as an alternative to the medical model with its emphasis on pathology, deficits and dependency. There is no single description or definition of recovery because recovery is different for everyone. However, central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy.

Also key to recovery, is a person's right to full inclusion and a meaningful life of their own choosing, free of stigma and discrimination.

Some characteristics of recovery commonly cited are:

- A unique and personal journey
- A normal human process
- An ongoing experience and not the same as an end point or cure
- A journey rarely taken alone
- Nonlinear and therefore, frequently interspersed with both achievement and setbacks.

The personal view of recovery is understood as a journey that is a unique and a personal experience for each individual. It has often been said to be about gaining and retaining hope, understanding of one's abilities and limitations, engagement in an active life, having personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.

Essentially, the personal view of recovery is about a life journey of living a meaningful and satisfying life.

Figure 1 depicts the concept of recovery, central to the delivery of mental health, psychosocial recovery and alcohol and other drug services.

Figure 1 - The Concept of Recovery[9]

Service provider recovery approaches will be different depending on where a person is in their recovery journey. During an acute phase of illness, the person's capacity may be impaired to the extent that alleviation of distress and the burden of symptoms, as well as safety, are the primary focus of treatment and care. Regaining capacity for self-determination or deeper engagement should be a focus in the next stage of treatment and support. At later stages, when capacity is improved, there are opportunities for the person to consider broader recovery strategies and goals.

It is expected that all Murray PHN funded organisations will have a commitment to working in a recovery-oriented framework and that programs will be delivered by a workforce trained in the principles and practice of recovery-oriented care.

4.1.1 Alcohol and other drug services

The National Drug Strategy (2016-2026)[10] highlights the importance of service provider investment in strategies that are critical to long-term recovery. Evidence indicates that ***maintenance of recovery*** is strongly associated with quality of life. Quality of life factors include family life, connection to community, employment and recreational opportunities. Therefore, investing in strategies to enhance social engagement, and where indicated, re-integration with community, is central to successful interventions that can reduce alcohol and drug demand and related problems, including dependence.

Approaches that seek to build protective factors and address issues underpinning social determinants of health, to prevent the initial uptake of drugs, can also enhance community health and wellbeing and reduce health inequalities among population groups that experience disproportionate risk of harm from alcohol, tobacco and other drugs. This includes social services and community groups collaborating to improve access to housing, education, vocational and employment support, as well as developing and enhancing family and social connectedness, and strategies to reduce the availability, accessibility and demand for drugs.

4.2 Shared care health records

Service providers are encouraged to:

- Register to participate in the My Health Record system at myhealthrecord.gov.au. My Health Record is a secure online summary of an individual's health information and aids communication for the person and their care team
- Advise, and support individuals referred to them to use the personally controlled My Health Record
- Consider use of electronic shared care tools with stakeholders to optimise shared care arrangements.

4.3 Delivery modalities

It is expected that a range of modalities, in individual and/or group mode, will be used to enable timely support to consumers, especially in rural and remote settings. This can include:

- Face-to-face i.e. in clinics, individual/family homes, or other community-based settings and locations
- Telephone
- Video conferencing
- Digital mental health resources.

4.4 Digital resources

The use of digital mental health resources, otherwise referred to as e-mental health, can benefit individuals in receipt of interventions and complement services across the stepped care approach, including for people living with a severe mental health disorder and those in receipt of psychosocial recovery and alcohol and other drug services. Types of e-mental health include information, self-directed support, therapeutic interventions and tele-psychiatry.

Places to access digital resources include but are not limited to:

- Head to health (the national digital mental health gateway): headtohealth.gov.au
- e-mental health in practice: eMHprac.com.au
- e-mental health for indigenous consumers: emhprac.org.au/directory
- Alcohol and other drug services specific digital resources include:
  - SMART Recovery smartrecoveryaustralia.com.au/online-smart recovery-meetings-2/
  - Turning Point turningpoint.org.au/

4.5 Crisis support

The service provider must ensure there is a well-articulated and communicated after-hours crisis support pathway and mechanism in place for individuals who are provided with treatment.

