phn MURRAY

An Australian Government Initiative

PART B
PROGRAM SPECIFIC INFORMATION

PRIMARY MENTAL HEALTH SERVICES

(REVISED JANUARY 2022)

Leadership | Collaboration | Knowledge | Innovation | Accountability

About these guidelines

This document provides guidance for health services commissioned by Murray PHN to deliver primary mental health services for people in the Murray PHN catchment. It outlines the aims, service functions, scope, eligibility and referral requirements, interventions and specific workforce requirements for the following primary mental health programs:

- Psychological Therapy Services (PTS), both generalist and specialist services for specific population groups
- Clinical Care Coordination (CCC)
- Youth Enhanced Services (Youth Severe)
- Services for Older People Socially Isolated by the Impact of COVID-19.

This document must be read in conjunction with Part A – Program Guidelines and Part C - Data Capture and Reporting Specifications.

Primary mental health services commissioned by Murray PHN represent 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 revised, newly structured version of the Murray PHN Primary Mental Health Guidelines. This document has been informed by feedback and ongoing collaboration with commissioned health services, consumers and other partners of Murray PHN, and by priority areas and PHN funding guidance from the Australian Government.

In addition, relevant state and national practice and accreditation standards, clinical governance and service frameworks and legislative requirements have been used to guide and inform these program requirements.

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

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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.

Part B: Primary Mental Health Services contents

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 2019	S McConnachie	P Wilkinson
3	Murray PHN Primary Mental Health Program Guidelines	June 2019	S McConnachie	P Wilkinson
1	Murray PHN Primary Mental Health, Psychosocial Recovery and Alcohol & Other Drug Services Guidelines	September 2020	T Moriarty	E Reid
2	Murray PHN Primary Mental Health Services Guidelines	January 2022	M Harding	I Johansen

1 Low intensity mental health services

Service aims

Low intensity mental health services aim to increase overall community access to evidence-based psychological intervention for people with, or at-risk of, mild mental illness who do not require traditional services provided through existing primary mental health stepped care intervention pathways. Providing a low intensity service option as part of stepped care should also:

- Increase ease of access to services early in the trajectory of mental illness in order to improve the chances of recovery and longer-term health, wellbeing, participation and productivity
- Enable more efficient use of finite resources and a broader workforce to ensure the resources directed to higher cost, higher intensity services are targeted to those with the greatest clinical need.

Low intensity services must deliver time-limited, structured interventions aimed at providing a less costly approach than standard psychological therapy.[1]

Service scope

Services that are in scope for Murray PHN commissioned activities must be evidence-based and can include:

- **Face-to-face** low intensity psychological services, delivered 1:1 or group basis
- **Telephone or online** low intensity psychological services
- **Psychological services or coaching** provided to support and/or supplement services provided online through Head to Health or other evidence-based digital services *(digital mental health services may also be used for high intensity needs)*.

Digital mental health services such as to Head to Health may be used for consumers and health professionals as a resource that complements low intensity services.

Low intensity services in a stepped care approach

Low intensity services must be provided in the broader stepped care framework. Figure 1 depicts low intensity services in this framework as providing Level 2 intensity of care to consumers. This diagram also demonstrates that consumers must be supported through appropriate step up mechanisms, should a consumer's care needs increase.

Figure 1 – Levels of Stepped Care

Access and referral

Murray PHN expects that service providers have established service access pathways that enable the consumer to easily self-refer. Low intensity services are designed and expected to be accessed:

- **Quickly**, without the need for a formal referral
- **Easily**, through a range of modalities available to consumers including face-to-face, group work, telephone and digital interventions
- **Efficiently**, typically involving a small number of services, short sessions and providing a less costly alternative to traditional psychological services, such as those available through the Medicare-based Better Access initiative and other PHN primary health care funded programs.

Intake and risk screening

Low intensity service providers must ensure they have appropriate intake and assessment arrangements to ensure services are available to those with low intensity care needs.

Low intensity service providers must draw on the Commonwealth Department of Health initial assessment and referral guidance when referring consumers to an increased (and appropriate) level of care.

Procedures must be in place for identification of individuals for whom escalation to higher intensity services is important, or who may need urgent services.

Murray PHN expects that service provider staff have the ***knowledge and ability to screen for mental health risk*** and monitor a consumer's progress and support them to move to more appropriate services when required.

Workforce

The essence of low intensity interventions for service providers is that they may use a broader workforce to deliver services. This includes use of individuals with appropriate competencies but who do not meet the requirements for registration, credentialing or recognition as a mental health professional. Services, however, should not be defined simply by the workforce delivering services, or by the mode of delivery (such as digital service provision). In employing a broader workforce, service providers must ensure:

- Workforce skills, training, qualifications and supervision arrangements are appropriate to the level of service provided
- The workforce is supported by an established clinical governance framework that includes formalised performance management and clinical supervision.

Peer support worker models can offer opportunity for people with a lived experience to participate in the delivery of services. There is a significant evidence base to indicate that appropriately trained peers, with the support of management and clinical supervision, can provide effective low intensity services, particularly if they have experienced mild forms of mental illness or have been at-risk of mental illness and are from the same cohort in terms of age or special needs groups.

Consumer and carer participation and feedback

The participation of consumers with or at-risk of mild to moderate illness is vital to the design, delivery and review of low intensity services. Where particular groups are targeted, such as young people or people with an intellectual disability, it is important to also target their views in service design and ensure information about services includes consultation with them and/or their carers.

2 Psychological Therapy Services: Generalist and Specialist

Functions of the service

Psychological Therapy Services (PTS) is a primary mental health service funded by the Australian Government Department of Health, to enable access to effective primary health-initiated evidence-based psychological interventions.

Service aims

PTS services provide support for consumers experiencing diagnosable mild, moderate and in some cases, severe mental illness who would benefit from access to evidence-based psychological interventions. PTS has the following aims:

- To produce better outcomes for individuals with diagnosable mild, moderate and in some cases severe mental illness, by providing short-term psychological interventions in a primary care setting
- Targeted services for those individuals who are not likely to be able to have their needs met through Medicare-subsidised or other mental health services
- Complement other fee-for-service programs and address service gaps involving rural, remote and other underserviced geographical areas and populations, offering referral pathway options for GPs to support them in accessing primary mental health care options
- Offer non-pharmacological approaches for individuals with mild to moderate and sometimes severe level mental health disorders
- Promote an integrated, multi-discipline intervention approach based on the stepped care approach.

Consumer priority groups

A key focus of PTS is individuals living in rural and remote areas and/or those experiencing locational disadvantage to accessing services because of a short supply of private providers to deliver Medicare Benefit Scheme services.

Other groups who may be also be underserviced through existing psychological therapy arrangements due to workforce limitations or the unsuitability of available services include (but are not limited to):

- Children up to and at 13 years of age
- People experiencing, or at-risk of, homelessness
- Individuals experiencing perinatal depression and anxiety
- People from culturally and linguistically diverse (CALD) backgrounds
- People who identify as lesbian, gay, bisexual, transgender, queer, intersex or asexual (LGBTQIA+[2]) for whom stigma and lack of appropriate services may provide barriers to care
- People with intellectual disability and co-occurring mental illness, for whom there are barriers to receiving appropriate mental health treatment
- Population groups that are the focus of separate guidance material:
  - Aboriginal and Torres Strait Islander people
  - People at-risk of suicide
  - People with mental illness in residential aged care facilities
  - People in drought impacted communities
  - Young people.

In addition to the key priority groups listed above, Murray PHN may identify particular priority groups in the region who require targeting. Such groups will be identified:

- Based on outcomes from the regional needs assessment and joint regional planning process
- Based on response to a newly emerging need for psychological services for a particular group
- Following natural disasters when a sudden need for psychological services emerge e.g. bushfire.

Murray PHN may also adapt the type and level of services that are commissioned, the service modalities and the service delivery formats. For example, PHNs may:

- Commission psychological services that are to be delivered by digital means to individuals deemed eligible
- Engage with the individual's family or carers in the provision of services
- Adapt services to the needs of particular groups. For example, this might include varying the ***workforce or service model*** to facilitate culturally competent approaches to service delivery.

Widening the safety net for consumers with suicide risk

It is an expectation that all service providers in **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 deliver.

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.

Eligibility

To be eligible for PTS, individuals need to have a diagnosable mental health disorder. The definition of a mental health disorder is based on the definition used by the Commonwealth Department of Health:

A mental disorder may be defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder – this definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD - 10 Chapter V Primary Health Care Version.

The short term, goal-oriented, psychological services that PTS General and Specialist programs provide are designed for individuals with mental health disorders with a mild to moderate level of severity. However, individuals with more severe mental ill-health and who are assessed as having potential to benefit from focused psychological strategies can also be provided with PTS.

It is the role of GPs to diagnose individuals, assess whether they would benefit from a short-term psychological intervention and if so, when referring to PTS, document that diagnosis in the Mental Health Treatment Plan (MHTP) and referral documentation. Additional specific eligibility criteria for PTS Specialist relates to the need for the individual being referred into a specialist stream and is contained in the specialist program sections below.

Referral pathways

Service providers are required to develop and promote local service access arrangements to optimise referral pathways and better support service access for vulnerable populations. Ongoing collaboration with GPs and local services who support vulnerable populations is expected. Individual consumer needs must be considered in a stepped care approach and based on the individual's level of need.

Needs are assessed as an integral component of the referral process and are based on Initial Assessment Domains of Care[2]. Assessment of need ensures that:

- Individuals are referred to appropriate services based on level of need
- Resources are effectively targeted in the service area
- Duplication is avoided
- Expected levels of demand are effectively and actively managed.

