phn MURRAY

An Australian Government Initiative

PRIMARY MENTAL HEALTH
Program guidelines

June 2019

About these guidelines

This document provides guidance for health services commissioned by Murray PHN to provide primary mental health services for people located across the Murray PHN catchment. It outlines the scope of service, clinical obligations and eligibility requirements that are specific to the provision of:

- Psychological Therapy Services (PTS), both generalist and specialist services for specific population groups
- Primary Mental Health Clinical Care Coordination (PMHCCC)

Primary mental health services commissioned by Murray PHN represents part of the overall mental health service system. As such, funded services are expected to ensure that service delivery and care is integrated and coordinated as part of the local service system, which is supported by well-understood referral options and pathways necessary to support the right care for clients at the right time.

These guidelines will be periodically updated, considering feedback and ongoing collaboration with health services, clients and other partners of Murray PHN.

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

Adrian Woodhouse
Mental Health AOD Coordinator
e: awoodhouse@murrayphn.org.au
p: 03 4408 5600

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1. Introduction

The Mental Health Commission's 'Contributing Lives, Thriving Communities' Report in 2014 provided key recommendations for future mental health services in Australia. The Australian Government welcomed the findings and, in its document, the *Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services* (released on the 26 November 2015) it recommended a new approach to primary mental health services within a Stepped Care approach. Consequently, the Commonwealth Government tasked PHNs with commissioning primary mental health services. Two objectives now guide the PHN approach:

- increase the efficiency and effectiveness of primary mental health and suicide prevention services for children and adults with, or at risk of, mental health disorder and/or suicidality
- improve access to the integration of primary mental health care and suicide prevention services to ensure children and adults with mental health disorders receive the right care, for the right reason, in the right place, at the right time.

This is the third version of the Murray PHN Mental Health Program Guidelines (Guidelines). The updated Guidelines have been informed by feedback from clinical leaders in the field, priority areas as funded by the Commonwealth Government of Australia, and additional early soundings with providers and community for the purpose to test, monitor and adapt system changes as required. These guidelines reflect human rights and the social determinants of health at best practice levels and acknowledges the Fifth National Mental Health and Suicide Prevention Plan.

2. Scope of the Guidelines

These guidelines are to be read in conjunction with the Funding Agreements and Deeds of Variation between Murray PHN and the primary mental health service providers. The following services must be provided in line with these guidelines and other legislative requirements and be free of charge:

- Primary Mental Health Clinical Care Coordination (PMHCCC)
- Psychological Therapy Services (General and Specialist).

This document can be distributed to others, in order to ensure there is service and community clarification of the purpose and scope of the mental health service provided within these guidelines. This may include (but not only) allied health providers, GPs, and state government health departments and associated services. It is recommended that health care providers contact either Murray PHN or the local service provider of these services, for information specifically related to eligibility and availability in the local area.

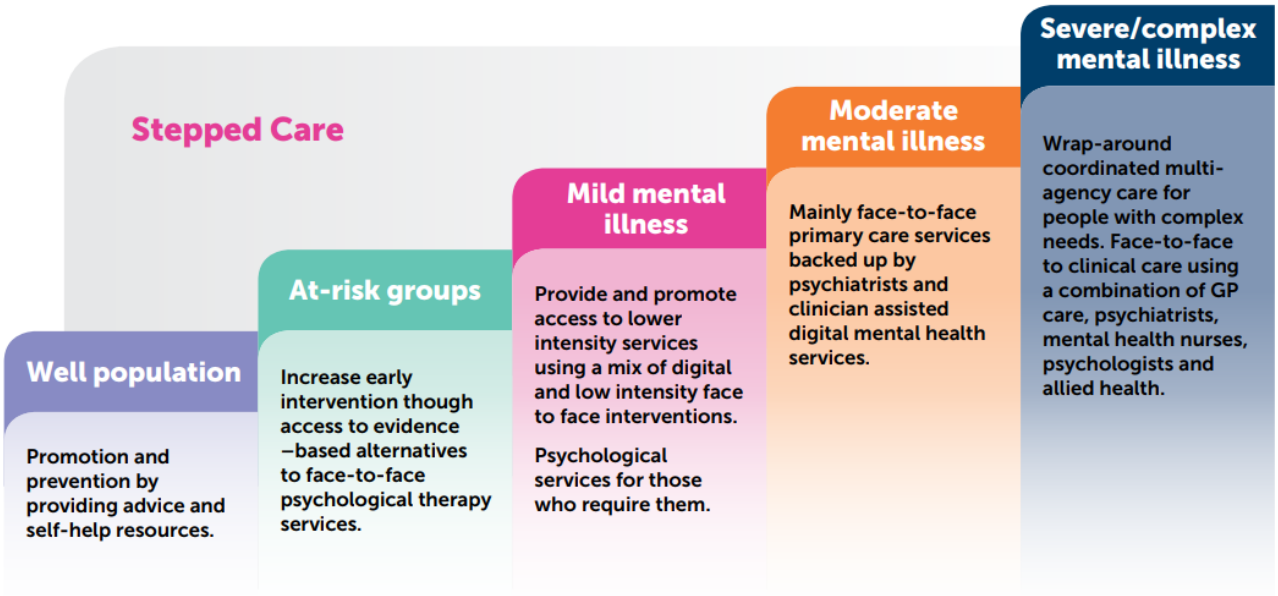
3. Principles for Murray PHN Stepped Care approach

Design and delivery of services within a Stepped Care approach

The Stepped Care approach is an integral aspect of a person-centred, effective and efficient service system. It structures the provision of services so people with mental health disorders, their families, carers and healthcare professionals, are supported to access the most appropriate interventions of their choice.

Stepped Care is a staged system model comprising of a hierarchy of interventions, from least intensive to most intensive, which are regularly reviewed to match with individual's current need or needs. This approach does not operate in silos nor as single directional steps, rather it is to offer an integrated care pathway and people may begin their journey at any step of the pathway, in accordance with their presenting needs.

Figure 1 Stepped Care



Client-centred care

Primary mental health care that is person centred, recognises that illness, health and wellbeing are influenced by a broad range of social, cultural, economic, psychological, and environmental factors at every stage of life. Care is provided within a holistic framework and system that is flexible and draws upon a combination of different interventions and health service partners. Person-centred care acknowledges the person's central role in their care, fostering a sense of responsibility for their own health and promoting self-management. This includes supporting and encouraging the individual to access a range of self-guided tools and resources as alternatives or adjuncts to clinician-led, face to face interventions.

The national guidelines for flexible and locality-based mental health service design recognises the rights of service users and ensures relevance to local communities. There is a mandate for mental health consumer and carer engagement and participation to:

- establish and foster collaborative partnerships with consumers and carers throughout the commissioning cycle.
- apply principles of experience-based co-design, with a focus on a recovery-orientated approach.
- recognise the rights of consumers and carers and seek to recognise and reduce stigma and discrimination in primary health care settings[1].