Appropriate after-hours crisis support contact numbers and details must be provided to consumers accessing services. In addition, *it is an expectation that all service providers have a role to play in supporting consumers referred and/or presenting with **suicide-risk**. This is irrespective of the program service scope providers are specifically funded to provide*.

5. Service provider obligations

5.1 Referral pathways and requirements

Service providers must have and promote local access arrangements that optimise ***referral pathways and access*** to their Mental Health, Psychosocial Recovery and Alcohol and Other Drug Services programs.

In addition, the service provider must have referral and intake tools, practice guidelines and protocols to ensure:

- Individuals seeking treatment are referred to appropriate services
- Referrals are screened for eligibility and appropriateness
- Resources are targeted within the local service area
- Duplication of processing of information is avoided
- Expected levels of demand are managed appropriately.

The GP/referrer should also be informed of the referral outcome, with one of the following options:

- Referral accepted and service available
- Referral accepted, service not available and individual placed on a waitlist (the GP/referrer must be informed of the expected wait time); or
- Referral not accepted and assistance provided for potential alternative interventions.

A Mental Health Treatment Plan (MHTP) is generally expected at the point of referral. Where there is no MHTP, the service provider can make a provisional referral and will also need to support the individual to access a GP or psychiatrist for assessment of appropriateness for a MHTP. This needs to occur within two weeks of treatment commencing (four weeks in rural areas).

For some PTS Specialist Programs where the individual is living in rural and remote communities; or at increased risk of suicide or self-harm; or experiencing, or at risk of homelessness, ***alternative and/or provisional referral pathways*** may be activated and a MHTP is not required for the referral to service. In such circumstances, intervention can commence with the expectation that the consumer is supported to link with a GP for completion of a MHTP.

Mental Health Hub Referrals

Referral to Murray PHN commissioned services may be made from Murray PHN's Mental Health Hubs. This may come from a hub service provider or hub intake provider. These referrals should be treated as a ***provisional referral*** and do not require a GP Mental Health Treatment Plan. Services should ensure a no-wrong-door approach to ensure a smooth consumer pathway to care, working collaboratively through issues that may occur.

A MHTP is required for children even if a diagnosis of a mental health disorder is not provided. The referring practitioner should document that the child is assessed as being at risk of developing a mental disorder in the MHTP. Referral for initial interventions (assessment process) for children still attending school, can be ***provisionally provided*** by the principal of the school a child is attending. A MHTP will still be required for continued interventions.

To support timely and appropriate referrals, Murray PHN has developed Murray HealthPathways; a free, web-based portal available for clinicians to plan, manage and coordinate clients care through primary, community and secondary health systems across the Murray PHN catchment area. Specific and localised mental health pathways are available via Murray HealthPathways, to support integrated and quality care for consumers. Service providers are encouraged to engage with Murray HealthPathways and provide feedback to ensure that the information provided there is up-to-date and accurate.

5.2 Demand and waitlist management

Service providers must have an appropriate demand management strategy and processes in place to manage service access and clinical risks of individuals referred to them.

A single consolidated and centralised system for recording and tracking all referrals, from the date of referral to the date of discharge, must be in place and service demand and waitlist strategies must include:

- Weekly review (at a minimum and/or more frequently where the clinical need is indicated) of all consumer referrals including screening for appropriateness and level of risk ***(note that the weekly review of referrals is not the same process as the three-monthly clinical case review)***
- Response to referrals in a timely manner to ensure consumers are seen within six weeks of referral to the service

- Active management of consumers on the waitlist. This means fortnightly monitoring is required for the period of time the consumer is on the waitlist, until they are seen for their assessment appointment and the planned intervention is commenced
- Service provider contact with and clinical monitoring of the consumer while on the waitlist must be recorded in the service provider client data system. All communication with the referrer must also be recorded in this system
- Advice to consumers regarding the anticipated wait time and that should their situation change while on the waitlist, they need to promptly contact the service provider and/or if required, emergency services
- A system of prioritisation which gives priority to clients who have serious or complex needs
- A process for allocation and confirmation of first appointment and removal of the consumer from the waitlist
- A process to ensure that consumers identified as being no longer suitable for a funded program while on the waitlist and/or requiring more intensive care, must be supported into an alternative program that more appropriately meets their needs
- A process for management and response to consumers who fail to attend the first and subsequent two initial appointments (this includes an assessment of consumer risk on the basis of referral information)
- Consumers are removed from the waitlist only on completion of the comprehensive mental health assessment and creation of a Consumer Recovery Care Plan
- **Reporting to Murray PHN about the number of consumers on the waitlist, when the waiting period exceeds six weeks.**