A set of Assessment Domains has been developed through the Commonwealth Department of Health as part of a national project for primary mental health care. These domains support the decision-making and level of care for consumers that occurs as part of the referral and initial assessment processes to primary mental health services. There is a total of eight domains - four primary and four contextual, presented in Table 1 on the following page.

Table 1 – Initial assessment and referral domains

Primary domains		Contextual domains	
1	Symptom severity and distress	5	Treatment and recovery history
2	Risk of harm	6	Social and environmental stressors
3	Functioning	7	Family and other supports
4	Impact of co-existing conditions	8	Engagement and motivation

It is expected that service providers will work with the GP/psychiatrist and other referrers to implement the assessment domains and related resources into their initial referral and assessment processes as outlined in detail in the Department of Health Guidance for Initial Assessment and Referral Guidance document.

Murray HealthPathways

To support a timely, appropriate referral, Murray PHN has developed Murray HealthPathways; a free, web-based portal available for clinicians to plan, manage and coordinate consumer care through primary, community and secondary health systems and localised pathways across the Murray PHN region.

Referral requirements

Generally, referrals should be provided by an individual's GP or psychiatrist. A Mental Health Treatment Plan (MHTP) is expected at the point of referral, ***however no individual should be restricted from the program due to the absence of a MHTP***.

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/psychiatrist for assessment of appropriateness for a MHTP. This must 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, is at increased risk of suicide or self-harm, or is experiencing, or at-risk of homelessness, alternative referral pathways may be activated and a MHTP is not required for referral to the service.

The MHTP may also be waived for referrals in response to natural disasters to expedite the referral process. In addition, in recognition of the difficulties in accessing GP/psychiatrists or other referring health professionals to obtain a referral, a ***provisional referral*** for Aboriginal and Torres Strait Islander people from Aboriginal Community Controlled Health Organisations (ACCHOs) could enable service provision to commence while arrangements are made to see a GP or a psychiatrist.

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.

HEAD TO HEALTH

Table 2, on the following page, lists non-medical practitioners who may make a referral to PTS programs. Service providers must also read the specific PTS Program for further details of the referral requirements.

Table 2 – Non-Medical Practitioner Referral Pathways

PTS program type	Non-medical practitioner referral
Perinatal	• Maternal and Child Health Nurse • Midwives and Neo-Natal Nurse • Lactation Consultant
Child Mental Health	• Appropriately trained allied health professional who is eligible to provide services under PTS (including Aboriginal Health Workers) • School Psychologist, Counsellor, Principal/Deputy Principal • Director of Early Childhood Service • Medical Officer in non-government organisation
Suicide Prevention	• Public sector (Area Mental Health Service) Mental Health Clinician • headspace Clinician
Aboriginal and Torres Strait Islander	• Aboriginal Health Workers • Managers of ACCHOs
Homeless	• Self-referral • Mental Health Clinician • Community Outreach Worker
Natural Disaster Response	• Other Health Care Provider • Disaster Recovery Agency Worker
Residential Aged Care Facility	• Registered Nurse • Psychologist
Youth Enhanced Services	• Self-referral • A young person's family/carers • Another service provider

Referral outcomes

Referrals must be screened for eligibility and appropriateness. The GP/psychiatrist (or referrer) should be informed/communicated with regarding the referral outcome, with one of following options:

- Referral accepted and service available
- Referral accepted, service not available and individual placed on a waitlist
- Referral not accepted, and assistance provided for potential alternative interventions.

Workforce scope

All clinicians providing PTS services must have currency of professional registration, a minimum of two years' experience in mental health and the required qualifications and training for the relevant specialist program in which they are providing services.

Clinicians providing PTS can include the following disciplines:

- Mental health social worker
- Mental health occupational therapist
- Aboriginal and Torres Strait Islander health workers
- Psychologist
- Mental health nurse.

Workforce qualifications and skills

To competently provide PTS interventions, clinicians must also have appropriate:

- Competency-level clinical and biopsychosocial knowledge, including the theory underpinning evidence-based interventions, and research into their effectiveness;
- Competency level skills, in delivering best mental health practice and evidence-based mental health psychological interventions;
- Competency in delivering suicide prevention interventions
- Post graduate and practice level experience in assessing and treating individuals with the range of mental health problems
- Relevant and discipline-specific and/or nationally endorsed specialist qualifications and training to provide PTS Specialist services including (but not limited to) the following:
  - trauma informed care
  - recovery focused care
  - cultural competence
  - suicide prevention
  - child mental health.

Service providers must ensure clinicians also have ongoing professional development and maintain currency of practice in line with:

- Evidence-based best practice treatment modalities
- Professional discipline practice standards requirements
- Professional discipline national registration continuing professional development standard requirements.

Further information on these requirements is outlined in the Murray PHN Part A Program Guidelines, 2020 (section 8.2 Continuing Professional Development, p 20).

Provisional/intern psychologists

Murray PHN supports the use of provisional/intern psychologists in the delivery of PTS programs. However, supervision arrangements for provisional/intern psychologists must meet the Psychology Board of Australia Guidelines for Provisional Psychologists[4].

Service providers must ensure that supervision arrangements for provisional/intern psychologists are in place and appropriate levels of professional indemnity insurance are also held and maintained.

Standards of practice

In providing the PTS service, service providers must ensure clinicians maintain practice consistent with discipline-specific clinical and national standards relevant to scope of practice and the specialist program in which the clinician is providing PTS services.

Further information on discipline-specific clinical practice standards is contained in the Murray PHN Part A Program Guidelines, 2020 (section 8.4 Clinical and Scope of Practice Standards, p 23).

Mental health evidence-based psychological interventions for PTS General and Specialist programs provided by clinicians can be provided in individual and/or group mode.

Number of service contacts

The Primary Mental Health Care Minimum Data Set (PMHC MDS) defines a service contact as the provision of a service by a PHN commissioned mental health service provider for a client where the nature of the service would normally warrant a dated entry in the clinical record of the client. A service contact must involve at least two persons, one of whom must be a mental health service provider. Service contacts can be either with the client or a third party, such as a carer or family member, and/or other professional or mental health worker, or other service provider.

Service contacts are not restricted to face-to-face communication and can include telephone, internet, video link or other forms of direct communication.

Service provision is only regarded as a service contact if it is relevant to the clinical condition of the client (this means that it does not include services of an administrative nature e.g. telephone contact to schedule an appointment).

Most clients of PTS General and Specialist services will require six or fewer service contacts. Service providers must ensure that the average number of service contacts provided for all consumers over a quarterly period does not exceed six contacts. By exception, additional service contacts to meet individual consumer need is allowable and must be assessed and delivered in accordance with the relevant program guidelines.

There is no limit to session numbers for PTS Specialist Suicide Prevention Services. It is anticipated that these service contacts would be conducted in a condensed timeframe (one – two months) and must be based on individual consumer need.

However, for all PTS services, a clinical case review (see section below) is required evidencing the need for continuation of services after the first six service contacts are completed.

Note: the extended sessions are a continuation of the original episode of care and are not to be recorded as a new episode of care. The consumer MHTP and Recovery Care Plan will also need to include planning for a 'step-up/step down' option as per the stepped care approach.

Clinical case review

The clinical case review is a requirement of both the National Safety and Quality for Healthcare Services (NSQHS) Standards 2017 (*Standard 6, Communicating for Safety, 6.11 Changes to Care Plans*)[5], and the National Standards for Mental Health Services 2010 (*Standard 10, Delivery of Care 10.4 Assessment and Review*)[5].

Service providers are expected to undertake regular review of the consumer's care, in keeping the required standards outlined above and for PTS this must occur at the completion of the sixth service contact session. In addition, for all PTS services a **clinical case review** is required, evidencing the need for continuation of services after each set of six service contacts is completed.

A clinical case review must include communication with and input from the GP/psychiatrist (particularly where there is case complexity) and other significant team members (with consumer consent) providing service to the consumer.

The clinical case review is an opportunity for the clinician and consumer to review the consumer's progress against the assessment of needs (as Assessment Domains[7]), made within the ***Initial Assessment and Referral*** (IAR) process, but must also include a brief assessment of the consumer's:

- MHTP and the consumer's Recovery Care Plan (particularly goals and strategies)
- Prescribed medication
- Focused psychological intervention
- Treatment progress
- Mental state and risk level
- Ongoing treatment needs/treatment plan
- Planning for step up/step down or discharge/exit from the PTS service
- Readministering of the K10 outcome measure.

As part of the clinical case review, the MHTP and Recovery Care Plan must be updated to reflect any changes made to the consumer's recovery goals, strategies and treatment and care. The PTS clinician must also provide written communication to the consumer's GP/psychiatrist and the outcome/s of the clinical review meeting.

Consumer step up/step down

Central to stepped care is an integrated service system approach that allows the consumer to 'step up' to more intensive health care when there is a need, or 'step down' to more low intensity support services as their mental health and wellbeing improves.

In accordance with Commonwealth Department of Health guidance, generally, indications for a **step up** from the PTS program will be when:

- The consumer has not experienced reduced symptoms within a reasonable timeframe
- The consumer has not experienced recovered functioning within a reasonable timeframe
- There is evidence of deterioration or a changing risk of suicide or harm to self, to others, or from others
- The consumer's identified recovery goals are not being or are unlikely to be met
- The consumer is experiencing new psychosocial stressors.

'Step down' refers to a decrease in service intensity and does not necessarily mean a transfer of care to a new provider. A step down also includes where an intervention is ceasing.

Generally, indicators for a **step down** from the PTS program will be when:

- The consumer has completed the recommended intervention in accordance with their care plan and now fits the description of a lower level of care
- There are reduced symptoms, over a consistent period
- There is improved or recovered functioning through improved productivity, performance and/or reduced days out of the consumer's normal role
- There is not a risk of deterioration; the consumer is able to independently identify signs of deterioration and take appropriate action e.g. initiate re-engagement with the GP or mental health service
- The consumer indicates they are ready to step down or exit.