The voice of service consumers and carers is a fundamental principle of Murray PHN's primary health services. Service providers are expected to work with clients and carers (or other key support person as nominated by the client) through co-design as part of localised service development, delivery, monitoring and evaluation. Services are also expected to be family-sensitive and provide family-friendly environments. The needs of family, especially with dependent children should be considered in service delivery.

[1] PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Consumer and carer engagement and participation, 2015.

Supporting an integrated and coordinated system of care

A Primary Mental Health Care model moves from the solitary provider model to a health care system that involves partnerships across the health and wellbeing service sectors to provide an integrated system of care. It enhances care, improves quality and avoids duplication of effort. The goal being that service providers, working together in developing localised pathways, will use innovative thinking to close systems gaps, reduce inefficiencies and provide holistic practice.
Integration between primary mental health providers, primarily GPs, other mental health clinical services, psycho-social and allied health supports, is necessary to support individual need and planning of integrated and coordinated care to ensure individuals receive the right care, for the right reason, in the right place, at the right time. Primary mental health services providers are expected to:

- design and implement a model of care that is client-centred and is integrated with the local area health system, particularly general practice
- strengthen the primary care service system to provide a broader service coordination and system integration for individuals presenting with mental health related presentations
- support GPs in their role to ensure individuals are referred to, and are in receipt of, the right care at the right time.

The role of the general practitioner in the Stepped Care approach

General practitioners (GPs) are key to the Stepped Care approach and will be responsible to undertake the initial assessment to determine the most appropriate treatment response. They provide the clinical leadership, in collaboration with their client and other identified key parties, to support recovery through an integrated (multiple resource/s as appropriate) client plan.

Team-based shared care

An individual, in receipt of mental health interventions, should expect to have access to a range of services, as required according to their specific needs, within a Stepped Care approach. This would include access to professional disciplines such as: GPs, psychiatrists, mental health nurses, psychologists, counsellors, social workers, occupational therapists, educators, employers, vocational support workers, housing support workers, other allied health and/or community support workers, peer workers, carers, family and/or friends.

PTS and PMHCCC will both provide services within a Stepped Care approach that relies on health care partners providing a range of teams-based shared care services. This is to be a comprehensive and collaborative intervention that may also include virtual/digital elements that allows flexibility in access for those who may have service access issues and allows broader potential for individuals to have different opportunities related to funding sources, and to optimise their integrated care.

Organisations are encouraged to consider integrated models that use existing service structures and blended funding streams and models including the Medicare Benefits Scheme (MBS).

It is expected that a range of complementary skills and clear scope of practice will exist within each Stepped Care team-based share approach. This team-based approach strengthens clinical governance through the inclusion of regular peer support, clinical supervision, reflective practice and team clinical case review.

As a support to this team-based, shared care approach, Murray HealthPathways is a dynamic decision enhancement tool providing local referral pathways. Murray PHN HealthPathways is systematically refreshed and published with input from local clinical teams and working groups. It supports clinical practice, care coordination and other service elements in team-based models of shared care.

Cultural safety

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 is an important part of ongoing reform to the mental health system and interconnected with many strategic responses to Aboriginal and Torres Strait Islander peoples' health[2]. Services must work under this framework and ensure they have a clearly articulated strategy for providing cultural safety in the delivery of services for Aboriginal and Torres Strait Islander peoples.

Services for the CALD communities must be delivered in keeping with the statement by the Australian Government Department of Health. Services for lesbian, gay, bisexual, transgender and intersex (LGBTI) are delivered in keeping with the with the statement by the Australian Government Department of Health.

Rural and remote

Many areas within Murray PHN are classified under the Modified Monash model as MM5. This describes areas that have a population less than 5,000. MM5 areas are considered as rural/remote for the purposes of eligibility for PTS and PMHCCC.

Local service delivery

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

Evidence-based practice

Evidence-based practice (EBP) is 'the integration of best research evidence with clinical expertise and client values' which, when applied by practitioners, will ultimately lead to improved client outcomes.

Treatment decisions need to be based on evidence and guidelines supported by clinical research and Australian standards of mental health practice, such as:

- Standards of Practice in Mental Health Nursing 2010: acmhn.org/publications/standards-of-practice
- National Practice Standards For The Mental Health Workforce 2013: health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-wkstd13
- Fifth National Mental Health and Suicide Prevention Plan 2017: coaghealthcouncil.gov.au/Publications/Reports

[2] National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023, Commonwealth of Australia 2017

4. Clinical governance and practice guidelines

The Australian Commission on Safety and Quality in Health Care (ACSQHC) describe clinical governance as the set of relationships and responsibilities established by a health service. It ensures that the community and health service can be confident that systems are in place to deliver safe and high-quality health care and continuously improve the quality and safety of care provided to clients. Murray PHN requires all funded services to comply with clinical governance obligations set out in the Funding Agreement and to provide continuous assurance of the quality of care.
Service providers are expected to apply the Victorian Clinical Governance Framework (2017) that describes the integrated systems, processes, leadership and culture that are at the core of providing safe, effective, accountable and person-centred healthcare, underpinned by continuous quality improvement. They are also required to operate within the national registration requirements, codes of conduct, competency standards, supervision and other professional requirements of all disciplines they have recruited to provide the interventions of PTS and PMHCCC under contract with Murray PHN.

With reference to PTS and PMHCCC services, it is expected that funded services clinical governance framework will solidify clinical roles and responsibilities with clear, evidenced clinical accountability, with some practical examples being:

- storage and sharing of client records/notes
- regular case conferencing (weekly or more frequently) of a sample of all clients managed
- three monthly review of care plans
- medical practitioner's regular review of their clients during appointments for medication management and other physical care needs.

The assurance that funded services are practicing within sound clinical governance parameters is critical to ongoing collaboration with Murray PHN. This will be supported by Murray PHN through its provision of regular clinical governance reviews of all its commissioned service providers.

A person-centred, stepped care approach, needs to be provided in an organised and planned approach, using evidence-based and systematic methodology that is clinically and ethically delivered. Relevant clinical, and professional discipline guidelines for the treatment of specific presenting mental health disorders signs and symptoms is mandated.

The following links provide additional resources and describe the standards of practice and clinical governance oversight that is required by all health services funded by Murray PHN:

- The Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines: ranzcp.org/publications/Guidelines-and-resources-for-practice
- Australian College of Mental Health Nurses Standards of Practice in Mental Health Nursing 2010: acmhn.org/publications/standards-of-practice
- The Australian Association of Social Workers Practice Standards 2013: aasw.asn.au/practitioner-resources/practice-standards
- The Occupational Therapy Australia (OTA): aota.org/About-Occupational-Therapy/Professionals/MH.aspx
- National Practice Standards for the Mental Health Workforce (2013): health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-wkstd13
- The Fifth National Mental Health and Suicide Prevention Plan (2017): coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf

5. 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 general practitioners and local services who support vulnerable populations is expected. Individual client needs must be considered within a Stepped Care approach.