In addition, service providers need to also consider alternate support service options such as e-mental health (e.g. Mindspot) and telehealth psychiatry during wait periods and consumers should be given information regarding supplementary and low intensity services and supports.

Service providers are encouraged to provide extended operating hours to improve consumer access, and to work proactively with individuals referred to them, to identify the appropriate service delivery arrangements that support individual specific need/s.

The use of service reminders and recall systems for individuals accessing the service is required to maximise client engagement.

In some instances, local arrangements may require the GP to maintain the clinical oversight of a consumer until an appointment for an assessment is available. In these situations, these demand and waitlist management obligations would not apply and would only become applicable when the consumer is added to the waitlist.

Widening the safety net for consumers with suicide risk

It is an expectation that all service providers in Low Intensity, PTS General and Specialist programs and those providing services to **consumers with severe and complex needs** have a role to play in supporting consumers referred and/or presenting with suicide risk. This is irrespective of the program service-scope providers are funded to provide.

Consumers with suicidal ideation are in all service program target groups and Murray PHN expects all providers to have:

- Established protocols and procedures for screening and/or assessment of suicide risk;
- Staff who have training in evidence-based treatment for people experiencing suicidal risk;
- Screening and assessment protocols and procedures appropriate to the level and skill of the workforce; and are
- Appropriate to the consumer group for whom providers are funded to service, regardless of whether the program is a generalist, specialist or a suicide prevention program.

5.3 Intervention data capture and reporting

The Department of Health established the Primary Mental Health Care – Minimum Data Set (PMHC-MDS) which provides the basis for PHNs and the Department of Health to monitor and report on the quantity and quality of service delivery, and inform improvements in the planning and funding of primary mental health care services funded by the Australian Government. All mental health commissioned services must report service activity as defined by the PMHC-MDS. For more information, visit: pmhc-mds.com. **Specific details and further guidance on PMHC-MDS collection can be found in Part C Data Capture and Reporting Specifications**.

Murray PHN currently maintains a client management system (Fixus) to capture client reporting data for some primary mental health services. Commissioned services who currently use Fixus can continue to report PMHC-MDS activity through this system. Murray PHN user guides for Fixus are available online: murrayphn.org.au/primary-mental-health-services. Alternatively, commissioned services who currently use Fixus but who have the capability to deliver the PMHC-MDS from their own systems, can contact Murray PHN to discuss altering this arrangement.

The Alcohol and Other Drug Treatment Services (AODTS) National Minimum Data Set (NMDS) is an annual collection of information regarding the clients who use alcohol and other drug treatment services, the types of drug problems for which treatment is sought and the types of treatment they receive. AODTS service providers must comply with these reporting requirements.

5.4 Privacy and consent

Consent to treatment

The service provider must obtain informed consent from an individual and/or their legal guardian before any intervention is commenced and ensure that, when obtaining and documenting consent to services, it is done so in accordance with legislative requirements such as the Victorian Privacy and Data Protection Act 2014, the Victorian Public Records Act 1973 and the Victorian Health Records Act 2001.

Consent to share information

Service providers must also ensure that permission is obtained from individuals and/or their legal guardian in receipt of their services before sharing any information about them. This includes sharing of de-identified information with Murray PHN and the Department of Health for the purposes of service reporting, review and evaluation.

5.5 Service activity, monitoring, evaluation and continuous improvement

Funded services are required to collaborate with Murray PHN by contributing to information exchange and building knowledge about the characteristics of the health service system, community context and population health outcomes. Regular reporting requirements are outlined in specific service provider funding agreements and work plans. Collaboration with Murray PHN is supported through the commissioning principles that recognise the value of enduring partnerships with the health service system and our shared accountability for innovation, quality and system improvement.