When a consumer is being stepped up or down to another service, the current service provider/ clinician must refer the consumer to the new service and ensure they are supported to proceed to their next step of care. Communication and relevant information sharing (with consumer consent), must occur and in addition, the clinician must undertake the following:

- Complete a referral to the relevant service provider
- Administer the relevant outcome measure specific to the PTS program
- Provide written communication to the GP/ psychiatrist regarding the consumer's step up or step down
- Administer the Your Experience of Service (YES) Consumer Survey.

Changes to the intervention arising from a step up or step down decision should be **fast-tracked** and wherever possible:

- Waiting periods avoided or eliminated
- Involve a facilitated and "warm" referral to the new service. *A warm referral should involve a supported introduction to the new service (e.g. supporting the individual to make the initial contact with the new service or provider) and (with consumer consent) providing relevant written reports.*
- Include a clear and documented handover of service provider duty of care.

Closing an episode of care

Once the consumer has been stepped up or down to a new service provider and/or discharged back to the referring GP/psychiatrist, the service provider must close the consumer episode of care.

This includes closing the consumer's case on the PHN consumer database Fixus. ***Note that closing the episode of care does not prevent the consumer from being referred to PTS any time in the future if/ when their needs change.***

Consumers that have not been seen for 12 months (but have an active status on the Murray PHN Fixus database), must have a clinical review of their case immediately for forward planning and potential discharge/exit from PTS and their case must be closed on the Fixus database.

National Disability Insurance Scheme (NDIS)

The NDIS provides psychosocial support for people living with disability. People in receipt of the NDIS are not precluded from receiving PTS. However, if an individual's NDIS package includes psychological counselling, they may not be eligible for PTS as they may no longer meet the PTS criteria of being in an "underserviced group."

Cancellation and Did Not Attend

If a consumer cancels within 24 hours of an appointment or fails to attend a scheduled appointment, the appointment may be categorised as a session for funding purposes, providing all efforts have been made by the clinician to identify and remove any access barriers contributing to the non-attendance.

3 PTS Specialist

PTS Specialist is provided for population groups that have been identified as being of significant need and currently include:

- Child mental health - for children up to and at 13 years with, or at-risk of developing, a mental illness
- Aboriginal and Torres Strait Islander - for Aboriginal and Torres Strait Islander people with, or at-risk of, a mental health disorder
- Suicide prevention - for individuals who have attempted suicide, or are at-risk of suicide
- Perinatal depression – for women/expecting or new parents with perinatal depression and anxiety
- Residential aged care facilities (RACF) - for residents of aged care facilities with presentations of mental illness
- Homeless - for individuals experiencing or at-risk of homelessness
- Natural disaster response – for people who have been affected by natural disaster events e.g. bushfire or flood.

Note: PTS General and Specialist programs are not designed for individuals who are actively being managed by state/territory government mental health services and are not intended to divert people from the care of state public mental health services. PTS Specialist aims to provide referral pathways for the GP/psychiatrist or other service providers to better support consumers in the primary care setting

3.1 PTS Aboriginal and Torres Strait Islander People

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing (2017-2023)[8], provides key strategies and action outcomes to guide and support PHNs and other relevant providers in collaboratively planning and commissioning culturally and clinically appropriate mental health services for Aboriginal and Torres Strait Islander people.

PTS Specialist Aboriginal and Torres Strait Islander is for Aboriginal and Torres Strait Islander people who have, or are at-risk of developing, a mild to moderate mental health disorder, and who could benefit from short-term focused evidence-based psychological strategies of up to 12 service contacts annually.

In determining whether this program meets the needs of the consumer, consideration must also be given to whether the individual is more appropriately supported by the state or territory acute mental health service or alternate service provider.

Aboriginal and Torres Strait Islander people who are at-risk of suicide or self-harm should also be considered for mainstream PTS Suicide Prevention or the state mental health service.

Interventions

The design, establishment and delivery of PTS Aboriginal and Torres Strait Islander People services must include:

- High quality services delivered in a culturally appropriate manner, equitable to those received by all Australians
- Services based on Aboriginal and Torres Strait Islander definitions of health incorporating spirituality, culture, family, connection to the land and wellbeing and grounded in community engagement
- Funded organisations to form practical partnerships with Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs), documented in funding applications, annual plans and budgets
- Two-way support mechanisms put in place to allow both non-Aboriginal and Torres Strait Islander funded organisations and ACCHOs to assist each other in service delivery
- Aboriginal and Torres Strait Islander people that are providing services should have the appropriate level of skills and qualifications to deliver services
- Aboriginal and Torres Strait Islander people provided with opportunities to develop the appropriate level of skills and qualifications to deliver services
- Non-Aboriginal and Torres Strait Islander clinicians have undertaken recognised cultural competency training such as the Aboriginal and Torres Strait Islander Cultural Competency Course provided by the Centre of Cultural Competency Australia.

Service providers must also have service mechanisms to ensure that:

- Appropriate referral pathways and linkages with government and non-government stakeholders (including those associated with the clinical mental health system such as ACCHOs) are established and maintained
- Efficient and effective services are provided and managed in the overall capacity of the organisation to meet demand for services
- A high-quality service is provided that is clinically appropriate for Aboriginal and Torres Strait Islander people, delivered by qualified and appropriately trained and skilled allied health professionals.

3.2 PTS Suicide Prevention

Suicidal behaviour is complex and may exhibit different forms and levels of severity ranging from suicidal ideation, suicide behaviours, suicide threats, suicide plans, suicide attempts, to completed suicide[9]. Murray PHN commissions specialist services to address and support the needs of people at-risk of suicide (including Aboriginal and Torres Strait Islander people) and gives priority to ensuring follow-up care and support is available in the period following a suicide attempt.

Murray PHN expects all primary mental health service providers to have established procedures to appropriately assess and manage suicide risk of their consumers.

Note – the PTS Suicide Prevention service is not designed to support people who are at ***very high or immediate risk*** *of suicide. These individuals should be immediately referred to the relevant state or territory government acute mental health team or emergency services*. Very high and immediate risk of suicide includes:

- Where a clinician has assessed the individual as being at very high or immediate risk of suicide through assessment
- The person is experiencing current suicidal intention with a plan, intent and the means to carry it out (with few or no protective factors)
- The person has a long-term history of repeated and life-threatening suicidal behaviour or dangerous behaviour to self or others that is prominent in their current presentation
- There is evidence of current severe symptoms e.g. hallucinations, avoidant behaviour, paranoia, disordered thinking, delusions, with behaviour that poses an imminent danger to self or others
- Extremely compromised self-care ability to the extent that the person is in real and present danger and experiencing harm related to these deficits.

Target group and eligibility

PTS Suicide Prevention is primarily designed for:

- People who, after a suicide attempt, have been discharged into the care of a GP from hospital, or discharged into the care of a GP from an emergency department
- People who have presented to GP after a suicide attempt
- People who have expressed suicidal ideation to their GP.

An individual does not require a diagnosis of a mental health disorder to be eligible for this program. In addition, alternative referral pathways and provisional referrals (other than a GP MHTP) may be made for those requiring access to this service. In assessing an individual's eligibility for this service, consideration must be given to whether the consumer can be safely managed in the primary care setting or would be more appropriately stepped up to and supported by the state or territory acute mental health service.

Initial contact

Individuals referred to PTS Suicide will have priority access to the service provider who is to make initial contact with the consumer within 24 hours of the referral. The initial contact must include an assessment of the consumer's suicide risk. The clinician undertaking the initial contact must be competent to assess and oversee any clinical decisions arising as a result of the suicide risk assessment.

At the point of initial contact, an appointment must be offered to the consumer within seven days and earlier if this is indicated. As with all referrals, should the consumer's mental state deteriorate and they become concerned about their own safety, they must be directed to re-contact the service provider and be provided contact details for the appropriate mental health and emergency services.

Waitlist management and risk assessment

Service providers must have the capability and knowledge to screen for suicide risk and undertake active waitlist management of the consumer until they are seen for their first appointment (see Part A Program Guidelines Section 6.2 Waitlist Management). For the consumer referred to this program, a mental health risk assessment must be included in the service provider's waitlist management protocols and procedures. The service provider is however, not expected to take on a crisis intervention role, but is expected to have well-developed communication links and referral pathways with the local acute mental health team/service in the event of an emergency. If unsure of the immediacy of risk of the consumer, the service provider clinician is to contact the acute mental health service. Where the service provider makes a clinical judgement that the consumer is at imminent risk of suicide and requires immediate/urgent assistance, Emergency Services – 000 must be contacted.

Service contacts

Unlike standard PTS arrangements, there is no limit on the number of service contacts a consumer can access under this program. However, it is anticipated that these service contacts would be conducted in a condensed timeframe (one – two months) and must be based on individual consumer need.

It should be noted that services provided under PTS Suicide Prevention have no impact on a consumer's entitlement to other PTS programs.

The service provider clinician will decide, in consultation with the consumer and their GP, when it is appropriate for the intensive suicide prevention treatment service to cease and assist in facilitating access to any further required services. This may include transition to PTS General or to other lower intensity models of care within a stepped care approach.

Engaging people with lived experience of suicide

People with lived experience of suicide are defined as those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone who has attempted suicide, or been bereaved by suicide[10]. People with lived experience can provide valuable insight into suicide prevention initiatives and can help guide suicide prevention planning, treatment, and education. Appropriately trained lived experience speakers and peer support workers can enhance community understanding of suicide, its impacts and help to reduce stigma. To ensure that the delivery of information is safe and appropriate, and to promote duty of care, service providers should ensure lived experience speakers are accessed and engaged through agencies and programs with clear structures for training and support of those who have lived experience.