Referral, intake tools and clinical practice guidelines and protocols must be added to ensure that:

- individuals are referred to appropriate services
- resources are effectively targeted within the service area
- duplication is avoided
- expected levels of demand are effectively and actively managed.

To support timely and appropriate referral, Murray PHN has developed Murray Health Pathways. It is a free, web-based portal available for clinicians to plan, manage and coordinate clients care through primary, community and secondary health systems across the Murray PHN catchment area. Specific and localised mental health pathways are available via Murray HealthPathways to support integrated and quality care for clients.

In entering into a funding agreement with Murray PHN, health services agree to support a collaborative approach in which service providers can:

- collaboratively provide interventions for those referred for PTS or PMHCCC
- collaboratively support GPs seeking assistance to navigate the level and type of services available.

6. Referral source and Mental Health Treatment Plans

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 individual should be restricted from the program due to the absence of a MHTP. Where there is no MHTP, the service provider will 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).

Where a person has been referred to PTS because they are at risk of, or have attempted, suicide or self-harm, a MHTP is not required.

A MHTP is required for children even if a diagnosis of a mental health disorder is not provided. But the referring practitioner should document that the child is assessed as being at risk of developing a mental disorder in the MHTP.

Referral for initial interventions (assessment process), for children still attending school, can be provisionally provided by the Principal of the school a child is attending but a MHTP will still be required for continued interventions.

7. Managing demand

Service providers must have an appropriate demand management strategy and processes in place to manage access and clinical risks for individuals referred to them. The demand management strategy must include:

1. regular review of all referrals including screening for appropriateness and level of risk
2. a timely, i.e. within six weeks from initial contact, mental health assessment must be conducted to determine the level of clinical intervention need of each client, until this occurs the client is to remain on the service providers waitlist and in receipt of active waitlist management by the service provider as described in point number three below
3. active management of the waitlist is mandatory. Active management is demonstrated through regular monitoring of all clients waiting for the initial mental health assessment. Contact with, and clinical monitoring of, the client while on a waitlist must be recorded in the Client data system, on a fortnightly basis, and must also include regular communication with the referrer
4. clients can only be removed from the waitlist on completion of the mental health assessment and creation of an intervention plan. Fortnightly review contact is to be maintained until the planned intervention is commenced.

8. Waitlist detail

Individuals who are placed on a waitlist are to be recorded on the client database reporting platform provided by Murray PHN. This includes recording all contacts with the client while on the waitlist.

Service providers need to also consider alternate support service options such as e-mental health (e.g. Mindspot) and tele-psychiatry during wait periods.

All clients on the waitlist must have fortnightly monitoring until a comprehensive clinical assessment is conducted to establish the required level of care and the appropriate timeframe for the individual to receive an intervention within the Stepped Care approach. At the time of initial contact and subsequent triage assessment clients are to be advised that should their situation change while on the waitlist, they need to promptly contact the service provider.

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

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

It is noted, that in some instances, local arrangements may require the GP to maintain the clinical oversight of a client rather than add the client to a waitlist. In these situations, this demand management procedure would not apply and would only become applicable when the client is added to the waitlist.

9. Referral outcomes

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

a) referral accepted and service available
b) referral accepted, service not available and individual placed on a waitlist
c) referral not accepted, and assistance provided for potential alternative interventions.

10. Service approaches

10.1 Recovery-oriented goal planning

The recovery-oriented goal plan developed to support the promotion of recovery from a mental health disorder, is underpinned by the National Framework for Recovery-Oriented Mental Health Services 2013: health.gov.au/internet/main/publishing.nsf/content/67d17065514cf8e8ca257c1d00017a90/$file/recovgde.pdf

10.2 Shared care health records

Service providers are encouraged to:

a) register to participate in the My Health Record system at myhealthrecord.gov.au My Health Record is a secure online summary of an individual's health information and aids communication for the person and their care team
b) advise, and support, individuals referred to them to use the personally controlled My Health Record
c) electronic shared care tools are also encouraged for consideration by the service provider and their stakeholders to optimise shared care arrangements.

10.3 Delivery modalities

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

- face to face i.e. in clinics, individual/family homes, or other community-based settings
- telephone
- video conferencing
- digital mental health.

10.4 Digital resources

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

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

- head to health (the national digital mental health gateway): headtohealth.gov.au/
- e-mental health in practice: eMHprac.com.au

10.5 Crisis support

The service provider must ensure there is an after-hours crisis support mechanism in place for individuals who are provided with treatment, and for the allied health professionals who provide treatment. Appropriate after-hours crisis support contact numbers and details are to be provided for each individual accessing PTS and PMHCCC.

10.6 Intervention data and reporting

The Australian Government's Department of Health has established the Primary Mental Health Care – Minimum Data Set (PMHC-MDS). The PMHC-MDS requires providers to capture client and service delivery data.

The PMHC-MDS provides the basis for PHNs and the Department of Health to monitor and report on the quantity and quality of service delivery, and to inform future improvements in the planning and funding of primary mental health care services funded by the Australian Government. All mental health commissioned services must report service activity as defined by the PMHC-MDS. You can find more details about this at: pmhc-mds.com

Murray PHN has a client management system (FIXUS) to capture client reporting data. All commissioned services are required to report PMHC-MDS activity through Fixus. Murray PHN User guides to Fixus are available on our website: murrayphn.org.au/primary-mental-health-services

10.7 Consent and privacy

Consent to treatment

The service provider must obtain Informed consent from an individual and/or their legal guardian before any intervention is commenced. The service provider must ensure that, when obtaining and documenting consent to services, it is done so in accordance with legislation and best practice. Gaining informed consent should be supported through the service providers safety and quality systems across all areas of the organisation to ensure that specific consent requirements are established in keeping with state and territory legislation, such as the mental health acts (National Safety and Quality Health Service standards, 2018).

Consent to share information

Service providers must ensure that permission is obtained from individuals and/or their legal guardian in receipt of their services before sharing any information about them. This includes sharing de-identified information with Murray PHN and with the Department of Health. Resources about consent and privacy are available for individuals receiving services, and service providers, on the Murray PHN's website.

10.8 Measuring clinical outcomes

Outcome measures should be used as clinical tools to establish a benchmark and track an individual's progress. The PMHC-MDS mandates the Kessler Psychological Distress Scale K10+ (in the case of Aboriginal and Torres Strait Islander people, the K5) as well as the Strengths and Difficulties Questionnaires when working with children and youth.

One of these three outcome measures should be used at a minimum at the beginning and end of service but should be considered more frequently from a clinical perspective particularly if there is a sudden or marked change in presentation and mental state.