By entering into an agreement with Murray PHN, funded services will:

- Share performance and effectiveness outcomes to inform the design and continuous improvement of services and address identified and current community needs and priorities; and
- Work collaboratively to measure service outcomes that are based on the Murray PHN Quadruple Aim model, which includes population health outcomes, client experience of service, workforce health and sustainability and cost per capita (value for money).

Service activity

Service providers are expected to demonstrate outcomes that are indicative of:

- Contract deliverables and service objectives being met;
- Improved outcomes for consumers;
- Expected service indicators being achieved; and that these demonstrate the provider is performing well and meeting the targeted needs of the consumers.

5.5.1 Measuring clinical outcomes

Consumer outcome measures must be used as clinical tools to establish a benchmark for tracking an individual consumer's progress. There are a number of tools such as the Kessler Psychological Distress Scale or K10 and, in the case of Aboriginal and Torres Strait Islander people, the K5, as well as the Strengths and Difficulties Questionnaires (SDQ) that service providers are required to use, at a minimum:

- At the beginning and end of service;
- At the clinical case review;
- When the consumer is being stepped up or down to another service; and/or
- More frequently, if there is a sudden or marked change in the consumer's clinical presentation and mental state.

These tools can be found at: www.amhocn.org/measures

5.5.2 Feedback and complaints

Mental health consumers' experiences of health care have long been identified by services, consumers, carers and families as being important in understanding how health services are performing and to drive service quality improvement[11]. As partners in service planning, design, measurement and evaluation consumer and carer feedback, complaints and compliments should be sought in all aspects of the service delivery.

Both the National Standards for Mental Health Services 2010, the Australian Commission on Safety and Quality in Healthcare Standards 2017, require all health care services to seek feedback from individuals in receipt of their care.

All health service providers in Victoria must meet the minimum standards for complaint handling as laid out in Schedule 1 of the Health Complaints Act, 2016.

Service providers must have:

- A mechanism in place for consumers to make a compliment or complaint about the service;
- Information available and assistance if required on how to complete a compliment or complaint; and
- All consumer information on making a compliment or complaints available in a plain English brochure and other languages.

Further information on complaints can be found at: hcc.vic.gov.au/healthcare-providers

Consumer feedback – YES Survey

The mechanism for measuring consumer feedback that service providers are required to use is the *(contained within the Survey Guidance document within the following link)* Your Experience of Service (YES) Survey. This survey was developed as a result of the Commonwealth Government Department of Health National Consumer Experiences of Care (2010) project for use in mental health services and has been specifically updated to include a version for use by Primary Health Networks' commissioned service providers. It can be located at the Australian Mental Health Outcomes Classification Network website.

Service providers must administer the YES Survey to the consumer ***at least at discharge/exit from service*** and are expected to use data/information collected to inform service planning, development, review, continuous quality improvement and service evaluation.

6. Clinical governance

As defined by the Australian Commission on Safety and Quality in Healthcare (ACSQHC) 2017,

"Clinical governance is an integrated component of health service organisations' corporate governance. It ensures that everyone, from frontline clinicians to managers and members of governing bodies, such as boards, is accountable to patients and the community for assuring safe, effective, integrated, high-quality and continuously improving health service delivery." [12]

Furthermore, Safer Care Victoria (2017) add that clinical governance is *"the integrated systems, processes, leadership and culture that are at the core of providing safe, effective, accountable and person-centred healthcare underpinned by continuous improvement"*.[13] The systems required to develop, guide and maintain good clinical governance are organised into five clinical governance domains, which are underpinned by continuous monitoring and quality improvement[14].

Murray PHN has adopted both the ACSQHC and Safer Care Victoria (SCV) definitions of clinical governance and the five domains to guide both its own and that of service providers clinical governance frameworks.

6.1 Clinical Governance Domains

Figure 1 Murray PHN Clinical Governance Framework Domains (adapted from SCV Domains, 2017)

The Clinical Governance Framework of Murray PHN is adapted from the Safe Care Victoria Clinical Governance Framework (2017).