Murray PHN is committed to collaborating with service providers to:

- Plan and develop peer support workforce models and the equitable employment of peer support workers in local communities and regions
- Support models of practice that incorporate peer support workers as specialised members of multi-disciplinary teams providing person-centred, recovery-oriented and trauma-informed stepped care in suicide prevention services
- Promote training, peer supervision and career development for peer support workers in partnership with relevant community mental health organisations, state/territory government agencies, and local consumer and carer networks.

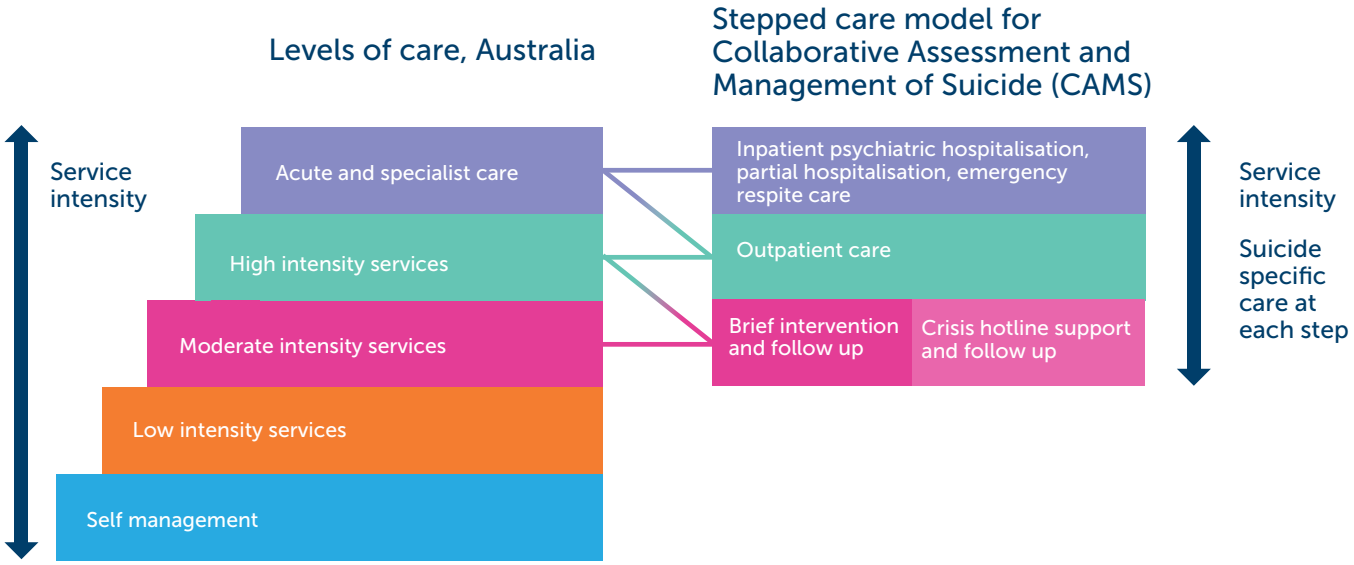
Workforce training for suicide prevention

In line with the expectation that service providers will have evidence-based approaches and treatment for the prevention and management of suicide, the service provider workforce must be appropriately trained and qualified to do so. Evidence-based suicide prevention training approaches/models that Murray PHN recommend are:

- 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.

Figure 2 illustrates how the CAMS model sits within a stepped care approach and aligns with Australian primary health levels of care.

Figure 2 – CAMS and Stepped Care



3.3 PTS Perinatal

Research indicates that each year, around one in 10 Australian women/expecting or new parents experience mental health problems during pregnancy and almost one in five experience depression in the weeks and months after giving birth. If left untreated, this can have a negative impact on new mothers, their babies, families and friends, including relationship problems and difficulties bonding with children. Many women/expecting or new parents who experience perinatal depression are not identified and so do not receive adequate support, placing them at-risk of more serious problems[11].

The PTS Perinatal program is targeted to women/expecting or new parents who are experiencing perinatal depression and anxiety. A MHTP is required for referral to this program, but where access to a GP is not readily available, alternate referral pathways may be made to a service provider.

Women/individuals presenting for access to the Perinatal PTS should be administered the Edinburgh Postnatal Depression Scale (EPDS) screening tool. This screening tool may be administered by a range of health care professionals including GPs, midwives, child and maternal health nurses, Aboriginal health workers, practice nurses and obstetricians. Others likely to be involved in screening include community support workers, especially in rural and remote areas, and non-government organisations, which are particularly important for culturally and linguistically diverse groups.

Service providers should use the COPE Perinatal Mental Health Clinical Guidelines tools and resources developed to improve the prevention and early detection of antenatal and postnatal depression, and to provide better care, support and treatment for expectant and new mothers experiencing perinatal depression and anxiety. These resources are also available through Beyond Blue.

Interventions

Available psychological interventions for expectant and new mothers/parents referred to this program must be evidence-based with a perinatal focus and provide clinical effectiveness for short-term treatment of perinatal depression and anxiety.

3.4 PTS Child Mental Health

PTS Child Mental Health is for the provision of short-term evidence-based mental health services for children up to and at 13 years of age presenting with mental health disorders. This includes ***children who have, or are at-risk of developing***, a mental health, childhood behavioural or emotional disorder. The psychological interventions provided under this program must be relevant to infants and children with mental health, emotional or behavioural disorders, and to their families, or to other individuals having responsibility for the child.

Interventions must also provide a level of service commensurate with the clinical needs of the individual and consideration must be given to whether the infant or child is more appropriately supported by an alternative service provider including the state or territory acute mental health service.

Eligibility

The eligibility criteria includes:

- A child assessed as having signs and symptoms of an emerging mental health disorder (including conduct disorder)
- A child at-risk of developing a mental health disorder, and/or where the child's development is disrupted by their mental health disorder
- The child is unable to access appropriate clinical intervention through the Medicare-funded Better Access program and rurality or remoteness limit access.

While infants and children do not need to have a mental health or childhood behavioural or emotional disorder diagnosed to access this program, there needs to be clear clinical evidence that they are at significant risk of developing a disorder.

PTS Child Treatment Plan (CTP)

Service providers are expected to ensure a Child Mental Health Treatment Plan (CTP) is completed by the GP/psychiatrist/paediatrician for a child to be referred for this program. However, if there is no diagnosed mental health disorder evident, the GP/psychiatrist/paediatrician should document in the CTP that there is evidence of significant risk for the development of a mental health, childhood behavioural or emotional disorder that would benefit from short-term focused psychological strategies.

Referrals

Infants and children who have, or are at-risk of developing, a mental health, childhood behavioural or emotional disorder must be referred to this program by a GP/psychiatrist/paediatrician. Referrals by other service providers may also be made but pre-empt a formal diagnosis and assessment in order to support early intervention. This is in recognition of barriers to timely access to medical practitioners in some regions and by some population groups. It is important however, that a full diagnosis by a GP/psychiatrist/paediatrician takes place when possible.

Provisional service provider referrals can be made by the following professions and clinicians:

- Appropriately trained allied health professionals who are eligible to provide services under PTS *(including Aboriginal and Torres Strait Islander health workers). Note: an allied health professional may not refer an infant or child to themselves or to someone operating in the same practice.*
- School psychologists/counsellors or deputy principals. Referrals from schools and early childhood services need to be made via senior staff members (*e.g. directors or principals/deputy principals*), where the school or early childhood service does not have a qualified psychologist or counsellor (*in consultation with and consent from the child's legal guardian*).
- Directors of early childhood services
- Medical officers in non-government organisations (NGOs).

In some circumstances, children between the ages of 13 and 15 can also access PTS Child Mental Health. In such circumstances, a child must have the clinical need and no other suitable mental health services exist in the region to which the child could be referred, such as a local headspace service.

Service providers should also ensure they have established referral pathways and linkages with government and non-government stakeholders at the community level (including those outside of the clinical mental health system).

A list of disorders and contextual factors (ICD-10) for treatment under PTS Child Mental Health is included in Table 2 and can be located at: who.int/classifications/icd/en/GRNBOOK.pdf and icd.who.int/browse10/2016/en#/Z63.7

Table 2 – PTS Child Mental Health Disorders

1	Attachment disorders
2	Depressive disorders
3	Adjustment disorder
4	Anxiety disorders, including: (a) generalised anxiety disorder (includes overanxious disorder of childhood) (b) separation anxiety disorder (c) social anxiety disorder/social phobias (d) phobic disorders/specific phobias (e) obsessive compulsive disorder (f) post-traumatic stress disorder (g) panic disorder
5	Elective mutism (or selective mutism)
6	Sleep disorders
7	Somatoform disorder
8	Neurasthenia (chronic fatigue syndrome)
9	Feeding disorders
10	Eating disorders
11	Encopresis
12	Enuresis
13	Bereavement disorders
14	Childhood behavioural disorders, limited to: (a) conduct disorder (b) attention-deficit/hyperactivity disorder (ADHD) (c) oppositional defiant disorder (d) disruptive behaviour disorder, not otherwise specified (NOS)
15	Tic disorders (e.g. Tourette's syndrome)
16	Substance use disorders (e.g. glue sniffing, alcohol and drugs)
17	Dissociative (conversion) disorder
18	Sexual disorders – including, but not limited to, gender identity disorder of childhood
19	Emotional disorders with onset specific to childhood
20	Mental disorder, NOS
21	Contextual factors – including, but not limited to: (a) problems related to upbringing (b) problems related to negative life events in childhood (c) other problems related to primary support group, including family circumstances

Interventions

Children up to and at 13 years of age with mental health issues require specific **age-related, evidence-based** psychological treatment interventions/options. The most common treatment option available is cognitive behavioural therapy (CBT), but it must be modified to suit the child's development level. Other appropriate options can include therapies which involve family-based therapies such as behavioural therapy, and parent training in behaviour management. Interventions that can be provided through this service may include:

- Attachment interventions
- Behaviour or CBT family-based interventions
- Behavioural interventions
- Modified cognitive behavioural therapy (CBT) interventions (*including individual child and family/parent based*)
- Parent-child interaction therapy (PCIT) for attachment and behavioural disorders (where expertise is available).