10.9 Feedback and complaints

Service related feedback, complaints and compliments are a valuable resource and should be encouraged in all aspects of the service. Service providers are required to seek feedback from individuals in receipt of their care - as detailed by Murray PHN and the Department of Health.

Service providers are to have a client feedback mechanism in accordance with section 1.16 of the National Standards for Mental Health Services (page 8), "The MHS upholds the right of the consumer to express compliments, complaints and grievances regarding their care and to have them addressed by the MHS": health.gov.au/internet/main/publishing.nsf/content/CFA833CB8C1AA178CA257BF0001E7520/$File/serv1.pdf). The Your Experience of Service (YES) Survey, is an example of a useful tool to do this. This mechanism is to be explained to all clients and augmented with a plain English brochure. The brochure is also to be provided, as appropriate, in other languages.

10.10 Service evaluation and continuous improvement

Funded services will collaborate with Murray PHN by contributing to information exchange and building knowledge about the characteristics of the health service system, community context and population health outcomes that inform and are influenced by the proposal. Monthly dialogue with successful bidders is an important process for Murray PHN to work with the service system and build shared knowledge and accountability for innovation, quality and system improvement. Performance and effectiveness indicators comprise an important part of the ongoing dialogue as does also the Quadruple Aims as outlined in the Murray Health Systems framework, namely improved:

- population health outcomes
- individual experience in receiving PTS or PMHCCC
- workforce health and sustainability
- cost per capita.

Collaboration with Murray PHN is supported through the commissioning principles that recognises the value of enduring partnerships with the health service system and our shared accountability for innovation, quality and system improvement. By entering into an agreement with Murray PHN, funded services will:

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

11. Stepped Care Service Provider obligations

11.1 Service providers

Murray PHN will commission suitably qualified service providers to deliver services, through a transparent and robust procurement process. Service providers may include:

- general practice
- private psychiatry practices
- private and non-government organisations (NGOs) mental health services
- Aboriginal and Torres Strait Islander primary health care services
- community health services
- public health services.

11.2 Corroboration of organisational obligations

To ensure a high-quality standard of service delivery, staff engaged to deliver services under Primary Mental Health should be:

1. appropriately qualified according to the requirements of their role and scope of practice
2. registered by an appropriate state or national authority to practice (where state or national registration exists)
3. members of a professional body with ethical and professional guidelines, and accountability and disciplinary procedures for dealing with malpractice, incompetence and unethical behaviour and agree to abide by their profession's Code of Ethics and Code of Conduct
4. demonstrated experience in the field of mental health with appropriate professional credentialing/endorsement
5. evidencing continuing involvement in relevant professional development in accordance with registration and professional association requirements
6. available to provide services within an agreed geographic region
7. satisfying all standards outlined in their professional disciplines' relevant practice standards or competency standards requirements.

Service providers employing staff or using sub-contractors must confirm the qualifications, experience and professional standing of personnel to deliver services as per the Standard Terms for Murray PHN Funding Agreement; in line with the Victorian Clinical Governance Framework; compliant with the Murray PHN Program Guidelines and the National Quality and Safety Standards for health services (second edition, released November 2017).

11.3 Required workforce qualifications and skills

Allied health professionals including psychologists, credentialed mental health nurses, accredited mental health occupational therapists, and accredited mental health social workers are eligible to provide focused psychological strategies under either PTS or PMHCCC.

Allied health professionals must be:

- registered/professional membership and be credentialed in the field of mental health
- meet the required qualifications and standards to provide the specified therapies including continuing professional development requirements.

To competently provide focused psychological strategies allied health professionals must also have appropriate:

a) competent level clinical and psycho-biosocial knowledge (including the theory underpinning evidence-based interventions, and research into their effectiveness)
b) competent level skills (in delivering best mental health practice, and evidence-based mental health interventions)
c) independent practice level experience (minimum one year **except for** Specialist Children and Suicide Prevention with two years of experience being required) in assessing and treating individuals with the range of mental health problems.

Service providers must ensure their staff have ongoing professional development and maintain currency of practice in line with up-to-date and latest evidence, treatment modalities, professional discipline practice requirements and professional discipline registration and practice requirements. This must include regular Clinical Supervision that is in keeping with the professional and accreditation/registration requirements of their specific professional discipline.

Provisional/intern psychologists and new graduate allied health professionals

Murray PHN supports the use of provisional/intern psychologists and graduate allied health professionals under direct supervision in the delivery of focused psychological strategies. Murray PHN recognises the important role provisional/intern psychologists and graduate allied health professionals play in providing services where it is sometimes difficult to attract workforce.

While the use of provisional/intern psychologists, and all new graduates i.e. nursing, occupational therapist, social worker, is important as it allows for entry of newly trained persons into the field of mental health, this must occur under the direct professional supervision of a fully qualified and accredited mental health professional with a minimum of two years' experience in the mental health sector. The definition and requirements of direct professional supervision will vary for each allied health profession and should be guided by the relevant professional standard/s of each discipline.

Provisional/intern psychologists, nurses, occupational health therapists or social workers still completing mental health post graduate credentialing or accreditation programs, are permitted to work in all areas of PTS (apart from PTS – Child Mental Health) and PMHCCC but must have a more experienced mental health credentialed/accredited clinician (i.e. minimum two years) co-managing their case load.

Service providers must ensure that provisional/intern psychologists and graduate allied health professionals engaged to deliver focused psychological strategies have the appropriate levels of insurance which allied health professionals are required to have prior to delivering focused psychological strategies under primary mental health and have a co-case manager allocated to their caseload).

It is important that case complexity is considered in the allocation of individuals and groups to provisional/intern psychologists and graduate allied health professionals and that regular (minimum of monthly) clinical supervision is provided.

11.4 Standards of practice

In providing the service, an organisation must maintain practice consistent with standards articulated in the National Standards for Mental Health Services 2010, the National Practice Standards for the Mental Health Workforce 2013, the Murray PHN Mental Health Program Guidelines and all other relevant standards and legislative/regulatory requirements and within the Victorian Clinical Governance Framework.

11.5 Clinical supervision and clinical governance

Commissioned services will ensure that all client services are provided by suitably qualified clinicians and that organisational clinical governance systems are in place to attest to the quality and safety of services provided to the client. This includes regular, scheduled clinical supervision time between service delivery clinician and a senior clinician. Clinical supervision is critical for ensuring that services delivered by mental health practitioners have the required clinical governance for them to provide services of best practice, and to support the mental health practitioners to maintain personal and professional resilience and wellbeing.

