phn MURRAY

An Australian Government Initiative

PART B
PROGRAM GUIDELINES

PRIMARY MENTAL HEALTH SERVICES

APRIL 2025

Leadership | Collaboration | Respect | Accountability | Innovation

Murray PHN acknowledges its catchment crosses over many unceded First Nations Countries following the Dhelkunya Yaluk (Healing River).

We pay our respects and give thanks to the Ancestors, Elders and Young People for their nurturing, protection and caregiving of these sacred lands and waterways, acknowledging their continuation of cultural, spiritual and educational practices.

We are grateful for the sharing of Country and the renewal that Country gives us.

We acknowledge and express our sorrow that this sharing has come at a personal, spiritual and cultural cost to the wellbeing of First Nations Peoples.

We commit to addressing the injustices of colonisation across our catchment, and to listening to the wisdom of First Nations communities who hold the knowledge to enable healing.

We extend that respect to all Aboriginal and Torres Strait Islander Peoples.

We aspire to be an anti-racist organisation, embedding cultural humility as a daily practice, to improve health outcomes and health equity in our communities. We recognise cultural humility as a life-long commitment to self-reflection, personal growth and redressing power imbalances in our society.

About this document

This document provides guidance for Murray PHN primary mental health commissioned service providers. It outlines the Initial Assessment and Referral (IAR) Levels of Care relevant to consumer need and eligibility and referral requirements. Psychological interventions, workforce requirements and specific service elements for consumer priority areas are also outlined.

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

The primary mental health services commissioned by Murray PHN represent a part of the overall service system. As such, commissioned service providers are expected to ensure that services are integrated into the regional model of care and supported by clear referral pathways to provide consumers with the right care, in the right place, at the right time.

This is a revised version of the Murray PHN Primary Mental Health Guidelines with a new structure. This document has been informed by collaboration with commissioned service providers, clinical governance and lived experience frameworks, and PHN funding guidance from the Australian Government.

For further information or clarification about any information outlined in this document, please contact the Murray PHN Mental Health and AOD team at MHAODTeam@murrayphn.org.au

Version	Document Title	Date released	Prepared by	Approved
7	Murray PHN Primary Mental Health Services Guidelines	April 2025	E Linneman	I Johansen
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5	Murray PHN Primary Mental Health Services Guidelines	January 2022	M Harding	I Johansen
4	Murray PHN Primary Mental Health, Psychosocial Recovery and Alcohol & Other Drug Services Guidelines	September 2020	T Moriarty	E Reid
3	Murray PHN Primary Mental Health Program Guidelines	June 2019	S McConnachie	P Wilkinson
2	Murray PHN Primary Mental Health Program Guidelines	November 2019	S McConnachie	P Wilkinson
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Contents

1. Introduction

The Australian Government Department of Health and Aged Care (DoHAC) released the Initial Assessment and Referral - Decision Support Tool (IAR-DST) guidance as a systematic and structured approach to assist in establishing assessment and referral systems founded on stepped care principles.

Note: Further details regarding the IAR-DST can be found in Murray PHN Part A Program Guidelines.

From 1 July 2024, Murray PHN primary mental health services are commissioned to provide services across the Initial Assessment and Referral (IAR) Levels of Care (LOC):

- IAR-DST LOC 2 - Low-intensity
- IAR-DST LOC 3 - Moderate-intensity
- IAR-DST LOC 4 - High-intensity.

This requires commissioned service providers to complete the IAR-DST at the start of the episode of care and use the recommended level of care to provide services aligned with the consumer's presenting needs. While the IAR-DST recommends a level of care, the final decision on the level of care is determined by the practitioner (known as the 'practitioner determined level of care'). The practitioner determined level of care is informed by the IAR-DST recommendation, clinical judgment and consumer choice.

Commissioned service providers should provide services in accordance with the LOC outlined in their contract. They are not expected to offer services at IAR-DST LOC 1 - Self-management, or IAR-DST LOC 5 - Specialist and acute care. However, if the IAR-DST indicates a consumer may benefit from IAR-DST LOC 1 - Self-management, commissioned services should provide information and advice.

Specialist and acute care (IAR-DST LOC 5) services are provided by Victorian Government funded Area-based Mental Health Services. If the IAR-DST indicates a consumer may benefit from IAR-DST LOC 5 care, commissioned service providers are required to proactively facilitate referrals to the relevant Area-based Mental Health Service or emergency services.

The service elements and workforce requirements for the LOC that are in scope for Murray PHN funded services are detailed below.

2. IAR-DST LOC Level 2: Low-intensity services

The National Initial Assessment & Referral (IAR) for Mental Healthcare Guidance describes IAR-DST Level 2 services as evidence-based mental health treatment/intervention services designed to be accessed quickly (without the need for a formal referral e.g. through a third-party service or provider), easily (through a range of modalities including face-to-face, group work, telephone and online services) and typically involving few or short sessions, or a specific manualised course or program of lessons/sessions designed to teach evidence-based strategies for managing symptoms of mental illness and/or distress.

Level 2 services are direct, although brief, engagement with a qualified mental health professional or appropriately trained professionals working under the clinical leadership of a suitably qualified and experienced mental health professional.

Providing a low-intensity service option as part of stepped care should:

- include psychoeducation on appropriate diet, sleep and exercise as foundational for good mental health
- increase access to services early in the trajectory of mental health and/or psychological distress to improve the chances of a person's recovery and longer-term health, wellbeing, participation and productivity
- enable the more efficient use of finite resources and a broader workforce.

Evidence-based low-intensity interventions

Murray PHN expects commissioned service providers to deliver evidence-based, low-intensity interventions. Some examples of such services may include, but are not limited to:

Assisted self-management

Designed for people who mainly self-manage their distress and recovery by behavioural activation and accessing digital tools and resources, but who may also require some encouragement, practical assistance or monitoring. Importantly, this approach involves a proactive transition to other IAR-DST LOC 2 services should the person not be making the desired progress or where there are signals or evidence of deterioration e.g. increased distress.

Assessment as therapy/therapeutic assessment

These models involve personalised assessment and feedback. They are designed to assist people in gaining insight and understanding of their social and emotional wellbeing and involve the development of simple plans to address the consumer's wellness goals.