For further information, see the Australian Psychological Society Literature Review of Evidence-based Psychological Interventions for the Treatment of Mental Disorders.

Interventions for parents

Evidenced-based psychological interventions under this scheme can include the child, the parent or both child and parent, as long as:

- The focus on the intervention is always on the mental health and emotional and social wellbeing of the child
- Sessions where the child is not present do not exceed the number of interventions where the child is present.

In addition, the interventions for parents will count towards the total number of services provided under this program.

Workforce requirements

In addition to the workforce requirements expected for delivery of all PTS programs, service providers must ensure clinicians providing PTS Child Mental Health are familiar with issues that are specific to working with infants. Clinicians must have a working knowledge of relevant legal and forensic topics, the mandatory reporting of abuse, privacy, confidentiality and managing risk and safety issues. Service providers and staff are also required to comply with Commonwealth and State legislation for working with children, such as the Working with Children Check.

3.5 PTS Residential Aged Care

Variable intensity mental health services have not been readily accessible to older people living in residential aged care facilities (RACF), nor had they been in scope of services that RACFs provide. There is evidence that RACF residents have high rates of mental illness presentations[12]. PTS RACF is intended to target people with mild to moderate symptoms or diagnosis of mental illness who are residents of aged care facilities. In addition, residents with severe mental illness who are not more appropriately managed by a State or Territory Government Older Persons Mental Health Services, and who would benefit from psychological therapy are also not excluded from this service.

Service features

The essential features of psychological services delivered to residents in aged care facilities are that they are:

- Offered as in-reach services at the aged care facility
- Person-centred
- Targeted to residents with a diagnosed mental illness or who are at-risk of developing mental illness if not in receipt of services
- Providing evidence-based, time-limited psychological therapies which are adjusted to be responsive to the needs of older people
- Implemented collaboratively, in close communication with RACFs and other key stakeholders including consumers and family members
- Subject to locally developed assessment and referral arrangements that ensure services are matched to need.

Referral pathways

A referral to this program may be triggered from a variety of sources including the resident, a family/carer, an Aged Care Assessment Team clinician or RACF staff. A clinician, such as a Registered Nurse, GP, psychiatrist or psychologist must then either confirm a diagnosis of mental illness and/or that the resident would benefit from this service. When the resident's GP is not involved in the initial referral, they must be advised of this occurring. While a MHTP is not available to residents in RACF and not required for referral to this program, the GP is required to contribute to and coordinate the general care plan for each resident.

Service providers are expected to ensure that the resident has been assessed for any physical causes of presenting mental health symptoms, particularly if the onset has been sudden (which could suggest delirium as opposed to mental illness). The GP/psychiatrist will also be required to provide medical diagnosis of mental illness to ensure that symptoms of cognitive decline, dementia or delirium are not mistaken for mental illness, and to ensure that physical illness and medication needs are considered in the overall care plan. However, there may be some circumstances where it is not possible to get a timely medical diagnosis and provisional referrals to commence service provision in anticipation of a formal diagnosis may occur.

Interventions

Service providers will need to make some ***adjustment and tailoring of evidenced-psychological interventions*** to meet the particular needs of RACF residents, including the following:

- Additional time to engage with residents because of hearing problems or degree of cognitive decline
- Cognitive behaviour therapy may need to be adapted to particular capabilities and needs of the residents and will not be appropriate for those residents with significant cognitive decline
- Language used in talking to older people must respect the attitudes of older people towards mental illness (the term mental wellbeing may be more appropriate than mental health)
- Group sessions may be more appropriate for some residents, particularly those with similar needs
- Quicker access to services while awaiting a formal diagnosis
- Fewer and shorter sessions that are less resource intensive than standard psychological care required
- Provision of services through a broader workforce that includes mental health professionals but also other service providers with training in evidence-based therapies suitable for older people
- Digital mental health services may be less suitable for many older people but should not be dismissed as a potential low intensity option
- Telephone or videoconference-based therapies, particularly for RACFs in rural and remote locations could play a role in services. Computer-based therapies, including the use of iPads, may help to engage older people and provide a point of focus or to assist in sharing photos or maps.
- Services must be inclusive, culturally safe and appropriate to the needs of people from diverse backgrounds including Aboriginal and Torres Strait Islander people, people who identify as LGBTQIA+ and people from CALD backgrounds
- Particular types of therapies that have proven to be effective with older people, including reminiscence therapies, validation therapy and adjusted cognitive behaviour therapy should be used in this PTS program
- Provision for liaison with other service providers for those with comorbid physical health issues or dementia that are known to impact mental health.

Most residents will require six or fewer sessions. This can be extended based on clinical need and evidenced with clinical case review recommendation.

Workforce

As with all PTS programs, all clinicians delivering PTS RACF services will require relevant registration and must have ***previous skills and experience in working with older persons' mental health***.

3.6 PTS Homeless

The relationship between mental illness and homelessness is complex and bi-directional. Mental illness is a common pathway into homelessness, often occurring after psychotic episodes and substance use. The experience of being homeless is traumatic and can lead to mental health issues such as anxiety and depression[13].

The PTS Homeless program is designed for individuals with mental health distress and disorders with a mild to moderate level of severity, as well as those with more severe mental ill-health who are assessed as having potential to benefit from focused evidence-based psychological interventions.

Central to the PTS Homeless program is that the focused evidence-based psychological strategies are ***delivered via an assertive outreach*** model to the consumer who is experiencing or at-risk of homelessness (referred to as an individual who is a "rough sleeper"[14]). Assertive outreach involves providing interventions that actively seek out and target consumers where they live and hang out[15]. Workers actively approach potential consumers on the streets and offer support related to accommodation and services. Assertive outreach enables workers to respond directly and immediately to an individual's needs by bringing services to people, rather than waiting for individuals to come to services on their own[16].

Service providers must have appropriate risk management protocols and procedures in place for assessing and managing environmental, location and rough sleeper/consumer risk to ensure the safety of staff undertaking assertive outreach.

Service aims

The aims of the PTS Homeless program are to:

- Provide assertive outreach PTS services as brief interventions to consumers who are experiencing or at-risk of experiencing homelessness
- Build the mental health knowledge and skill of community-based outreach staff working with consumers experiencing or at-risk of homelessness
- Develop partnerships and referral pathways between primary and tertiary services providers that improve and increase consumer access to services such as general practice, public mental health services, alcohol and other drug services, psychosocial recovery services, housing, legal and family violence services
- Promote an integrated, multi-disciplinary, intervention approach based on the stepped care approach to support consumers with mild to moderate and severe mental health issues and disorders
- To improve outcomes for consumers with mild, moderate and severe levels of mental health distress and disorders, by providing evidence-based, short-term psychological interventions in an assertive outreach recovery-focused model of care and service provision to gather meaningful data on homelessness.

Service functions

The PTS Homeless program functions are contained within three main objectives and outcomes that relate to:

- Mental health capacity building for community outreach staff
- Improving rough sleeper engagement with the GP, mental health and other service providers
- Improving rough sleeper access to the NDIS.

The specialist service functions of this program will be undertaken by the employed mental health clinician (see section Workforce Scope below). The service functions are outlined below:

1. **Capacity building**
    a. Mentoring community outreach workers some of which will include working alongside staff as they provide assertive outreach
    b. Providing secondary mental health consultation to community housing and outreach staff on how to best engage and respond to consumer mental health issues, distress and disorders
    d. Developing mental health training materials and education resources for use as staff mandatory induction and annual refresher sessions
    c. Provision of relevant evidence-based psychological intervention training to staff.

2. **Improving rough sleeper engagement with services to ensure needs are met**
    a. Mentoring and working alongside service provider staff to undertake assertive outreach to consumers
    b. Facilitating:
        – Physical health screening of consumers (the mental health clinician employed in the PTS Homeless Program will support service provider staff to undertake a Physical Health Check Screen)
        – Consumer GP and other relevant service provider contact and appointments
        – Timely and appropriate referrals to service providers
        – Development of referral pathways to primary and tertiary mental health services
    c. Supporting community outreach staff to:
        – Provide consumer advocacy
        – Undertake motivational interviewing and brief solution-focused therapy
        – Provide health and service provider information to consumers
        – Assist consumers to navigate mental health, housing, medical and psychosocial recovery support programs/ services
        – Develop consumer recovery plans
        – Broker funding for medical, housing, social, mental health and other needs
        – Collect consumer data.

3. **Improving rough sleeper access to NDIS**
    a. Supporting outreach and housing staff to help consumers on a pathway to access the NDIS – network with local NDIS Local Area Coordinator (supporting a quality application).

Eligibility

Consumers experiencing or at-risk of homelessness and experiencing mental health issues, distress or a mental health diagnosis/disorder.

Referral pathway and requirements

For consumers experiencing or at-risk of homelessness, flexible and sensitive referral pathways, other than that of the GP referral and use of the MHTP, may be activated. The referral may come from the mental health clinician or a community outreach staff member, or the consumer may self-refer as an alternative pathway to this program. When the consumer is seen by a GP, this will then activate a MHTP.

A referral form must be completed by either the mental health clinician or the service provider community outreach worker and this will be processed in the same manner of other PTS Specialist referrals.