Table 1 – Murray PHN Clinical Governance Domains

Domain	What this means to Murray PHN
Leadership and culture	Integrated corporate and clinical governance systems are established, and used to improve the safety and quality of health care for consumers
Partnering with consumers	Systems are designed and used to support patients, carers, families and consumers to be partners in health care planning, design, measurement and evaluation
Patient safety and quality improvement systems	Safety and quality systems are integrated with governance processes to actively manage and improve the safety and quality of health care for patients
Workforce/ clinical performance and effectiveness	The workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients
Safe environment for the delivery of care	The environment promotes safe and high-quality health care for patients

Murray PHN expects that all commissioned service providers have a clinical and governance framework in place, that incorporates the five domains/components of clinical governance described above in Figure 1 and Table 1

6.2 Responsibilities of Murray PHN

The Commonwealth Department of Health expects that PHNs will have clinical governance systems in place to guide the implementation of stepped care arrangements in each region, to ensure the service pathways established and services commissioned are clinically appropriate and effective. PHNs are expected to ensure a high-level of service quality for mental health, psychosocial recovery and alcohol and other drug services commissioned within a stepped care approach. Murray PHN will commission suitably qualified service providers to deliver services, through a transparent and robust commissioning process. Service providers may include:

- General practice
- Private psychiatry practices
- Private and non-government organisations (NGOs) mental health services
- Aboriginal and Torres Strait Islander primary health care services
- Community health services
- Public health services.

6.3 Responsibilities of commissioned service providers

Murray PHN expects that all commissioned service providers have a clinical governance framework (in keeping with the ACSQHC and Safer Care Victoria definitions and frameworks) in place that also incorporates the Murray PHN Clinical Governance Domains outlined on page 19 (Table 1).

Service providers are also required to uphold the ACSQHC Safety and Quality Goals for Health Care (2013)[15] and maintain up-to-date clinical and practice policies, aligned with the ACSQHC National Standards (2017).

6.3.1 Safety and quality

Safety and quality in health care are essential to the delivery of all commissioned services. Murray PHN undertakes a range of clinical governance activities to support the safety and quality assurance of programs across its catchment. As a component of these activities, Murray PHN has developed a Service Provider Program Guidelines Self-Assessment Tool to support service providers to assess and monitor their safety and quality processes in line with program guidelines, clinical governance frameworks and the national Safety and Quality in Health Care Service Standards.

Service providers are expected to use this self-assessment tool as an element of the service's auditing program to support safety and quality and continuous improvement of funded programs. This tool will be made available to service providers following the implementation of these guidelines.

In addition, as a component of its own quality assurance activities, Murray PHN will undertake clinical governance audits and reviews of service provider programs where this is indicated.

As an expectation of commissioned funding, service providers must have a commitment to ensuring the ASQHC Safety and Quality Goals for Healthcare are an integral part of their clinical governance and risk management frameworks. These safety and quality goals should also directly inform relevant elements of service delivery and clinical practice across all funded programs. The ASQHC Goals are:

Goal 1 - Safety of Care goal is that consumers will receive care without experiencing preventable harm.

Priority areas for service providers are:

- **Medication safety** – reducing harm to consumers from medications through safe and effective medication management
- **Health care associated infection** – reducing harm to consumers from health care associated infections through effective infection control and prevention and antimicrobial stewardship
- **Recognising and responding to clinical deterioration** – reducing harm to consumers from failures to recognise and respond to clinical deterioration through implementation of effective recognition and response systems.

Goal 2 - Appropriateness of care goal is that consumers receive appropriate evidence-based care.

Priority areas for service providers are:

- Providing and/or ensuring appropriate evidence-based care for all domains of need.

Goal 3 - Partnering with consumers goal is that there are effective partnerships between consumers and service providers and organisations at all levels of health care provision, planning and evaluation.

Priority areas for service providers are to ensure:

- Consumers are empowered to manage their own condition as clinically appropriate and desired;

- Consumers and service providers understand each other when communicating about care and treatment;
- Service providers are health care literate organisations; and
- Consumers are involved in a meaningful way in the governance of service provider organisations.