Single-session therapy

A structured approach designed to deliver therapeutic benefits in each session. The session (or sessions) addresses the consumer's most pressing needs, issues and goals. The objective is to locate solutions, resources or strategies the consumer can work on immediately. More information is available from the Bouverie Centre: https://www.latrobe.edu.au/research/centres/health/bouverie/practitioners/specialist-areas/single-session-thinking

Low-intensity cognitive behaviour therapy (li-CBT)

Operates from the evidence base of traditional cognitive behavioural therapy but is delivered in a brief and structured way, with a reduced number and frequency of sessions and length of intervention. Typically, there is an increased emphasis on psychoeducation, self-help and homework. More information: https://www.wapha.org.au/wp-content/uploads/2021/06/210308_WAPHA_LIPI-Clinical-Manual.pdf

Manualised courses and programs

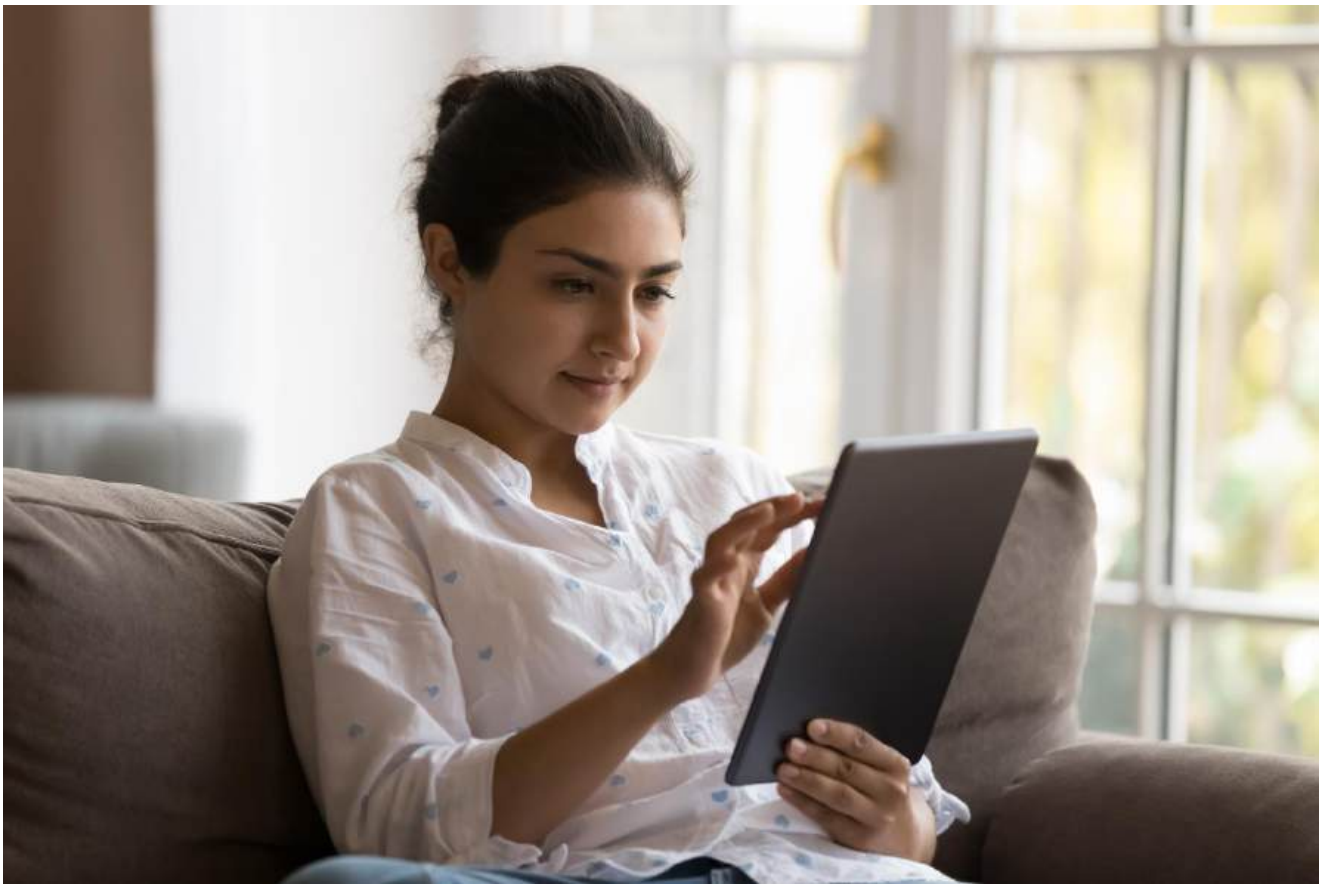
Specific manualised courses or programs of lessons/sessions designed to teach evidence-based strategies for managing symptoms of mental illness and/or distress.

Other low-intensity psychological interventions may include:

- brief solution-focused therapy delivered to individuals or groups
- mental health coaching
- behavioural prescribing and monitoring
- social prescribing and monitoring.

Low-intensity service frequency and duration

Low-intensity services involve time-limited interventions aimed at providing a less intensive approach than standard evidenced-based psychological therapy. Low-intensity services may include shorter sessions (e.g. 30 minutes), a shorter course of sessions (from a single session to a short course of a few sessions) or a specific manualised course or program.



3. IAR-DST LOC Level 3: Moderate-intensity services

The IAR Guidance for Mental Health Part A describes IAR-DST Level 3 services as a course (or repeated courses) of structured, reasonably frequent and individually tailored treatment/interventions for mental health symptoms and psychological distress e.g. a defined number of regular psychological sessions.

Moderate-intensity services are recommended if a consumer is experiencing moderate to severe mental health symptoms, and mild to moderate problems associated with risk of harm and/or functioning.

Moderate intensity services commissioned by Murray PHN aim to:

- include a primary focus on psychoeducation about the impact of appropriate diet, sleep and exercise on good mental health
- deliver short-term psychological interventions in a primary care setting
- meet the needs of individuals who are not likely to have their needs met through Medicare-subsidised or other mental health services, for reasons such as a lack of available services in the local area or inability to pay gap or service fees
- complement other fee-for-service programs by addressing service gaps in rural, remote and other underserviced geographical areas
- offer referral pathway options for GPs to support people in accessing primary mental healthcare options
- offer non-pharmacological approaches
- promote integrated, multi-discipline interventions based on the stepped care approach.