Evidenced-based psychological interventions

In addition to the service functions of this program, evidence-based psychological interventions that use a motivational intervention approach may be offered to consumers. Other appropriate evidence-based psychological interventions may also be undertaken, but staff providing these must undertake relevant training and/or be qualified to do so.

For further information on evidence-based interventions, see the Australian Psychological Society Literature Review of Evidence-based Psychological Interventions for the Treatment of Mental Disorders.

Workforce scope

Clinicians providing PTS Homeless can include the following disciplines (*who must hold current professional registration*):

- Mental health nurse
- Mental health social worker
- Mental health occupational therapist
- Aboriginal and Torres Strait Islander health worker
- Psychologist.

Workforce qualifications and skills

To competently provide PTS Homeless interventions, clinicians/professionals must have appropriate:

- Competency-level clinical and psycho-biosocial knowledge (including the theory underpinning evidence-based interventions, and research into their effectiveness)
- Competency-level skills (in delivering best mental health practice, and evidence-based mental health interventions)
- Training and qualification in evidence-based psychological interventions.

Service providers must ensure the mental health clinician has ongoing professional development (also required for annual re-registration) and maintains currency of practice in line with contemporary evidence-based/best practice treatment modalities, professional discipline practice, registration and professional development requirements. This must include management and clinical supervision that is in keeping with professional and accreditation/ registration requirements of their specific discipline.

3.7 PTS Natural Disaster Response

The psychological impacts of natural disasters can be long lasting and widespread. The relationship between natural disasters and psychological distress, mental health issues and disorders is complex and unequivocal. Severe psychological distress is common following natural disasters, and if left unsupported or not engaged in psychological, mental health therapy, a significant number of people will develop long-term mental health problems. Psychological interventions with an emphasis on problem solving skills and resilience building/training are the most appropriate interventions for service providers to offer[17].

Service aims

The aims of the PTS Natural Disaster Response program are to:

- Provide outreach services as brief evidence-based psychological interventions to people most directly affected by the disaster who are experiencing or at-risk of experiencing longer-term mental health issues
- Provide evidence-based psychological interventions based on problem-solving skills and resilience that build affected individuals' coping skills to manage post-disaster stressors
- Encourage technology-enabled mental health services such as mobile apps, telehealth and online treatments that are efficient and a practical means of delivering treatment to affected individuals and remote communities
- Improve outcomes for people affected by natural disaster events who have mild, moderate or severe levels of psychological distress and mental health disorders, by providing evidence-based, psychological interventions in an outreach recovery-focused model of care and service provision.

Eligibility

People who have been affected by natural disaster events who are at-risk of experiencing, or are experiencing mental health issues, psychological distress or a mental health diagnosis/disorder as a result of a natural disaster.

Referral pathways and requirements

For people who have been affected by a natural disaster, flexible and sensitive referral pathways, other than that of the GP referral may be activated. The MHTP may be waived for referrals in response to natural disasters to expedite the referral process. The referral may also come from other health care providers, recovery agency workers, community organisations, or consumers may self-refer as an alternative referral pathway. When the consumer is seen by a GP, this will activate a MHTP, but this it is not required for the initial referral to the PTS Natural Disaster Response program.

Initial contact

People referred to PTS Natural Disaster Response program will have priority access to the service provider who is to make ***initial contact with the consumer within 24 hours of the referral***.

Evidence-based psychological interventions

In addition to the service functions of this program, appropriate evidence-based psychological interventions must be based on problem-solving skills and resilience that build affected individuals' coping skills to manage post-disaster stressors. These interventions may include:

- Cognitive-behavioural therapy including:
  - Behavioural interventions
  - Behaviour modification
  - Exposure techniques
  - Activity scheduling
  - Cognitive interventions
  - Cognitive therapy
- Relaxation strategies
  - Progressive muscle relaxation
  - Controlled breathing
- Skills training
  - Problem solving skills and training
  - Stress management
- Solution-focused therapy.

Workforce qualifications and skills

To competently provide PTS Natural Disaster Response interventions, clinicians must have appropriate:

- Competency-level clinical and biopsychosocial knowledge, including the theory underpinning evidence-based interventions, and research into their effectiveness
- Competency-level skills (in delivering evidence-based psychological interventions)
- Post graduate qualification practice level experience (minimum of two years' experience) in assessing and treating individuals with a range of mental health problems
- Relevant and discipline-specific and/or nationally endorsed specialist qualifications and training to provide PTS Natural Disaster Response services including, but not limited to:
  - Trauma informed care
  - Recovery focused care
  - Cultural competence
  - Suicide prevention.

Service providers must ensure clinicians also have ongoing professional development and maintain currency of practice in line with:

- Professional discipline practice standards requirements
- Professional discipline national registration
- Continuing professional development standard requirements.

4 Primary Mental Health Clinical Care Coordination

People with severe mental illness who are supported in primary care require integrated services, particularly if they have persistent mental illness and/or complex needs. Integrated services must encompass clinical mental health needs. This includes medication management, physical health, alcohol and drug services, psychosocial support and broader community services such as housing, education and employment.

There are four core components of the clinical care coordination around which all service functions derive:

- Clinical treatment, including suicide risk and medication management
- Physical health care
- Community support by way of psychosocial, vocation or other non-clinical support
- Alcohol and drug services as required.

The intensity of the coordinated clinical care will need to vary according to the needs of the consumer.

Service aims

Primary Mental Health Clinical Care Coordination (CCC) is designed for consumers with persistent and severe mental illness who require high intensity services within a stepped care team approach.

CCC aims to:

- Improve care coordination and service integration for consumers living with a severe and persistent mental illness
- Reduce the likelihood of unnecessary hospital admissions and readmissions
- Work in partnership with consumers in their recovery and during periods when greater clinical support is required
- Improve the physical health of consumers through comprehensive assessment, efficient management and timely onward referral arrangements.

Service functions and interventions

The service functions of CCC have been broken into two main streams which combine the four service aims of care outlined above and provide detail for the service interventions. They are:

1. **Clinical care** – incorporating all elements of clinical treatment, assessment (including risk assessment), medication management and physical health care. Service providers are expected to ensure clinical care provision includes:
    - A ***comprehensive mental health assessment*** at commencement of service
    - A separate ***physical health assessment*** and monitoring of the consumer's physical and medical health/health care needs
    - Communication with the GP and other physical and medical practitioners involved in care and/or referring the consumer to appropriate physical or medical practitioner (including co-occurring health needs such as alcohol and other substance use issues/disorders) to assess, monitor and support the management of these consumer needs
    - ***Reviewing/monitoring the consumer's mental state*** and intervention plans to identify any potential or emerging risk to the consumer or others
    - ***Psychoeducation*** (other than for medication) on:
        - Mental health diagnosis
        - Early warning signs, triggers and stress factors that impact on the development of symptoms and relapse (where appropriate to recovery goals)
        - The use of and management of psychoactive substances, tobacco and alcohol
        - General health and wellbeing (including exercise and nutrition/diet)
    - ***Medication management:***
        - Monitoring and supporting the consumer to take medication as prescribed
        - Providing and supporting the consumer with medication adherence strategies
        - Monitoring side-effects and collaborating with the consumer and the GP to manage these
        - Monitoring and providing medication education regarding indications for use, side-effects, therapeutic effects, dosage requirements, blood/pathology testing if required and medication scripts and the consequences of interruption or discontinuation of medication
    - Administration of medication where appropriate and part of Recovery Care Plan/Mental Health Treatment Plan
    - Liaison and communication with the treating GP, health care/medical practitioner prescriber regarding the consumer's medication
    - Ensuring the Care Plan/Mental Health Treatment Plan and medication are reviewed at a three-month interval and/or when the consumer's mental state indicates this is required.

Note: Some elements of clinical care interventions such as physical health care and monitoring/supporting referral and assessment of the consumer's alcohol and drug co-morbidities also require care coordination activities. They are primarily included in clinical care service functions because they include some direct care provision by the CCC clinician.

2. **Care coordination** - incorporates linking with and coordinating a range of community services and support for the consumer by way of psychosocial, vocation or other non-clinical services. A minimum expectation of this care coordination includes:
    - Liaising (with consent) with family, carers, employers, educators or other key consumer supports
    - Shared care planning and coordinating services
    - Providing links with programs established to support consumers to access other appropriate services based on need
    - Assisting with connections to local community activities and groups to optimise meaningful activity
    - Establishing specific links and partnerships between clinical care coordination services, psychosocial services and drug and alcohol services to ensure consumer's complex needs are met.

Eligibility

Consumers who have been diagnosed with a severe and persistent mental illness, have been hospitalised at least once for treatment, or are at-risk of needing hospitalisation in the future if appropriate treatment and care is not provided, are eligible for referral to CCC.

In addition, service providers must ensure individuals from the following groups who have been diagnosed with severe and persistent mental illness, are able and supported to access CCC services. These groups are:

- People experiencing, or are at-risk of, homelessness
- Those from culturally and linguistically diverse (CALD) communities
- Aboriginal and Torres Strait Islander people
- People with intellectual disability
- People impacted by drought.

Referral requirements

Generally, referrals should be provided by an individuals' GP or psychiatrist. A Mental Health Treatment Plan (MHTP) is expected at the point of referral however **no consumer should be restricted from the program due to the absence of a MHTP.**

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/psychiatrist for assessment of appropriateness for a MHTP. This needs to occur within two weeks of treatment commencing (four weeks in rural areas).

Referral outcomes

Referrals must be screened for eligibility and appropriateness. The GP/psychiatrist (or referrer) should be informed/communicated with of the referral outcome, with one of following options:

- Referral accepted and service available
- Referral accepted, service not available and individual placed on a waitlist
- Referral not accepted, and assistance provided for potential alternative interventions.

Consumer Recovery Care Plan

In keeping with the principles of recovery-focused care, a consumer Recovery Care Plan that is based on both the MHTP and the consumer's recovery goals should be developed within the first two weeks of service commencement.