Policies and procedures

In addition to the provision of safe and quality care, service providers must maintain up-to-date safety and quality policies, procedures and protocols aligned with the ACSQHC and National Health Services Standards. These include:

- Quality improvement
- Risk identification and management
- Recognising and responding to clinical deterioration
- Clinical monitoring and auditing
- Medication safety
- Preventing and controlling health care-associated infections
- Incident management and open disclosure
- Communicating for safety
- Complaints management
- Consumer feedback
- Information management (including confidential management of consumer information)
- Staff recruitment, accreditation/credentialing, registration and continuing professional development (ensuring compliance with discipline-specific requirements)
- Staff management and clinical practice supervision (ensuring compliance with discipline-specific clinical supervision requirements)
- Staff performance development, management and scope of practice monitoring
- Organisational cultural safety and awareness
- Supporting consumer choice and shared decision-making
- Transfer of care.

Service providers must ensure that their workforce maintain practice consistent with:

- National Standards for Mental Health Services (NSMHS) 2010
- National Practice Standards for the Mental Health Workforce 2013
- Murray PHN Mental Health, Psychosocial Recovery and Alcohol and Other Drug Services Program Guidelines 2020
- Relevant discipline-specific registration and professional association Standards of Practice requirements, including:
  - Australian Association of Social Workers (AASW) Practice Standards 2013
  - Occupational Therapy Australia (OTA) Position Statements and Frameworks 2017
  - Australian College of Mental Health Nurses Standards of Practice in Mental Health Nursing 2010
  - Australian Health Practitioner Regulation Agency (AHPRA) National Registration Board.

6.4 Management and clinical supervision

Integral to commissioned service providers' clinical governance framework is the management and monitoring of staff performance and clinical practice. The supervision of service provider staff is central to the delivery of high-quality safe and effective services and positive outcomes for consumers.

Management and clinical supervision support the mental health of staff to maintain personal and professional resilience and wellbeing. It is an expectation that service providers ensure that clinical staff are in receipt of monthly management and clinical supervision arrangements.

Service providers are expected to have formalised and established ***management and clinical*** supervision mechanisms in place and these arrangements should be provided in keeping with the Victorian Clinical Governance Framework (2017) and the requirements of professional discipline-specific standards of practice and supervision frameworks.

For example, the Clinical Supervision Framework for Mental Health Nurses in Victoria: and the Australian Association of Social Workers supervision requirements contained with the Social Work Standards of Practice.

7. Workforce requirements

7.1 Recruitment, credentialing/ accreditation, registration and qualifications

To ensure a high-quality standard of service delivery, staff engaged to deliver services under funded programs, ***where appropriate and required***, must:

- Be qualified, trained and have relevant and appropriate level of experience according to the requirements of their role, position description and discipline specific scope of practice
- Have currency of registration with state or national practicing authorities and demonstrate evidence of the continuing professional development requirements for annual re-registration
- Have membership with their discipline-specific professional association
- Agree to abide by their discipline-specific professional code of ethics and code of conduct
- Have a working knowledge and be able to demonstrate compliance with relevant discipline-specific professional practice standards and competency standards requirements.

It is expected that service providers' recruitment and on-boarding processes will ensure that the appropriately qualified staff will be employed where discipline-specific qualification and training are a requirement of the funded program. In some rural and remote areas of the PHN catchment and **where service providers are not able to recruit program specified staff, they must be able to demonstrate unsuccessful recruitment attempts**.

Murray PHN will consider working with service providers to identify potential and flexible workforce models, where there is evidence that recruitment of specific workforce staff has been unsuccessful, to ensure the objectives and service functions of the program will meet the needs of the consumers the service is targeted to.

Service providers must also demonstrate procedures to **verify annual and other re-registration and qualification requirements of staff and provide evidence of this**. Recruitment and annual re-registration requirements must also ensure services comply with:

- Standard Terms for Murray PHN Funding Agreement
- Murray PHN Program Guidelines (Part A) and requirements for Program Specific Information (Part B) relevant to the program in which the staff is employed.

Note: where additional workforce qualifications, training and experience is required for delivery of service these are outlined in the relevant program stream Murray PHN Program Guidelines Part B, Program Specific Information document.