Evidence-based moderate-intensity interventions (Psychological Therapy Services)

Murray PHN expects commissioned service providers to deliver evidence-based, moderate-intensity interventions, to cater to the variety of treatment needs and service expectations of consumers. This includes Specific Focused Psychological Strategies as defined by the Medicare Benefits Schedule:

- Psychoeducation (including motivational interviewing)
- Cognitive behavioural therapy, including both behavioural and cognitive interventions
- Relaxation strategies
- Skills training
- Interpersonal therapy
- Eye-Movement Desensitisation Reprocessing (EMDR).

Other evidence-based therapeutic interventions

Commissioned service providers may also make a broader range of therapeutic interventions available, with appropriate workforce skills and clinical governance. These may include:

- family therapy
- grief and loss (bereavement) counselling
- art, music and play therapy
- dialectical behavioural therapy.

Moderate-intensity service frequency and duration

Many consumers accessing moderate-intensity interventions will only require up to six occasions of service. However, additional occasions of service can be delivered if indicated following a clinical case review. The stepped care system works best when the least intensive and least intrusive evidence-based intervention is applied. This principle is also likely to increase consumer participation in treatment.

Note: extended sessions are a continuation of the original episode of care and are not to be recorded as a new episode of care.

Clinical case review

The National Standards in mental health services states that regular review of a consumer's treatment, care and recovery plan is key to recovery-oriented service delivery. Commissioned service providers are expected to have procedures for regular review with clinical leadership and this should occur at the completion of the sixth service contact for moderate-intensity services. A clinical case review should be completed to determine the need for continuing services if required and completed after each additional set of six occasions of service.

Clinical case reviews should include written communication with the consumer's GP or psychiatrist. Communications should include:

- mental healthcare and recovery plan summary (particularly identified goals)
- focused psychological strategies employed
- treatment progress and outcomes, including outcome measures e.g. K10
- mental state examination (including suicide risk)
- ongoing treatment needs and plan
- change in levels of care or discharge from service provision
- outcome of the case review.

When identified in the written informed consent, others should also receive advice about the outcome of the clinical case review e.g. family/carers and other service providers.

Moderate-intensity referral requirements

Referrals for IAR-DST LOC 3 services may come from an individual's GP or psychiatrist. Where this is the case, a MHTP or IAR-DST report (indicating the level of need) is encouraged at the point of referral. However, the absence of a MHTP or IAR-DST report should not be a barrier to accessing help.

Further information regarding referral requirements is outlined in Section 9 of Part A – Program Guidelines.

4. IAR-DST LOC 4: High-intensity services

The National IAR for Mental Healthcare Guidance describes IAR-DST LOC 4 high-intensity services as those designed for people who may require periods of intensive intervention, and involve multidisciplinary support and care coordination. People requiring IAR-DST LOC 4 high-intensity care may be those who are experiencing enduring mental illness, significant impairment in their daily functioning, and impacted by co-existing physical and medical conditions. Concerns about risk to the consumer and others may also exist and in such instances, referral to IAR-DST LOC 5 services may need to be considered.

Modalities for delivery of services

For people assessed with high-intensity care needs, the modalities of service delivery that should be offered as options may include:

- face-to-face interventions in the service provider location and/or other community locations e.g. general practice and other consulting rooms
- outreach to the consumer in their home (following a home-safety risk assessment) or another community-based environment.

Clinical care coordination

In general, clinical care coordination is a function that ensures clinical support and review, monitoring of mental, physical health and medication, liaison with health professionals and linking to other needed services. This is a key function of the services for IAR-DST LOC 4.

Core services required by people accessing this level of care include:

- comprehensive biopsychosocial assessment (if not already undertaken)
- lifestyle interventions regarding nutrition, sleep, exercise and meaningful social connections
- clinical care within the scope of practice of the professional providing care and in accordance with the collaborative treatment plan
- regular monitoring of a person's mental state
- liaising with family and carers as appropriate
- administering and monitoring of prescribed medication/s (where applicable, appropriate and agreed)
- providing information on physical healthcare and assisting the improvement physical health
- linking to other health professionals and service providers as needed
- evidence-based psychological interventions provided by a qualified mental health clinician
- community-based mental healthcare
- active engagement with a GP.

Additional support services that may be needed include:

- active engagement with a psychiatrist
- Psychosocial Recovery Services (including peer support, daily living support and social participation support)
- assistance to access support and advice relating to known environmental stressors.

High-intensity service frequency and duration

High-intensity interventions may need to be delivered periodically over time as the consumer's mental health treatment needs change. The number, frequency and length of sessions are determined as part of the collaborative care planning process and are not prescribed. However, commissioned service providers are expected to deliver services with a focus on recovery and anticipating that people will improve sufficiently to disengage from service delivery and manage their health independently. This supports the efficient use of the finite resources available for the program and minimising the risk of over-servicing or creating dependence.

High-intensity service referral requirements

Generally, referrals for high-intensity services will come from an individual's GP or psychiatrist. However, the absence of a referral from a GP or psychiatrist should not exclude people from receiving a service. Where possible, a MHTP and a copy of an IAR-DST report (indicating the level of care being sought by the referrer) are expected at the point of referral. Where a consumer is already receiving services from a provider, a MHTP is not required. However, communication with the consumer's GP is expected.

Further information regarding referral requirements is outlined in Section 9 of Part A – Program Guidelines.

5. Workforce requirements for IAR-DST levels of care

In recognition of the challenges of recruiting and retaining mental health professionals in regional areas, Murray PHN has broadened the categories of professionals able to deliver its commissioned mental health services. Murray PHN is also encouraging commissioned service providers to create developmental workforce pathways that increase the number of credentialed primary mental health professionals in communities. While this strategy introduces new opportunities, it also increases the responsibilities of commissioned service providers in ensuring robust clinical governance and that the broader workforce is deployed safely.