Clinical supervision should be provided in keeping with the Victorian Clinical Governance Framework and the requirements of the mental health practitioners professional discipline standards of practice, for example please see the Victorian Office of the Senior Psychiatric Nurse Clinical Supervision Framework for Mental Health Nurses: health.vic.gov.au/mental-health/chief-mental-health-nurse/clinical-supervision-framework and the Australian Association of Social Workers: aasw.asn.au/document/item/6027

All commissioned services are required to maintain appropriate clinical governance and quality assurance arrangements in accordance to an established clinical governance framework or policy. Clinical governance systems and practice will meet the Victorian Clinical Governance Framework (2017): health.vic.gov.au/about/publications/policiesandguidelines/Delivering-high-quality-healthcare-Victorian-clinical-governance-policy and the National Safety and Quality Health Service Standards: safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf in the delivery and oversight of health services commissioned by Murray PHN.

12. Primary Mental Health Clinical Care Coordination

12.1 Service aims

Primary Mental Health Clinical Care Coordination (PMHCCC) is for individuals with persistent and severe mental illness who require clinical support within a team approach. These individuals are not to be currently in receipt of interventions from state level area mental health services.
The PMHCCC has the following aims:

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

12.2 Workforce scope for primary mental health clinical care coordination

A credentialed mental health nurse (through the Australian College of Mental Health Nurses) is a required team member for the provision of PMHCCC. Other clinical team members can include the following disciplines with current professional registration, mental health credentialing /endorsement:

- accredited mental health social worker
- accredited mental health occupational therapist
- psychologist
- mental health support facilitators.

Examples of other Stepped Care team members that can be included:

- exercise physiologist
- dietician
- mental health peer worker (the development of a peer worker role is encouraged)
- or other disciplines as required to address identified client need with the Stepped Care approach.

Please note:

- all team members are required to work within their role and scope of practice as per their relevant professional/discipline specific scope of practice
- provisionally registered allied health professionals are not to independently provide services for suicide prevention, children or people with a severe mental health disorder.

12.3 Functions of the PMHCCC service

Providing clinical care coordination and maintaining a therapeutic relationship for individuals with a severe mental health illness by:

- establishing a therapeutic relationship
- undertaking a comprehensive mental health assessment (including a risk assessment) at commencement of service, the three-monthly clinical review and referral onward
- liaising (with appropriate consent) with family, carers, employers, educators or other key supports
- regularly reviewing the individuals mental state and intervention plans to identify any potential or emerging risk to client or others
- supporting the individual and GP/psychiatrist with medication management
- actively monitoring physical health care and providing onward referrals, information and strategies to support improved physical health outcomes.
- shared care planning and coordinating services
- maintaining links and undertaking case conferencing with general practitioners (GPs), psychiatrists and allied health workers, including psychologists, mental health occupational therapists and accredited mental health social workers (health professionals may be eligible to claim case conferencing items under the MBS where they have a Medicare provider number)
- assisting with onward referrals
- providing links of programs established to support individuals with complex mental health illness and other needs, for example Partners in Recovery, NDIS and Personal Helpers and Mentors Service
- assisting with connections to local community activities and groups to optimise meaningful activity.

A minimum expectation of clinical care coordination includes:

- a MHTP that includes assessment, recovery goals and care plan
- clinical assessment and monitoring, including medication management and three-monthly assessment and monitoring with regular case review
- referral and care coordination
- a physical health assessment and plan
- discharge planning.

12.4 Service entrance criteria

To be eligible for PMHCCC, each of the following criteria must be met:

- diagnosis of a mental illness according to the criteria defined in the World Health Organisation Diagnostic and Management Guidelines for Mental Health Disorders in Primary Care: ICD 10 Chapter V Primary Care Version, or the Diagnostic and Statistical Manual of Mental Health Disorders - Fifth Edition (DSM-5) that is significantly impacting on social, personal and work life
- individuals who are **not** 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. It aims to provide referral pathways for GPs or other approved professionals to better support their clients in the primary care setting
- hospitalisation at least once for treatment of a severe and persistent mental illness, or at risk of needing hospitalisation in the future if appropriate treatment and care is not provided
- permission for referral to the program has been provided by the individual being referred.

12.5 Priority populations

Individuals from the following groups, and who have been diagnosed with severe and persistent mental illness, have been identified as under serviced and at-risk of potential barriers to accessing access:

- people experiencing, or are at risk of, homelessness
- culturally and linguistically diverse (CALD) communities
- Aboriginal and Torres Strait Islander people
- people with intellectual disability
- referral pathways should consider these priority populations to assist with service access as such referrals may be more challenging.

12.6 Treatment planning and monitoring

A Team Care Plan that is based on the MHTP should be developed within the first month of the service. The development of this plan should include the individual receiving the intervention, any nominated supports, the GP/psychiatrist and the team members.

The involvement of the GP or psychiatrist in the Team Care Plan could be facilitated through:

- the use of chronic disease management (CDM) MBS items[3]
- the use of the four-week MHTP review MBS item.

The format of the Team Care Plan could use the CDM Team Care Arrangements (TCAs) templates. The care plan should include:

- participation of clinician, the individual receiving the intervention and any others involved (i.e. service provider/carer)
- agreed levels of contact that meet the individual's clinical requirements (this may include telephone contact)
- recovery oriented goals
- responsibilities of the clinician and the individual receiving the intervention
- plan for three monthly clinical case review.

12.7 Interventions

It is expected that a range of interventions are provided by the care team within the scope of the PMHCCC program and Stepped Care approach. Examples of these interventions are listed below – they are to be considered for individual and/or group settings:

- psycho-education
- liaison and support for the individual accessing the service, potentially including: family, carers, employers, educators and/or other professionals
- medication management
- liaison, networking, collaboration and managing referral to other services
- advocacy
- addressing/managing co-occurring conditions
- peer support.

[3] Chronic Disease Management MDS Items: *health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement*

Focused psychological strategies including:

d) acceptance and commitment therapy
e) cognitive behavioural therapy
f) dialectical behaviour therapy
g) brief solution focused therapy
h) motivational interviewing
i) narrative therapy
j) trauma informed and responsive approaches
k) suicide prevention strategies such as safety plans
l) physical health assessment and intervention.

Physical health assessment and intervention

The integration of physical health and mental health is a key element of this service. The Physical Health Assessment Tool and the Physical Health and Overall Wellbeing Resource Book have been developed through Murray PHN's Partners in Recovery program and should be used within this service. These resources are located at: murrayphn.org.au/primary-mental-health-resources

Levels of support

The service would be expected to assist individuals who require varying levels of support that fall broadly into two areas:

Monitoring: this area includes individuals with severe and persistent mental illness whose clinical symptoms are well controlled but who would be at risk of relapse without ongoing clinical monitoring.

Regular support: this group will have active symptoms which can only be well controlled with regular clinical contact and need close monitoring to prevent deterioration. This may include those who have persistent or fluctuating clinical symptoms, despite active treatment and are at risk of hospitalisation or further deterioration if not actively managed.

Clinical case review

Treatment plans should be reviewed every three months within a clinical case review process. A clinical case review involves an all of team review including the individual in receipt of the intervention and his or her nominated supports, the GP/psychiatrist and other team members.