7.2 The peer workforce

The peer workforce refers to both consumer and carer peer workers. **Consumer peer support workers** apply their personal lived experience of mental illness and recovery in supporting consumers. **Carer peer support workers** apply their experience from caring and supporting family or friends with mental illness in supporting other carers and family members. Both consumer and carer peer support workers play a valuable role in supporting the primary health care team.

Peer work is a professional role that is distinguished from other forms of peer support by the intentionality, skills, knowledge and experience that peer workers bring to their role. Peer support workers are employed as professional subject matter experts and can be employed for the expertise developed from their personal lived experience of mental illness, alcohol and other drug disorders and recovery of their experience as a mental health consumer or carer, and can be a key conduit between a consumer, carers and services they use.

The inclusion of peer support workers in the primary mental health, psychosocial recovery and alcohol and other drug services care teams can help to improve the culture and recovery focus of services and help to reduce stigma within the workforce and wider service community. Appropriate supervision and mentoring should be provided, including support from other experienced peer support workers, and clinical support from other service provider team members.

Peer support workers can be especially helpful to vulnerable groups such as children and adolescents, older persons, and people from culturally and linguistic diverse (CALD) groups, Aboriginal and Torres Strait Islander people or LGBTQIA+ communities, particularly if they share a common culture. Peer support workers with this shared experience and expertise can help people to better communicate their needs, feel more comfortable,

and support their recovery efforts. They can work alongside liaison officers to advise on support or appropriate recovery approaches for people with mental health, psychosocial recovery and alcohol and other drug services needs in their community, as well as provide systemic advocacy in order to improve the ability of mental health services to meet diverse needs.

Suicide prevention

Peer support workers can provide a unique form of support in suicide prevention. Peer support programs and networks have long been important for suicide prevention across the lifespan.

As peer support workers work closely with consumers and carers in the dual roles of a professional and a peer, they provide important early intervention support for people contemplating suicide. They can be particularly valuable in supporting consumers and carers in the vital month following discharge from hospital or an emergency department after a suicide attempt when the risk of further suicide attempts is high.

7.3 Developmental workforce models

PHNs have flexibility to augment service provision in a way that best complements services available in a region[16]. Murray PHN is committed to the design of care models that are innovative, evidence-based, integrated within the local service system and meet the needs of targeted and priority consumers in a region.

In addition, Murray PHN is willing to support the development of a range of service provider flexible workforce models to ensure services are delivered, particularly where rural and remoteness of services and recruitment of program specified clinicians under these guidelines is a barrier to service delivery.

7.4 Continuing professional development

Service provider clinical staff who require annual re-registration with the Australian Health Practitioner Regulation Agency (AHPRA) must regularly participate in continuing professional development (CPD) that is relevant to their scope of practice in order to maintain, develop, update and enhance their knowledge, skills and performance to help them deliver appropriate and safe care[17].

AHPRA registered clinical staff must comply with registration and CPD standards and therefore, service providers must ensure that clinical staff undertake no less than the required number of hours annually of continuing professional education relevant to their profession and to the funded service in which they are working.

Information regarding AHPRA annual continuing professional development standards and requirements can be located at:

- ahpra.gov.au/Registration/Registration-Standards.aspx
- ahpra.gov.au/Registration/Registration-Standards/CPD.aspx

7.4.1 Workforce support resources

Resources currently available and relevant to supporting the mental health workforce include:

Murray PHN CPD presentations

Murray PHN has created a collection of presentations and information from CPD events. These can be located on the Murray PHN website.

Mental Health Professionals' Network (MHPN)

The Department of Health funds the MHPN to develop profession-specific material and activities including webinars to support the provision of quality mental health care. The MHPN also facilitates multidisciplinary, inter-professional networks to support the delivery of primary mental health care at the local level. The networking model assists clinicians to gain a better understanding of the service providers available in their region and enhances their professional development by sharing skills and expertise with other clinicians.

Information and resources can be located at the MHPN website.