The development of the Recovery Care Plan is a collaborative process that must include the consumer, their nominated family/carer and other supports, the GP/psychiatrist and other team members and service providers who have input into the consumer's treatment and care.

The Recovery Care Plan should include:

- Consumer focused recovery-oriented goals
- Strategies designed to support goal achievement
- Nominated supports and providers involved in goal and strategy achievement
- A plan for the three-monthly clinical case review
- Inclusion of planning for potential step up/step down and/or discharge from CCC.

In addition, the Recovery Care Plan should be signed at a minimum by the consumer and the CCC clinician, a copy given to the consumer and reviewed and updated as required at the three-month clinical case review.

Clinical case review

The clinical case review is a requirement of both the National Safety and Quality for Healthcare Services (NSQHS) Standards 2017 (*Standard 6, Communicating for Safety, 6.11 Changes to Care Plans*)[18] and the National Standards for Mental Health Services 2010 (*Standard 10, Delivery of Care 10.4 Assessment and Review*)[19].

Service providers are expected to undertake regular review of the consumer's care, in keeping the required standards outlined above. In addition, for CCC services a **clinical case review** is also required evidencing the need for continuation of services every three-month interval.

A clinical case review is an all-of-team meeting that should involve:

- The consumer
- The clinician providing the CCC service
- Any consumer nominated family/carer and other supports
- The GP/psychiatrist and other significant team members (with consumer consent), providing service to the consumer.

All efforts must be made by the CCC clinician to set up and invite the above participants to the clinical case review meeting, which can occur face-to-face or via video/telephone conferencing. If the consumer's nominated family/carer or other supports and/or GP/psychiatrist and other service provider are not able to attend a clinical review meeting, their input and feedback into the review process should be sought.

The clinical case review is an opportunity for the clinician, consumer and members of the team to review the consumer's progress against:

- The MHTP and the consumer's Recovery Care Plan (*particularly goals and strategies*)
- Prescribed medication
- Elements of clinical care and care coordination
- Overall treatment progress
- Mental state and risk-level
- Ongoing treatment needs/treatment plan
- Planning for step up/step down or discharge/exit from the service
- Readministering of the K10 outcome measure.

As part of the clinical case review, the MHTP and Recovery Care Plan must be updated to reflect any changes made to the consumer's recovery goals, strategies, treatment and care. The PTCCC clinician must also provide written communication to the consumer's GP/psychiatrists with the outcome/s of the clinical review meeting.

Psychological services

Psychological services can be provided to address gaps in access to PTS for consumers with severe mental illness who are supported in primary care. These services should complement Medicare Benefit Scheme services available under the Better Access initiative and be provided as part of broader efforts to address the needs of hard-to-reach populations.

Murray PHN may commission additional psychological services for people with severe mental illness who have a clinical need for these services. This could include, for example, additional sessions beyond the 10 sessions available under the Better Access initiative.

Psychological services include all those evidence-based psychological interventions typically available in the PTS Generalist programs.

Workforce scope

Mental health nurses play a significant role in clinical care coordination for people with severe mental illness. Service providers are expected to continue to recruit mental health nurses to provide CCC services and ensure the focus on the clinical needs of consumers are met. However, in some rural and remote areas and where service providers are not able to recruit credentialed mental health nurses, Murray PHN will consider supporting other flexible workforce models. All other relevant workforce requirements (*including those for Peer Workforce*) for CCC are included in Part A Program Guidelines.

5 Youth Enhanced Services (Youth Severe)

Service target group

Severe mental illness is defined by its duration and the disability it produces. It can include psychosis, major depression, severe anxiety, eating disorders and personality disorders. Severity can also relate to the level of risk that a young person presents with as a result of their illness, in combination with any number of external factors or circumstances such as homelessness, family violence and poor social supports. This can be exacerbated through lack of access to appropriate treatment or a reluctance to seek help from mainstream services[20].

Murray PHN has funded Youth Enhanced Services to ensure that young people with or at-risk of, severe mental illness can be appropriately treated in the primary care setting.

Furthermore, there are a number of population groups that are more prone to severe episodes of mental ill-health, particularly if left untreated, including Aboriginal and Torres Strait Islander people, homeless young people, young people who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual (LGBTQIA+), Culturally and Linguistically Diverse (CALD) people, those with comorbid alcohol and other drug (AOD) problems and those experiencing or at-risk of suicide.

Service system outcomes and program objectives

The intended outcomes for the Youth Enhanced Services service system are:

- A flexible and joined-up service system focused on the needs and views of consumers which maximises their potential to participate
- A system that is planned, integrated, coordinated and delivered at a regional level and includes primary mental health care services, state child and adolescent services and alcohol and other drug services.

Youth Enhanced Services objectives are to provide:

- Region-specific, cross-sectoral approaches to early intervention for young people with, or at-risk of severe mental illness
- Mental health services for young people with severe mental illness to be managed in primary care settings
- Care coordination for young people with severe and complex mental illness.

Eligibility

A young person with or at-risk of severe mental illness who can be appropriately managed in a primary health setting is eligible for Youth Enhanced Services. In line with a stepped care model, there is a need to match the intensity and mix of services to the intensity of need. Some young people may simply require additional services. Others may require more complex packages of care, or access to a broader range of professional support. Eligibility is also based on the clinical model (outlined below). Young people who have symptom severity at Stage 1b and Stage 2 are eligible for Youth Enhanced Services.

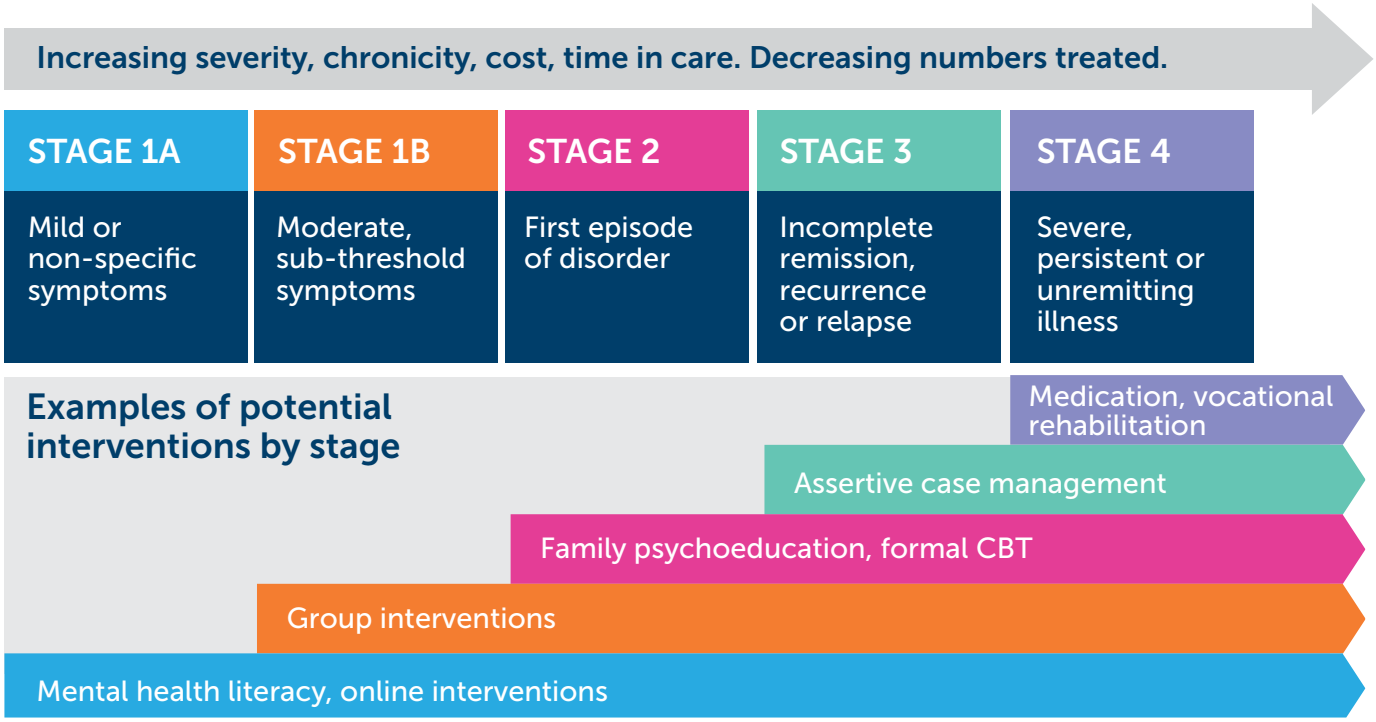
Clinical Staging Model

Clinical staging is a framework developed to assist in the identification of appropriate interventions for young people, given the extent of progression of a mental illness. Originally used in other areas of medicine, clinical staging has been more recently applied to youth mental health in an attempt to guide treatment selection across the range of mental health difficulties that a young person might present with, including early, mild symptoms that do not yet fit within a diagnostic category. This makes the model particularly useful for young people who often present with symptoms that are below the threshold for a mental disorder, but who nevertheless, may experience high levels of distress and impairment in their functioning.

The clinical staging model uses a combination of help-seeking, symptoms and functioning information to ***categorise a mental health problem into one of six potential stages***, ranging from Stage 0 ("at-risk but no symptoms") to Stage 4 ("severe, persistent or unremitting illness"). For young people with severe and complex presentations in the primary care setting, most would be expected to fall within Stage 1b ("subthreshold symptoms") or Stage 2 ("first episode of severe disorder").

Clinical staging can be used alongside the stepped care model to provide comprehensive guidance on which interventions should be provided to young people at what time and in what way. Staging adds to the stepped care model by allowing for matching of the needs of young people experiencing potentially significant levels of distress and functional impairment (but who don't meet the threshold for a mental disorder), with appropriate interventions aimed at both the presenting problems and preventing progression towards a more serious illness (see Figure 3 below).