When employing a broader workforce across the IAR levels of care, commissioned service providers must ensure:

- workforce qualifications, skills, training and supervision arrangements are appropriate to the level of care provided
- the workforce has access to planned and unplanned operational and clinical supervision to support clinical care, decision-making and caseload management
- clear escalation pathways and procedures that are communicated to staff to support a consumer who presents with a level of risk or suicidality that the practitioner needs support to manage
- A clinical governance framework with associated policies and procedures.

IAR-DST LOC 2 Low-intensity services workforce

With appropriate clinical leadership, LOC 2 services may be delivered by the following health professionals:

- Australian Associated of Social Workers and Australian Health Practitioner Regulation Agency registered allied health professionals with bachelor qualifications in social work and occupational therapy
- Provisional psychologists
- Social and Emotional Wellbeing Workers/Aboriginal Mental Health and Health Workers
- Registered nurses
- Counsellors registered with the Australian Counselling Association or the Psychotherapy and Counselling Federation of Australia
- Registered art, music, play or family therapists
- Professionals with Bachelor of Youth Work
- Peer support staff with Certificate IV in Mental Health Peer Work or greater.
- A range of qualified mental health professionals such as mental health social workers, mental health nurses, occupational therapists with mental health qualifications, Aboriginal and Torres Strait Islander (mental health) workers or psychologists, or other appropriately trained staff (sometimes called therapists or coaches).

Providers may also use staff to provide Level 2 services from the range of professions outlined below (Levels 3-4) – where this is deemed appropriate and relevant to consumer need.

IAR-DST LOC 3-4 Moderate to High-intensity services workforce

Where recruitment allows, LOC 3-4 intensity services are ideally provided by qualified and registered mental health clinicians with training and experience relevant to the services and consumers' needs. These professionals usually include:

- accredited mental health social workers
- mental health occupational therapists
- mental health nurses
- psychologists.

However, commissioned service providers may recruit from a broader workforce when supported by appropriate clinical governance structures and processes as previously described in ***Workforce requirements for IAR levels of care***. This may include:

- social workers registered with the Australian Association of Social Workers
- Australian Health Practitioner Regulation Agency registered occupational therapists
- provisional psychologists
- Social and Emotional Wellbeing Workers/Aboriginal Mental Health Workers
- registered nurses
- counsellors registered with the Australian Counselling Association or the Psychotherapy and Counselling Federation of Australia
- registered art, music, play or family therapists
- professionals with Bachelor of Youth Work
- peer support staff with Certificate IV in Mental Health Peer Work or greater
- drug and alcohol workers/dual diagnosis clinicians
- dieticians
- provisional psychologists, allied health graduates, and students in their final year of training (see additional information below: The developmental ***workforce***).

Other qualifications and skills

To competently provide focused psychological interventions, staff must have:

- clinical and biopsychosocial knowledge, including the theories and research underpinning evidence-based interventions
- competency in delivering evidence-based focused psychological strategies
- competency in delivering suicide risk assessments and prevention interventions
- experience in assessing and treating individuals with the range of mental health presentations.

It is recommended that program staff have training in:

- trauma informed care
- recovery focused care
- cultural safety and humility
- suicide prevention assessment and management
- peri-natal mental health
- child mental health
- older person's mental health.

Commissioned service providers must ensure staff also have ongoing professional development opportunities to support the above competencies.

Peer support workforce

Providers are encouraged to use the Self-Assessment tool for Lived Experience Mental Health Employers to assess their readiness to support a lived experience workforce prior to embarking on peer workforce implementation. The self-assessment tool should be used in partnership with the National Lived Experience (Peer) Workforce Development Guidelines to effectively incorporate these peer workforce professionals into models of care.

Specifically, Murray PHN requires that commissioned service providers support peer workers with:

- ongoing training and development
- discipline (peer workforce) specific supervision
- opportunities to participate in peer networks e.g. communities of practice
- connection to information and updates from state and national peak bodies
- Intentional Peer Support training or other evidence-based training, such as the Certificate IV in Mental Health Peer Work.

The developmental workforce

Murray PHN supports commissioned service providers in using a range of developmental workforce models, particularly where rurality and remoteness present barriers to recruitment of program-specified staff under these guidelines.

In using provisional and graduate professionals, and students in their final year of training, providers must ensure this cohort of staff are closely supported and supervised in their practice. Commissioned service providers are therefore required to have appropriate governance mechanisms to ensure this cohort is supported in their practice and working within a scope of practice with clear escalation procedures in place.

Discipline-specific supervision arrangements should be secured during work hours along with regular caseload review opportunities. Practice debriefing, training and other forms of reflective practice must be in place.

Provisional and graduate staff, and students in their final years of training, may come from the following disciplines and workforce groups:

- Social workers registered with the Australian Association of Social Workers
- Australian Health Practitioner Regulation Agency registered occupational therapists
- Provisional psychologists
- Registered nurses
- Counsellors registered with the Australian Counselling Association or the Psychotherapy and Counselling Federation of Australia
- Art, music, play or family therapists
- Professionals with Bachelor of Youth Work
- Dual diagnosis clinicians
- Dieticians.

Where student candidates are considered, ongoing employment should be linked to attainment of the qualification.

6. Consumer priority areas

Murray PHN commissioned services are for consumers who would not otherwise be able to access treatment and care. A key focus is on ensuring equitable access for individuals living in rural and remote areas and those unable to afford paying for services.

Murray PHN may also identify priority areas in the region that require targeting by commissioned service providers. Such groups may be identified:

- through regional needs assessment or joint regional planning processes
- in response to emerging needs for psychological services
- following natural disasters when a sudden need for psychological services emerges.

Consumer priority groups currently commissioned by Murray PHN are outlined below.

6.1 Psychological treatment services for people in the perinatal period

Research indicates that each year, around one in 10 expecting or new parents experience mental health problems during pregnancy, and almost one in five experience depression in the weeks and months after the birth. If left untreated, this can negatively impact new parents, their babies, families and friends, the parental relationship and the parent/child bond.

These services are targeted to expecting or new parents who are experiencing perinatal depression and anxiety. This may include the birth or non-birth parent, and be inclusive of adoptive and foster parents of babies aged under 12 months.

The Edinburgh Postnatal Depression Scale (EPDS) screening tool should be offered to parents presenting for access to perinatal services. Commissioned service providers may also find the COPE Perinatal Mental Health Clinical Guidelines (2023) tools and resources helpful to improve the early detection, prevention and treatment of antenatal and postnatal depression.