The service provider must provide regular reports to the GP/psychiatrist following any clinical case review, subject to the consent of the individual in receipt of the intervention.

Organisations are expected to have an effective clinical case review framework that is supported by effective clinical supervision within the Victorian Clinical Governance Framework (2017)[4] as detailed in the clinical governance section of these guidelines.

Clients that are inactive for 12 months must be clinically reviewed immediately for forward planning and potential discharge.

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[4] Victorian Clinical Governance Framework, State of Victoria, Department of Health and Human Services, June 2017: *health.vic.gov.au/about/publications/policiesandguidelines/Delivering-high-quality-healthcare-Victorian-clinical-governance-policy*

Exit criteria PMHCC

Support provided under PMHCCC are for individuals with severe and persistent mental illness experiencing periods of significant disability. Individuals should exit the program when they no longer require the level of support as outlined in this document.

To ensure best practice in service demand management, the service provider must undertake a periodic (recommended 3 monthly) clinical review to identify those who no longer meet the Guidelines for receiving the service. An individual's episode of care will conclude when:

a) he or she has achieved the recovery goal's and/or is not presenting with mental illness signs and./or symptoms that are significant disabling social, personal and occupational functioning
b) no requirement for clinical services of the program.

13. Shared care with Specialist Clinical Services

If the needs of the individual in receipt of the intervention increase so that they require support from Specialist Clinical Mental Health Services (Area Mental Health), clinical care responsibilities are transferred. But linkages with the PMHCCC provider should be maintained for service continuity and to support effective discharge planning.

14. National Disability Insurance Scheme (NDIS)

The NDIS provides psychosocial support for people living with a disability. Participants of the NDIS are not precluded from receiving PMHCCC.

15. Psychological Therapy Services - Generalist and Specialist

15.1 Service aims

PTS services provide support for clients with low to moderate needs that require brief psychological interventions.

PTS has the following aims:

- produce better outcomes for individuals with mild to moderate level mental health disorders, by providing evidence-based, short-term psychological interventions within a primary care setting
- target services for those individuals requiring primary mental health care who are not likely to be able to have their needs met through Medicare-subsidised mental health services
- complement other fee-for-service programs and address service gaps involving rural, remote and other underserviced geographical areas and populations
- offer referral pathway options for general practitioners (GPs) to support them in accessing primary mental health care options
- offer non-pharmacological approaches for the presentations of individuals with mild to moderate level mental health disorders
- promote an integrated, multi-discipline, intervention approach based upon the Stepped Care approach to support individuals with mild to moderate level mental health disorders.

15.2 Functions of the service

PTS is a primary mental health service funded by the Australian Government Department of Health to enable access to effective primary health-initiated interventions. It is provided at no cost to the recipients with a mental health disorder presenting at a mild to moderate level of severity, and who may otherwise not be able to access such services.

15.3 Workforce scope for Psychological Therapy Services

A credentialed mental health nurse with the Australian College of Mental Health Nurses is highly recommended to be a team member for the provision of PTS programs.

Other clinical team members can include the following disciplines (They must hold current professional registration, mental health credentialing /accreditation/endorsement):

- accredited mental health social worker
- accredited mental health occupational therapist
- psychologist.

In keeping with client need, other Stepped Care team members can include:

- exercise physiologist
- dietician
- mental health peer worker (the development of a peer worker role is encouraged)
- or other disciplines as required to address identified client need with the Stepped Care approach

Allied health professionals including psychologists and credentialled mental health nurses, accredited mental health occupational therapists, and accredited mental health social workers can deliver services under the *PTS General* and the *PTS Specialist* program streams.

Aboriginal and Torres Strait Islander health workers can deliver services under *PTS - Aboriginal Torres Strait Islander* program stream in keeping with their qualification.

Specialist training requirements must be met for the provision of PTS Specialist programs relating to child mental health.

15.4 Priority populations

The following population groups are included as requiring additional support to access PTS:

- individuals experiencing, or are at risk of, homelessness
- culturally and linguistically diverse (CALD) communities
- Aboriginal and Torres Strait Islander people
- individuals with intellectual disability
- individuals who have attempted, or who are at risk of, suicide or self-harm (but not acute or at immediate risk) are also considered eligible for PTS
- individuals who experience barriers in accessing Medical Benefits Schedule (MBS) based psychological intervention
- residents in residential aged care facilities.

PTS referral pathways should consider the potential service access challenges of these population groups when planning client access strategies.

16. PTS streams (Generalist and Specialist)

16.1 Generalist PTS

These services are targeted to the following cohorts:

- individuals aged 12 years or older
- individuals who are less able to pay fees
- individuals living in rural and remote communities
- individuals experiencing, or at risk of, homelessness
- culturally and linguistically diverse (CALD) communities
- individuals with intellectual disability.

16.2 PTS Specialist

Specialist PTS are provided for these population groups as they are identified as being of significant need:

- PTS Child Mental Health - for children under the age of 12 years with, or at risk of developing, a mental health disorder
- PTS Aboriginal and Torres Strait Islander - for Aboriginal and Torres Strait Islander people with, or at risk of, a mental health disorder
- PTS Suicide Prevention - for individuals who have self-harmed or attempted suicide or are at risk of suicide
- PTS Perinatal Depression – for women with perinatal depression
- PTS Residential Aged Care Facilities (RACF), for RACF residents with presentations of mental illness.

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. It aims to provide referral pathways for GPs or other approved professionals to better support their clients in the primary care setting.

Those who are at acute or immediate risk of suicide or self-harm, or who have a severe and persistent mental health disorder should be referred to the emergency department of an appropriate hospital (if available) or relevant state/territory government acute mental health service or a psychiatrist.

16.3 Service entrance criteria – PTS Generalist and Specialist

To be eligible for PTS General and Specialist, individuals need to have a clinical diagnosis of a mental health disorder. The definition of a mental health disorder is based on the Department of Health's Better Outcomes in Mental Health Care Program:

> *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 strategies services that PTS General and Specialist provides are designed for individuals with mental health disorders with a mild to moderate level of severity. However, individuals with a 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 general practitioners to diagnose individuals, assess whether they would benefit from a short-term psychological intervention and if so, when referring to a PTS, document that diagnosis into the MHTP.

Additional specific eligibility criteria for PTS Specialist relates to need for the individual being referred into a Specialist stream having the clinical, age and/or cultural connection to the set streams: Children (under 12 years), residents of RACFs, Aboriginal and Torres Strait Islander, women with perinatal mental health issues and suicide prevention.