Figure 3 – Clinical Staging



(Adapted from Cross SPM, Hickie I. Transdiagnostic stepped care in mental health. Public Health Res Pract. 2017;27(2):e2721712[21])

Consumers accessing Murray PHN funded Youth Enhanced Services are expected to fall within **Stage 1b** (subthreshold symptoms) or **Stage 2** (first episode of severe disorder) of the clinical staging model. The clinical staging model also outlines some of the interventions appropriate at each relevant stage that service providers can offer through Youth Enhanced Services.

Determining the clinical stage of a young person allows better matching of the intensity of the intervention with the level of need and improves safety and efficiency by ensuring that interventions with the least risk and requiring the least time and resources are offered, before more intensive, invasive and costly interventions.

Referral and risk assessment

Referrals to Youth Enhanced Services may come from a range of sources, including:

- Self-referral
- A young person's family/carers
- A young person's GP
- Another service provider.

Referrals from or of young people in the population groups who are prone to severe episodes of mental health including those described in the section above (Target Group), must be given priority access to services. In addition, given the heightened risk of crisis and suicide among young people with severe mental illness, service procedures and protocols to ensure ease of access to crisis support and to ensure staff are skilled in identification and assessment of individuals at-risk of suicide and are able to respond in emergency situations, must be established. These procedures and protocols must include clear internal and external escalation and access pathways to crisis and emergency services.

Service interventions

Specific service provider interventions for Youth Enhanced Services may differ depending on where the young person presents in the clinical staging model (outlined above), and what their care needs are in relation to this. However, interventions provided at a minimum, must include:

- Risk screening and assessment
- Integrated, extended mental health counselling and evidence-based psychological therapy (including one-on-one and family)
- Care planning and review

- Case management and care coordination as part of a stepped care approach e.g. referring clients to appropriate other services, coordinating access to service and follow up
- Ensuring that a minimum of 20 per cent of all services provided are delivered via mobile outreach.

Note: Young people must not be charged any fee to access Youth Enhanced Services.

Intervention detail

1. Active engagement and mobile outreach

Service providers must be flexible when, where and how they contact, connect and engage with young people. It is important to use a range of ways to connect with young people and to continue this throughout the period of care to ensure they feel safe and comfortable.

Any outreach/offsite service delivery provided to suit the needs of young people, for part or all of the period of care may also include (but is not limited to):

- Home visits meeting at home, or public location such as shopping centre, café or park
- Meeting the young person at the service and going for a walk
- Collecting the young person from their location and commencing interaction in transit to the service
- Telephone or videoconferencing.

Service providers must have appropriate risk management protocols and procedures in place for assessing and managing environmental, location and young person risk to ensure the safety of both staff undertaking assertive outreach and the young person they are providing outreach to.

Active engagement may need to be preceded with a period of rapport building, in order to establish a partnership approach with the young person.

2. Comprehensive assessment

A comprehensive biopsychosocial assessment must be used to:

- Determine severity and complexity of needs
- Identify mental health issues, needs and concerns
- Identify physical and other health needs
- Understand what is happening for the young person in all areas of their lives.

3. Care planning and review

The service provider must engage in collaborative care planning with the young person and develop a care plan that meets the needs of the young person and identifies strategies, goals (and nominated significant others/services) to support these needs to be met. Where relevant, the care plan must include a safety plan. In addition, the young person's care plan must be reviewed on a regular basis to update changes to goals and strategies and to ensure it continues to be relevant to the young person's needs.

4. Clinical care coordination and case management

The roles and functions performed under the clinical coordination and case management of care requirements vary but may include:

- Proactive client follow-up for monitoring mental health symptoms and encouraging treatment compliance
- Provision of psychoeducation to facilitate self-management of mental and physical health concerns
- Ensuring communication between professionals (including the young person's GP) providing care.

Service providers must coordinate a range of services in response to support the other issues young people may have in their lives. Issues could include homelessness, not going to school, using alcohol and other drugs and/or family issues. Service providers must use a multidisciplinary team of staff who have skills in these different areas.

Case management must ensure that one central worker links the young person to all the different types of care that they need. This worker takes on a case manager role and is responsible for organising and coordinating the different types of care needed, team meetings, keeping in contact with the young person and encouraging and supporting them to attend all appointments. The case manager may also work directly with the young person as part of their treatment and safety plan and goals to ensure their needs are met.

Ideally, a case manager should be also be appropriately qualified to provide evidence-based psychological interventions. Case management can be delivered by nurses, mental health nurses and allied health professionals with the specific skills and competencies to fulfil the role. In addition, the case manager role is the key liaison between the primary care and mental health specialist services.

Psychological interventions

Service providers must ensure that evidenced-based psychological interventions offered to young people are provided by clinicians who have the appropriate qualifications, training and experience required to undertake these interventions.

Workforce scope

To ensure a high-quality standard of service delivery, staff engaged to deliver Youth Enhanced Services must be appropriately trained and qualified to provide the range of services required by young people and those outlined in this program. Service providers must also comply with relevant workforce requirements outlined in the Workforce section Part A Program Guidelines.

6 Services for Older People Socially Isolated by COVID-19

The National Mental Health and Wellbeing Pandemic Response Plan (the Plan) was released in May 2020. The plan identified that older Australians are one of the groups that are particularly vulnerable to COVID-19 and are therefore, disproportionately impacted by physical and social distancing measures, and the loss of support from family, friends and services this may entail. Physical distancing restrictions associated with the pandemic have increased social isolation for older people, whether through self-isolation, decreasing accessibility of in-community visiting services or increased restrictions on visiting of care facilities. Older people and people with disability living in the community may be isolated from family, with no access to online services and with a fear of accessing face-to-face services due to the risk of infection[22]. In addition, the closure of or reduced access to many aged care facilities to visitors, given the risk of spreading the virus, may have also reduced access to normal support from family members and friends and caused heightened anxiety and confusion among residents[23].

Service aims

The aim of Mental Health Services for Older People Isolated by the impact of COVID-19 is to reduce the disproportionate impact of physical distancing measures associated with the pandemic on the mental health and wellbeing of older people by:

- Promoting and coordinating connections to services and support in the region for socially isolated older people
- Improving access to physical and mental health services for isolated older people with mental health problems, including those who may have experienced service disruption.

Murray PHN will be implementing this program over the period during which physical distancing restrictions (associated with the COVID-19 pandemic) will be in place and to varying degrees, as restrictions are gradually lifted across jurisdictions. Service providers are expected to offer a safe environment for both their own clinical staff providing the program and older people in receipt of services. This may mean implementing digital means of service delivery where appropriate, but also ensuring appropriate safety practices in face-to-face service delivery where this is able to be delivered. As COVID-19 restrictions lift, it is expected that more face-to-face service delivery will be provided.

Target group

Those targeted to benefit from this program are individuals aged 65 years and over (for Aboriginal and Torres Strait Islander individuals aged 55 and over) who are socially isolated and meet the following criteria:

- Have been impacted by the pandemic;
- Are at-risk of mental illness;
- Are experiencing loneliness and need assistance reconnecting with social networks;
- Have ongoing mental health issues that need psychological therapies or referral to specialist support;
- Have physical health needs which exacerbate mental health issues and need management, and;
- May have also been impacted by the cumulative impact of bushfires and the pandemic, and for those that have a heightened risk of loneliness and need help with situational distress; and
- For residents of residential aged care facilities who are experiencing distress or anxiety and physical and mental health problems because of their disconnection from loved ones.

Note: this program is also for older carers of people with mental and physical health problems, who meet the above criteria.

While the target group for this program is older people, service providers also have flexibility to offer information, advice and assurance on their wellbeing, to carers, families and friends, who may be separated from the older person due to COVID-19.

Note: a mental health diagnosis is not a requirement for eligibility to this program.

Program delivery

This program must be delivered as in-reach services at residential aged care facilities and community-based locations such as home and/or other accommodation via face-to-face, telephone, internet and other electronic platforms that are able to be accessed by the consumer.

Program elements

Service providers are required to provide the following in-reach services:

- **Clinical nursing services** - establishing a therapeutic relationship in which to **assess** and **manage** mental and **physical health needs** including assessing health risks, **monitoring medication** and providing **support and information to carers**.
- **Care coordination** – **promoting connections to needed services and support**, including helping to restore access to services and social networks where these have been disrupted by the pandemic.
- **Psychological therapy** – the provision of **evidence-based psychological interventions and therapies** appropriate to the identified needs of the older person.

Workforce requirements

While mental health nurses are the priority workforce for this program, where there are workforce shortages and other barriers to the recruitment of mental health nurses, Murray PHN will work with service providers to develop workforce models to ensure the delivery of the scope of services described above. Registered nurses with mental health training, or allied health professionals with formal mental health competencies may be included as clinical members of the workforce team. Murray PHN may also work with service providers to establish teams supervised by a credentialed mental health nurse and the appropriate clinical governance arrangements.

Other workforce requirements outlined in Part A Program Guidelines also apply.

Workforce resources

Training resources are available to assist clinicians, RACF staff and other community service providers to develop capacity to support the emotional wellbeing and mental health of older people in their care. This includes:

- The Australian Psychological Society (APS) series of interactive online training modules for the mental health workforce. Topics will enhance and upskill clinicians and low intensity support workers in the provision of mental health services focused on aged people living in residential aged care facilities. The course will be inclusive of the stepped care approach.
- Resources and online training available through beyondblue including:
  - What works to promote emotional wellbeing in older people: A guide for aged care staff working in community or residential care settings
  - The Professional Education to Aged Care Program (PEAC).

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