Interventions and workforce

Available psychological interventions for expectant and new parents must be evidence-based with a perinatal focus, and provide clinical effectiveness for short-term treatment of perinatal depression and anxiety. These interventions must be provided by qualified staff with appropriate knowledge and skills. Workforce requirements for staff will depend on the **level of care** the consumer has been assessed at through use of the IAR-DST. Please refer to the ***Workforce requirements for IAR-DST levels of care*** section in these guidelines.

6.2 Psychological treatment services for children

Evidenced-based psychological interventions provided under this program must be relevant to children aged 4-12 years with mental health, emotional or behavioural difficulties, and their families/carers. Children aged 0-3 should not receive individual, therapeutic services. Research indicates that interventions are more appropriately directed to parents for this age group. However, parents may receive services that are recorded under the child's details.

The Strengths and Difficulties Tool (SDQ) is an accredited tool for children aged four years and above and should be used in conjunction with the provision of services.

Current research for children aged 4-9 indicates that interventions that include parental involvement and cognitive behavioural interventions have the strongest evidence base (Hudson, J.L., Minihan, S., Chen, W. *et al.* Interventions for Young Children's Mental Health: A Review of Reviews. *Clin Child Fam Psychol Rev* **26**, 593–641 [2023]. https://doi.org/10.1007/s10567-023-00443-6). Clinicians should consider referring parents to the Tuning into Kids program which teaches emotion coaching skills to parents and carers of children aged 3-10 years old, or similar programs.

Eligibility

The eligibility criteria for services under this program include children:

- assessed as having signs and symptoms of an emerging mental health disorder
- at risk of developing a mental health disorder, and/or where a child's development is disrupted by their mental health difficulties
- with diagnosed mental health disorders (not receiving care from the public mental health system)
- who cannot access appropriate interventions through the Medicare Better Access program or where rurality, remoteness or financial issues limit access.

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

Role of the GP

GP/psychiatrist/paediatrician for children referred for psychological therapies will often undertake the initial assessment with the consumer to determine the most appropriate level of care and continue to play the central role in the provision and coordination of physical and mental healthcare within the primary care setting. As part of a referral from the GP, children accessing Psychological Therapy Services may have a GP Mental Health Treatment Plan (MHTP) though, the absence of a MHTP should not be a barrier to accessing help. However, if there is no diagnosed mental health disorder, the GP/paediatrician/psychiatrist should document that there is evidence of significant risk that the child will develop a mental health, behavioural or emotional disorder that would benefit from short-term focused psychological strategies.

While a MHTP is not required, communication with the consumer's GP is expected when the consumer has provided informed consent to share information, even where a family self-refers. Although, if the consumer does not provide consent, communication with the GP is not required. Because the GP is central to the consumer's recovery journey, service providers are expected to communicate with the consumer's GP at critical stages of care.

While it is acknowledged that direct communication with GPs may not be possible, at a minimum, providers must communicate with the GP in writing:

- at the beginning of services to communicate:
  - receipt of referral (if relevant)
  - that the consumer is receiving service
  - the type of service being received
- the outcomes of any clinical case reviews
- on conclusion of services or referral/transfer to different level of care or service provider.

Referrals

Children who have, or are at risk of developing, a mental health, behavioural or emotional disorder are generally referred to this program by a GP/paediatrician/psychiatrist. Referrals by other service providers may also occur, but it is important, where consent is provided, to obtain a full assessment by a GP/paediatrician/psychiatrist takes place as soon as possible in the episode of care.

While the IAR-DST Child (5-11) and Adolescent (12-17) are now available online, there is no current requirement for these to be used by commissioned service providers for children accessing this service.

- Referrals can be made by the following professions and clinicians:
- Appropriately trained allied health professionals who are eligible to provide services, including Aboriginal and Torres Strait Islander health workers. ***Note:*** an allied health professional may not refer a child to themselves or to someone employed by the same commissioned service provider
- School psychologists/counsellors or senior staff. Referrals from schools can be made by senior staff members (e.g. 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.

Children aged 13-15 years can access this program for psychological interventions where a child has clinical need and no other suitable mental health services exist in the region, such as a local **headspace** service.

Interventions

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

- attachment interventions
- family-based interventions
- behavioural interventions
- modified CBT interventions (including individual child and family/parent-based)
- parent-child interaction therapy for attachment and behavioural disorders (where expertise is available).

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

Interventions for parents

Evidenced-based psychological interventions for children should routinely include the child in the context of their family, as long as:

- the focus on the intervention is always on the mental health and social and emotional wellbeing of the child
- sessions where the child is not present do not exceed the number of interventions where the child is present (except for parent sessions for children aged under four).

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

Workforce requirements

Commissioned service providers must ensure staff providing these services have the knowledge and skills to work with children. Staff must have a working knowledge of relevant legal and forensic topics, the mandatory reporting of abuse, privacy, confidentiality, and managing risk and safety issues. Commissioned service providers must comply with the Victorian Child Safety Standards and NSW Child Safe Standards where relevant and ensure staff have the relevant Working With Children Check for the service location.

6.3 Assessing and managing suicide risk and self-harm

Suicidal behaviour and self-harm are complex and may occur for people at every level of the IAR-DST. Murray PHN expects all primary mental health service providers to have established procedures to appropriately screen, assess and manage consumers who present with risk of suicide and self-harm. Commissioned service providers must ensure staff are trained in and using risk assessments to assess and manage suicide thoughts and behaviours and self-harm. For providers of Child PTS services, providers must ensure that procedures are appropriate to children and staff are appropriately trained for presentations with that demographic.

Commissioned service providers must have procedures in place to identify consumers where escalation to higher intensity services is indicated, or who may need urgent services due to their risk of suicide.

Murray PHN expects commissioned service providers to have:

- protocols and procedures for screening, assessment and management of suicide risk
- staff who have been trained in evidence-based treatment for people at risk of suicide
- screening and assessment protocols and procedures appropriate to the level and skill of the workforce and the consumer group.