16.4 Mental Health Clinical Interventions for PTS General and Specialist (other than children)

The services covered are psychological interventions that have demonstrated the best research evidence of clinical effectiveness for short term treatment of mental disorders, such as cognitive behavioural therapy. These interventions (focused psychological strategies) include, in individual and/or group mode:

- psycho-education
- advocacy
- peer support
- acceptance and commitment therapy
- cognitive behavioural therapy, including:
  - Behavioural interventions
  - Behaviour modification
  - Exposure techniques
  - Activity scheduling
- interpersonal therapeutic strategies (especially for depression)
- dialectical behaviour therapy
- brief solution-focused therapy
- motivational interviewing
- skills training
- problem solving skills and training
- anger management
- social skills training
- communication training
- stress management
- parent management training
- interpersonal therapeutic strategies (especially for depression)
- narrative therapeutic strategy
- trauma-informed and responsive approaches
- relaxation and mindfulness strategies (including progressive muscle relaxation, controlled breathing)
- suicide prevention strategies such as Safety Plans (e.g. Beyond Now by beyondblue)
- physical health assessment and intervention
- liaison, collaboration and managing referral to other services.

It is clear from the recommended list of evidence-based, focused psychological interventions that all allied health professionals must have undertaken rigorous training and be competent in the delivery of these therapeutic techniques when providing interventions for individuals with mental health disorders.

16.5 PTS Aboriginal and Torres Strait Islander people

PTS Specialist – Aboriginal and Torres Strait Islander is designed 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 psychological strategies services, up to 12 service contacts annually (subject to consultation with Murray PHN should a clinical review indicate a need for additional service contacts). Consideration will also factor whether the individual is more appropriately supported by the state or territory acute mental health service or a more appropriate, alternate service provider.

The short term, goal oriented psychological strategies services that PTS provides are of most therapeutic value for individuals with common disorders, such as anxiety and depression, of mild to moderate severity. The services are not intended to provide long-term intensive treatment and support, and organisations should ensure individuals accessing the service and other stakeholders are aware of this intention. This can include individuals with a more severe mental health disorder and for whom it is considered that short-term focused psychological strategies services would be of benefit.

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

16.5.1 Interventions PTS Aboriginal and Torres Strait Islander people

The guiding principles which should underpin the design, establishment and delivery of PTS – Aboriginal and Torres Strait Islander include the following:

- high quality services delivered in a culturally appropriate manner equitable to those received by all Australians
- services are 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 form practical partnerships with Aboriginal and Torres Strait Islander community controlled organisations (ACCOs) and these are documented in funding applications and annual plans and budgets
- two-way support mechanisms are put in place to allow both non- Aboriginal and Torres Strait Islander funded organisations and ACCOs to assist each other in the delivery of services
- 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 are provided with opportunities to develop the appropriate level of skills and qualifications to deliver services
- non-Aboriginal and Torres Strait Islander practitioners have undertaken recognised cultural competency training such as the Aboriginal and Torres Strait Islander Cultural Competency Course: ccca.com.au/content/course-details?CourseID=3531 provided by the Centre of Cultural Competency Australia.

To achieve this service providers' business plans, linkages and service mechanisms underpinning PTS – Aboriginal and Torres Strait Islander ensure that:

- appropriate referral pathways and linkages with government and non- government stakeholders at the community level (including those associated with the clinical mental health system such as ACCOs) are established and maintained
- efficient and effective services are provided, that are managed within 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 and delivered by qualified and appropriately trained and skilled allied health professionals.

16.6 PTS Suicide Prevention

PTS - Suicide Prevention is designed to provide support to people in the community who are at increased risk of suicide or self-harm. However, this service is not designed to support people who are at acute and immediate risk of suicide or self-harm. Individuals at acute risk should be referred immediately to the relevant state or territory government acute mental health team (or equivalent).

PTS - Suicide Prevention is primarily designed for the following cohorts:

- people who, after a suicide attempt or self-harm incident, 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 an incident of self-harm
- people who have expressed suicidal ideation to their GP.

This service may also provide support to those who are considered at increased risk in the aftermath of a suicide. In considering a person's eligibility for these services, providers should consider the complexity of the individual's circumstances and the number of contributing factors. This service is not designed for individuals who are being managed on an ongoing basis by state government mental health services following discharge from a hospital acute mental health ward or an emergency department.

This service aims to better integrate care between acute and primary mental health care for the management of this group and provide referral pathways for GPs to better support their existing clients. Consequently, the service is also not designed for individuals who have been directly discharged from a psychiatric accident and emergency department. This PTS is also not designed to reduce the responsibilities of acute mental health services, but to support those who are not appropriately supported through this setting.

There are a small number of individuals who have persistent or recurrent thoughts of self-harm for months or years, as a part of a mental disorder, and are at risk of acting on these thoughts. These individuals are best treated by state government mental health services or a private psychiatrist and are not a focus for this service.

Up to 12 service contacts annually are available per person (subject to consultation with Murray PHN should a clinical review indicate a need for additional service contacts). Consideration will also factor whether the individual is more appropriately supported by the state or territory acute mental health service, or a more appropriate, alternate service provider.

People who have been referred because they have attempted or are at risk of attempting suicide or self-harm do not require a diagnosis of a mental disorder to be eligible for PTS.

Interventions: PTS Suicide Prevention

This service provides priority access to PTS for people who have self-harmed, attempted suicide or who have suicidal ideation and are being managed in the primary health care setting. The primary objective of the service is to provide treatment and support to individuals at increased risk of suicide or self-harm at a critical point in their lives.

PTS - Suicide Prevention complements other PTS and the Better Access to Mental Health Care initiative. It is designed to provide immediate and short-term support for individuals during a period of increased suicide risk. The service is not intended to provide long-term intensive support. In most cases people would access services for a period of up to two months.

People referred will have priority access to the allied health provider and the allied health provider is to contact the person within 24 hours of referral. The first session with the allied health provider must occur within 72 hours of referral or earlier if clinically indicated.

Unlike standard PTS arrangements, there is no limit on the number of service contacts an individual can access. However, it is anticipated that these service contacts would be conducted in a condensed timeframe, of around one to two months and will be based on individual needs.

It should be noted that services provided under PTS - Suicide Prevention have no impact on a person's entitlement to other PTS. The services provided under PTS - Suicide Prevention also have no impact on an individual's entitlement to Medicare subsidised allied mental health services.

Service providers will engage allied health professionals to provide PTS - Suicide Prevention. The allied psychological services to be provided through this service shall be broadly consistent with those provided across PTS. The services should be tailored to meet the needs of individuals who are in psychosocial distress associated with suicide or self-harm and be part of the treatment for any mental disorder identified as causing the suicidal thinking or behaviour.

Service provision by the allied health provider is expected to be a mixture of face to face consultations and follow up phone calls to promote ongoing therapeutic contact. Clinical service delivery should be primarily face to face. Allied health providers may also undertake an education/clinical support role (for example, provide support to GP practice staff/nurses in a capacity building role). This role should be a small component of PTS - Suicide Prevention, with direct service delivery being the primary role of the service.