General Practice Mental Health Standards Collaboration (GPMHSC)

The GPMHSC is responsible for establishing standards of education and training for the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative. The collaboration promotes development and uptake of quality professional development in mental health for GPs to effectively manage the clinical care of consumers with mental health issues/ illness in a primary care setting and

prevent escalation of a patient's condition, or future high cost interventions such as hospitalisation. Completion of GPMHSC accredited focused psychological skills training allows GPs to access specific mental health items under the Medicare Benefits Schedule in relation to the Better Access initiative. The GPMHSC maintains a register of GPs who complete mental health training and notifies Medicare Australia of those GPs who complete the training in order to claim relevant Medicare items. Information and resources can be located at gpmhsc.org.au

Social Workers Online Training (SWOT)

SWOT is the Australian Association of Social Workers' (AASW) online professional development platform. It provides access to a range of online content for social workers and other allied health professionals, on a diverse scope of practice and theoretical topics and including dedicated courses, together with recordings from symposiums, conferences and workshops.

The AASW also has an Empowering Excellence professional development program for accredited Mental Health Social Workers and those looking to apply, with a specific mental health focus. Training topics are aligned with Focused Psychological Strategies, a CPD requirement under Medicare. See the AASW SWOT website for other professional development information.

Australian Psychological Society

The Australian Psychological Society (APS) has a number of training opportunities and events, including conferences, online courses, national workshops and webinars to assist with annual CPD requirements.

Online training is extensive with a strong focus on current and relevant mental health topics. See the APS website for further information.

The Australian College of Mental Health Nurses

The Australian College of Mental Health Nurses (ACMHN) aims to provide members and the broader nursing community with high quality CPD that is focused on the mental health needs of service users, their families and communities. There are a number of eLearning activities and webinars available to members, as well as a list of endorsed professional development events available on the ACMHN website.

See the ACMHN website for further CPD information.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP)

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has a comprehensive range of resources, professional development, conferences/events available for members. In addition, there are clinical practice guidelines and endorsed guidance information on a range of relevant mental health topics. Some of the RANZCP clinical practice guidelines have been included in section 7.6 Clinical and Scope of Practice, below. Information on professional development and resources can be located at the RANZCP website.

The Victorian Youth Sector Code of Ethical Practice

The Code of Ethical Practice for the Victorian Youth Sector (2008) is a document developed by a body of practitioners to provide an agreed framework and set of values for professional youth work practice. It provides a frame of reference in which to develop ethical and safe practice.

This document was developed through a consultative process in which members of the Victorian youth sector provided advice on the principles and practice responsibilities inherent in the code.

Occupational Therapy Australia

Occupational Therapy Australia (OTA) has a range of mental health specific CPD activities, resources library, training programs and mental health interest groups in a number of states. Information on professional development can be located at the OTA website.

Australian College of Nurse Practitioners

The Australian College of Nurse Practitioners (ACNP) is the national peak body for Nurse Practitioners and Advanced Practice Nurses in Australia and is active in advancing nursing practice and improving access to health care. Information on a range of professional resources can be located at the ACNP website.

Cultural competence training

- Centre for Cultural Competence Australia
- Cultural Competence Program
- Centre for Ethnicity & Health

Suicide prevention training

- Applied Suicide Intervention Skills Training (ASIST)
- Advanced Training in Suicide Prevention
- Collaborative Assessment and Management of Suicide (CAMS)
- Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention

7.5 Staff remuneration

Service providers are expected to remunerate staff providing funded programs at pay rates that are at or comparable to discipline, profession and/or program-specific state or national Enterprise Agreements or Awards, such as:

- Nurses and Midwives Award (Victoria) 2015
- Victorian Public Mental Health Services Enterprise Agreement 2016 – 2020
- Victorian Allied Health Award 2016 – 2020.

7.6 Clinical and scope of practice

Service providers must ensure that staff are practising within their area of qualification and competence and scope of practice as defined by each discipline-specific professional association. In addition, there are several clinical practice guidelines for specific therapeutic approaches to working with consumers:

- Australian College of Mental Health Nurses Standards of Practice in Mental Health Nursing 2010
- The Australian Association of Social Workers Practice Standards 2013
- National Practice Standards for the Mental Health Workforce (2013)
- The Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines
- National Health and Medical Research Council (NHMRC)
- Code of Ethical Practice for the Victorian Youth Sector (2008).

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