Note: People who are at **high or immediate risk** of suicide should be referred immediately to the relevant area-based mental health service or emergency services. High and immediate risk includes:

- where the person is experiencing current suicidal intention with a plan, intent and the means to carry it out (with few or no protective factors)
- where the person has a long-term history of repeated and life-threatening suicidal behaviour or dangerous behaviour to self or others that is evident in their current presentation
- where there is evidence of current severe symptoms such as psychosis, avoidant behaviour, paranoia, disordered thinking and delusions, with behaviour that poses an imminent danger to self or others
- where there is extremely compromised self-care where the person is in real and present danger and experiencing harm related to these deficits.

Consumers who are vulnerable:

- 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 a GP after a suicide attempt
- People who have expressed suicidal ideation to their GP or other professional
- People presenting with significant situational stressors including, but not limited to, loss or bereavement, relationship breakdown, financial and housing instability, domestic and family violence, and job loss.

In assessing an individual's level of risk, consideration must be given to whether the consumer can be safely managed in the primary care setting, or would be more appropriately referred to and supported by the state or territory acute mental health service.

Initial contact

Individuals who have a high level of suicide risk must have priority access to services and commissioned service providers must make ***initial contact with the consumer within one business day of the referral.*** The initial contact must include a suicide risk screen and the staff member undertaking the initial contact must have the support of clinical leadership to assess and oversee any arising clinical decisions. Where this is conducted by a staff member who is not a mental health clinician, they must be able to escalate to a staff member in the organisation who is.

At the point of initial contact, a consumer with suicide risk must be offered an **appointment within seven days of the referral date** and earlier if indicated. As with all referrals, consumers must be given contact details for emergency services should their mental state deteriorate and they become concerned about their own safety. Commissioned service providers must also inform consumers that they can contact them should their circumstances change.

Occasions of service

It is anticipated that occasions of service for an individual at risk of suicide may be conducted in a condensed timeframe (1-2 months), based on their level of risk and need. Commissioned service providers should routinely consult the consumer and their GP/psychiatrist for the management of suicide risk and facilitate access to any further services required. This may include movement to a lower intensity level of care.

Engaging people with lived and living experience of suicide

People with lived and living 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. People with lived experience can provide valuable insights into suicide prevention services and help to guide suicide prevention planning, treatment and education.

Workforce training for suicide prevention

In line with the expectation that commissioned service providers will have evidence-based approaches and treatment for the prevention and management of suicide, their 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 (Black Dog Institute)
- Collaborative Assessment and Management of Suicide (CAMS)
- Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention
- Question, Persuade, Refer (QPR) Institute
- LivingWorks START

If commissioned service providers need support to improve their risk response guidelines, assessments or procedures for suicide and self-harm, they can approach Murray PHN for assistance in identifying development opportunities.

6.4 Mental health services for Aboriginal and Torres Strait Islander or First Nations Peoples

In this document the terms 'First Nations people' and 'Aboriginal and Torres Strait Islander' describe the same cohort and are used interchangeably. Murray PHN provides Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs) with funding to provide specialist services to support this population (PTS First Nations). Additionally, it is expected that **all** commissioned service providers will provide culturally safe services to First Nations people.

PTS Specialist Services for Aboriginal and Torres Strait Islander people (delivered by ACCHOs)

Murray PHN is committed to commissioning services that strengthen First Nations self-determination and worldviews on health and healing. This enables strong, healthy and vibrant First Nations Communities and best practice models of care.

ACCHOs deliver high-quality and culturally informed primary care services, grounded in local values and holistic understandings of health and healing. Murray PHN acknowledges the critical role of ACCHOs in providing healthcare that best meets the needs of local First Nations Communities.

ACCHOs are not required to use the IAR-DST tool for service delivery and this is not mandated because there is no specific module of the IAR-DST for First Nations people and insufficient research has been undertaken to determine whether this tool is appropriate. However, ACCHOs that consider the tool appropriate in their model of care are welcome to use it.

Murray PHN expects these services to be delivered according to the Social and Emotional Wellbeing Framework set out in the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing, represented by Figure 1 below.

Figure 1 - Social and Emotional Wellbeing model

Murray PHN recognises that ACCHOs hold knowledge about the best way to provide mental health support to First Nations people and therefore provides no specific guidance for the delivery of these services in these guidelines.

Services for First Nation Peoples – general guidance

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing provides strategies and actions to guide commissioned service providers in collaboratively planning and delivering culturally and clinically appropriate mental health services for Aboriginal and Torres Strait Islander Peoples.

All commissioned service providers are expected to offer mental health services to Aboriginal and Torres Strait Islander people in line with program guidelines specific to the funded program streams included in service agreements. The design, establishment and delivery of culturally safe mental health services for Aboriginal and Torres Strait Islander Peoples must consider the following factors:

- high-quality services must be delivered in a culturally appropriate, sensitive and safe manner
- services must be based on Aboriginal and Torres Strait Islander definitions of health incorporating spirituality, culture, family, connection to the land and grounded in community engagement
- support mechanisms must be 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 who are providing services should have the appropriate level of skills, qualifications and experience to deliver services
- Aboriginal and Torres Strait Islander people working in these services should be provided with opportunities to develop the appropriate level of skills and qualifications to deliver services
- non-Aboriginal and Torres Strait Islander staff must undertake cultural safety, humility and competency training such as:
- the Aboriginal and Torres Strait Islander Cultural Competency Course provided by the Centre of Cultural Competency Australia
- the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives Murra Mullangari: Introduction to Cultural Safety and Cultural Humility
- Victorian Aboriginal Community Controlled Health Organisation Cultural Safety Training

Ensuring non-ACCHO services are culturally safe

The Australian Health Practitioner Regulation Agency (APHRA) provides the following definition and description of Cultural Safety:

> *Cultural Safety is determined by Aboriginal and Torres Strait Islander individuals, families and Communities. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.*

To ensure culturally safe and respectful practice, health practitioners must:

- acknowledge colonisation and racism, social, cultural, behavioural and economic factors that impact individual and community health
- acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism
- recognise the importance of self-determined decision-making, partnership and collaboration in healthcare that is driven by the individual, family and community
- foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander Peoples and colleagues.

In ensuring cultural safety in practice, service providers should consider the following *key elements and focus areas:*

KEY ELEMENT 1: GOVERNANCE

Governance structures and mechanisms support a whole-of-organisation approach to embedding cultural humility in all aspects of core business.

Focus areas

- **Leadership:** Those in organisational and team leadership positions demonstrate culturally responsive and safe knowledge, attitudes, behaviours and actions.
- **Governing documents:** A commitment to addressing First Nations health inequity through the provision of culturally responsive and safe service delivery is made visible in organisational governing documents.
- **Policy and practices:** A whole-of-organisation approach to addressing First Nations health inequity through the provision of culturally responsive and safe service delivery is embedded across organisational policies and practices.
- **Resources:** Adequate, appropriate and sustainable resources are allocated for initiatives to meet the needs and improve the experiences of service users.
- **Monitoring and evaluation:** Mechanisms to monitor and evaluate outcomes of strategies, including the identification of barriers and enablers for success are embedded across the organisation to inform continuous quality improvement processes.
- **Data management:** Data is collected, processed and shared in ways that uphold the principles of Cultural Safety and Indigenous data sovereignty and governance.

KEY ELEMENT 2: PARTNERSHIPS

The organisation embeds a commitment to privileging the voices of First Nations Peoples through mechanisms that enable respectful, mutually beneficial and self-determined collaborative partnerships with local Communities.

Focus areas

- **Understanding Community:** An understanding of demographic, health and cultural contexts of local Communities underpins targeted improvements in hearing and meeting the needs of service users.
- **Community collaboration:** The critical role of respectful, mutually beneficial and self-determined collaborative partnerships in meeting Community needs is recognised and reflected in organisational ways of working.
- **Consumer participation:** The voices of those who use the service are empowered and prioritised to inform organisational ways of working.
- **Feedback:** Organisations are culturally responsive in actively, adequately and accurately collecting and responding to feedback from service users and local Communities.

KEY ELEMENT 3: WORKFORCE

The crucial role of a culturally capable health workforce, including First Nations Peoples employed across all areas of service delivery, in meeting the needs of local Communities is reflected in organisational policy and practice.

Focus areas

- **First Nations employees:** Valuing and building a strong First Nations workforce is prioritised through developing culturally responsive recruitment and creating culturally safe workplaces.
- **Non-First Nations employees:** Building the cultural capacities of all non-First Nations employees to work in culturally responsive ways with colleagues, service users and Communities is valued and strategically prioritised.

KEY ELEMENT 4: INCLUSIVE CARE

An organisational commitment to improving the experiences of and outcomes for First Nations service users through the delivery of culturally informed, responsive and safe care is incorporated into policy and practice.

Focus areas

- **Understanding needs:** All employees providing care and services have a well-developed understanding and working knowledge of the individual, Community and population level health considerations for First Nations Peoples.
- **Welcoming environment:** The service provider creates and maintains culturally responsive and welcoming spaces that reflect First Nations cultural values, practices and needs.
- **Identification:** Processes are in place for accurate identification of First Nations service users and information is collected and managed in culturally responsive and safe ways.
- **Communication:** The organisation recognises that culturally responsive communication is the foundation for the delivery of care judged by First Nations Peoples as safe to approach and use.

Holistic care: ***The care/service provided incorporates holistic understandings of the determinants of health and wellbeing, tailored to the service user's needs, preferences and desired outcomes.***

Murray PHN has developed a Cultural Humility Framework, along with a user guide, designed to support organisations in implementing culturally safe practices in line with Murray PHN's Cultural Humility Framework. This is available at: https://murrayphn.org.au/focus-areas/first-nations-health-and-healing/cultural-humility-framework/ Information about implementing culturally safe services can be found at: https://www.reconciliation.org.au/ and https://www.vaccho.org.au/cultural-safety-services/

6.5 Psychological treatment services for people living in residential aged care (PTS in RAC)

Under this priority area, psychological interventions are intended to target people who are residents of aged care facilities - specifically, residents with mild to moderate symptoms of mental distress or a diagnosis of a mental illness (IAR-DST LOC 2 and 3). Residents with severe symptoms of mental illness, or severe mental illness which is episodic in nature (IAR-DST LOC 4), may access this service. However, residents who have severe and persistent mental illness with complex needs are more appropriately managed by a state government Older Person's Mental Health Service, and are not in scope for commissioned service providers.

The essential features of PTS in RAC are:

- in-reach services at the residential aged care facility
- person-centred
- services targeted to residents who have, or are at risk of developing, a diagnosed mental illness with no existing psychological services
- evidence-based, time-limited psychological therapies tailored to the needs of older people
- implemented collaboratively in communication with consumers, the aged care facility, GP and other key stakeholders 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, family or carer, Aged Care Assessment Team clinician or a residential aged care (RAC) staff member. Clinicians must confirm a diagnosis of mental illness 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 required for referral to this program, Murray PHN expects that the ***GP is engaged to contribute to and coordinate the general care plan for each resident.***

Commissioned service providers are expected to ensure that the resident has been assessed for any possible 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 or geriatrician should also be engaged to provide medical diagnosis of mental illness and to ensure that symptoms of cognitive decline, dementia or delirium are not mistaken for mental 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 a referral may be made to begin service provision in anticipation of a formal medical review/diagnosis.

Note: The IAR-DST includes older adults (65 years and older) and from January 2025, commissioned PTS in RAC providers are expected to complete this version of the IAR-DST at the beginning of the episode of care. Commissioned service providers should provide service in accordance with the levels of care outlined in their service agreement and if the IAR-DST indicates a consumer may benefit from a level of care that is out of scope, the provider must proactively facilitate referrals to appropriate services using existing referral pathways.

Interventions

Commissioned service providers may adjust and tailor psychological interventions in the following ways to meet the needs of residents:

- provide additional time to engage with residents because of hearing problems or degree of cognitive decline
- cognitive behavioural therapy may be adapted to the capability of the residents and is not appropriate for residents with significant cognitive decline
- language used in talking to older people must respect the attitudes of older people towards mental illness (the term '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 medical review or formal diagnosis
- fewer and shorter sessions that are less intensive than standard psychological care
- 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
- telephone or videoconference-based therapies, particularly for facilities in rural and remote locations could play a role. 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. Digital mental health services may be less suitable for many older people but should not be dismissed
- therapies that have proven to be effective with older people, including reminiscence therapies, validation therapy and adjusted cognitive behavioural therapy
- liaison with other service providers for consumers with comorbid physical health issues or dementia.

Provision of mental health services to residents with comorbid dementia

Most RAC residents will have some degree of cognitive decline or dementia and they should not be ruled out of receiving mental health services due to this, particularly given that residents with coexisting cognitive decline, anxiety and depression can receive positive benefit from psychological therapy. It is also important that commissioned service providers providing psychological therapies in a RAC environment are familiar with dementia symptoms and management. However, caution should be exercised in referring residents with dementia to psychological services without careful assessment, for the following reasons:

- psychological services will not be able to support the management of significant behavioural issues experienced by residents with dementia
- people with significant cognitive decline associated with dementia may not respond to cognitive behavioural therapy
- referring individuals with dementia treatment needs to a mental health service may delay them receiving more appropriate support to alleviate distress and support the RAC in managing behaviour
- residents whose behavioural symptoms of dementia are affecting their wellbeing and care should continue to be referred to the Dementia Behaviour Management Advisory Service, delivered by Dementia Support Australia.

Workforce

PTS in RAC services commissioned by PHNs are expected to be provided by trained mental health professionals who deliver other mental health treatment services in the community consistent with workforce expectations for IAR-DST LOC 2 and 3, including those from the broader workforce outlined in ***Workforce requirements for IAR-DST levels of care***.

All staff working with people living in residential care settings should also be well briefed on the other services that may intersect with the provision of mental healthcare. These services include personal care and leisure-based activity programs in the aged care facility. Staff delivering PTS in RAC must be provided with opportunities to engage in professional development in this area, such as The Wellbeing Clinic for Older Adults at Swinburne University, which provides online training programs for staff working with older adults.

6.6 Youth Enhanced Services

Service target group

Murray PHN has funded Youth Enhanced Services to ensure that young people with, or at risk of, severe and complex mental illness can be appropriately supported in primary care settings. Severe mental illness is often defined by its duration and level of disruption to daily function 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, drug and alcohol use, poor social supports and contact with the youth justice/out of home care systems. This can be exacerbated through lack of access to appropriate treatment or a reluctance to seek help from mainstream services.

Eligibility

Youth Enhanced Services are designed to target young people aged 12-25:

- with or at risk of a severe mental illness
- who require more support than what primary mental healthcare traditionally provides
- who are unable or unwilling to attend centre-based appointments.

Youth Enhanced Services require matching the intensity and mix of services to the level of need. Some young people may simply require additional services. Others may be better supported with more creative packages of care, or access to a broader range of professional support.

Referral and risk assessment

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

- self-referral
- family or carers
- GPs
- other service providers.

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 must be established. In addition, staff must be skilled in assessment of individuals at risk of suicide, be able to respond in emergency situations and have clear escalation pathways for clinical input and leadership. These procedures and protocols must include ***clear internal and external escalation, and access pathways to crisis and emergency services.***

Service interventions

Youth Enhanced Services interventions will differ depending on the level of care required by the young person. However, at a minimum, interventions must include:

- risk screening and assessment
- comprehensive care planning and review
- integrated mental health counselling and psychological therapies (including one-on-one and family)
- care coordination to support the young person in accessing other appropriate services and follow-up e.g. employment and study, physical and sexual health services
- a minimum of 20 per cent of all occasions of service provided by community outreach
- dee-free access to Youth Enhanced Services.

Service intervention detail

1. Active engagement and community outreach

Commissioned service providers must be flexible when, where and how they 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 community outreach or offsite service delivery should be provided to suit the needs of young people, not the service provider. This may include, but is not limited to:

- meeting at home or a public location such as shopping centre, café or park (where a risk and safety assessment has been undertaken prior)
- meeting the young person at the service provider location and going for a walk
- collecting the young person from their location and beginning interaction in transit to the service location
- telephone or videoconferencing.

Commissioned service providers must have appropriate risk management protocols and procedures for assessing and managing environmental and location risks to ensure the safety of staff and the young person. Active engagement may also need to be preceded by an extended period of rapport building to establish a partnership approach with the young person.

2. Comprehensive assessment

A comprehensive biopsychosocial assessment must be used to:

- determine the 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 commissioned service provider must engage in collaborative care planning with the young person and develop a care plan that meets their needs, identifies goals and strategies, and other required services. 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

The roles and functions performed under the clinical care coordination vary, but may include:

- proactive follow-up for monitoring mental health symptoms and encouraging treatment compliance
- providing psychoeducation to facilitate self-management of mental and physical health concerns, including psychoeducation on appropriate diet, sleep and exercise as foundational for good mental health
- ensuring communication between professionals (including the young person's GP) providing care
- ensuring communication between the young person's significant others (including family members or other key members of their broader support networks) is proactive as required.

Commissioned service providers must coordinate a range of services in response to support the other needs young people may have in their lives. These could include homelessness, school refusal, employment, study, alcohol and other drugs misuse, and family issues. Commissioned service providers should engage a multidisciplinary team of staff who have skills in these different areas.

One central worker should take on a central role in organising and coordinating the different types of care needed, care team meetings, keeping in contact with the young person, and encouraging and supporting them to attend all appointments. The staff member may also work directly with the young person as part of their treatment and safety plan and goals to ensure their needs are met.

5. Psychological interventions

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

6. Workforce scope

To ensure a high-quality standard of service delivery, staff engaged to deliver Youth Enhanced Services must have the appropriate knowledge and skills to provide the range of services required by young people. Murray PHN would expect that staff are skilled to provide all intensity levels of care needs - refer to the section on ***Workforce requirements for IAR-DST levels of care*** for more detail.

headspace services

headspace is Australia's National Youth Mental Health Foundation, providing early intervention mental health services to young people aged 12-25.

headspace services support young people with mental health, physical health (including sexual health), alcohol and other drug services, as well as work and study support. With a focus on early intervention, headspace services work with young people to provide support at a crucial time in their lives, to help get them back on track and strengthen their ability to manage their mental health in the future.

headspace centres in the Murray PHN region are located in:

Albury Wodonga	Bendigo	Echuca	Mildura	Shepparton	Swan Hill	Wangaratta

Murray PHN expects commissioned service providers to collaborate with their local headspace service to ensure timely and appropriate care for young people.