The allied health provider may also undertake a care coordination role and facilitate access to other care providers such as a private psychiatrist. Whilst providing care coordination the allied health provider will retain responsibility for the clinical suicide prevention intervention services. Medical practitioners who participate in case conferences may be eligible to bill that service against a Medicare item.

If in any doubt as to the immediacy of risk of the client, the allied health provider is to contact the acute mental health service. This PTS Specialist service is not intended to have the allied health provider take on the crisis intervention role. The allied health provider is expected to have well developed communication links with the acute mental health team for referral in the event of an emergency.

The allied health provider will decide, in consultation with the person 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 (but is not limited to) transition to PTS General, Medicare based mental health services or specialised mental health services.

16.8 PTS Perinatal: women with perinatal depression

Obstetricians and maternal and child health nurses may refer women to the PTS - Perinatal Depression Initiative. However, the individual must have a Mental Health Treatment Plan prepared in consultation with a GP as soon as possible, preferably within two weeks of the first session or four weeks in a rural and remote area, or as soon as practical where access to GPs is not readily available.

Interventions PTS Perinatal

Psychological interventions, with a perinatal focus, that provide clinical effectiveness for short term treatment of mental disorders.

The Department of Health (DoH) notes that research indicates that each year around one in ten Australian women experience depression 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 who experience perinatal depression are not identified and so do not receive adequate support, placing them at risk of more serious problems[5].

Individuals presenting for Perinatal PTS will been administered the Edinburgh Postnatal Depression Scale (EPDS) screening tool which the DoH has put is "well accepted by women, including those from culturally and linguistically diverse and Aboriginal and Torres Strait Islander populations." [6]

It is anticipated that the screening tool will be administered in primary care setting settings and will be undertaken by various health care professionals including general practitioners, midwives, child and maternal health nurses, Aboriginal Health Workers, practice nurses and obstetricians. Others likely to be involved in screening are community support workers, especially in rural and remote areas, and non-government organisations, which are particularly important for culturally and linguistically diverse groups.

The EPDS cut-off scores set out below should be used as a guide only and the application of clinical judgement in determining current distress and depressive symptoms is most important.

Score of 0-9: the likelihood of depression is considered low (may indicate the presence of some symptoms of distress that may be short-lived and are not likely to interfere with day-to-day ability to function at home or at work).

Score of 10-12: the likelihood of depression is considered moderate (may indicate the presence of symptoms of distress that may be discomforting). A score above 10 indicates that the EPDS should be repeated within two weeks. Two scores above 12 indicate that further assessment is required to establish if a clinical disorder is present.

Score of 13 or more: the likelihood of depression can be considered high (14 or more antenatally).

Positive responses to Q10 of the EDPS (thoughts of self-harm) - must be immediately addressed and such interventions provided outside of the PTS.

[5] health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-f-perinat-toc~mental-pubs-f-perinat-fra

[6] health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-f-perinat-toc~mental-pubs-f-perinat-fra

As a screening instrument, the EPDS is only used to assess a woman's mood over the past seven days. As such, it is recommended that a psychosocial assessment tool is used in conjunction with the EPDS and, at a minimum, should include the following broad domains:

- lack of social or emotional support
- recent stressors (in the last year)
- low self-esteem (including self-confidence and perfectionistic traits)
- history of depression, anxiety or other mental health problem
- partner's history of mental health problems and substance misuse
- adverse childhood experience (including poor relationship with the mother)
- domestic violence
- the couple's relationship
- experience of parenting the baby (postnatal).

The sharing of information regarding a woman's screening status is an important and sensitive issue. The following general principles are proposed where care is or may be shared:

- given that routine and universal screening for perinatal depression should be undertaken by one of the main health care professionals involved in the woman's care during the perinatal period, details of the screening (date, score and any actions required/taken and by whom) should be communicated to other relevant health care professionals
- the woman should be advised that her EPDS score will be shared with other relevant health care professionals involved in her care
- the EPDS score should be shared with other health care professionals, irrespective of the score, to ensure that there is no omission or duplication of screening
- specific consent will be requested from the woman regarding sharing of broader psychosocial assessment information
- information may need to be shared (without consent) in exceptional situations where the woman is unable to give consent, or the woman and/or child may be at risk (in accordance with relevant jurisdictional legislation as it relates to privacy, child protection, mental health and domestic violence)
- wherever possible, existing communication pathways should continue to be used in relation to perinatal depression screening.

17. PTS - Children

PTS - Children is for the provision of short-term mental health services for children, under the age of 12 years, presenting with mental health disorders. This includes children who have, or are at risk of developing, a mental health, childhood behavioural or emotional disorder.

17.1 The objective of PTS – Children

The objective is to provide eligible children with evidence-based, short-term psychological strategies within a primary care setting. The psychological services and interventions 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.

Up to 12 service contacts annually (subject to consultation with Murray PHN and a clinical review evidencing the need for additional PTS service contacts). Consideration will also factor whether the individual is more appropriately supported by the state or territory acute mental health service or an alternative, more appropriate, service provider.

17.2 The eligibility criteria to access PTS - Children

The eligibility criteria includes:

- a child assessed as having signs and symptoms of an emerging mental health disorder (including conduct disorder), where this causes “significant dysfunction in everyday life”
- a child at risk of developing a mental health disorder, where the child shows one or more signs or symptoms (social-emotional-behavioural) of developing a mental health disorder and/or where the child’s developmental pathway is disrupted by their mental health disorder – and is not limited to disruptive disorders. Signs of disruption to functioning in one or more settings are included. That is, one setting is considered sufficient to warrant the child’s eligibility to receive services under PTS - Child Mental Health (e.g. home or school)
- the child is unable to access appropriate clinical intervention through the Medicare-funded Better Access program due to:
    - The supporting family or carer is less able to pay fees
    - Limited access to Medicare funded service provision due to rurality or remoteness
- infants and children do not need to have a mental health or childhood behavioural or emotional disorder diagnosed to access PTS - Child Mental Health. However, if they do not have a diagnosed disorder, there needs to be clear clinical evidence that they are at significant risk of developing a disorder.

17.3 The PTS Child Treatment Plan (CTP)

This must be developed for a child to be eligible for PTS - Child Mental Health. If there is no diagnosed mental health disorder evident, a referring medical practitioner should then document in the PTS 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.

17.4 Referrals

Infants and children under 12 years who are assessed as having mild to moderate mental health presentations can be referred to PTS - Child Mental Health by their GP, paediatrician or psychiatrist.

17.5 Provisional referrals for PTS - Children

This can be initiated while arrangements are made to see a GP (within two weeks) and have an PTS Child Treatment Plan (otherwise known as a “GP Mental Health Treatment Plan”) developed.
A provisional referral can be made by the following professions and clinicians:

- allied health professionals who are eligible to provide services under PTS (appropriately trained occupational therapists, social workers, psychologists, mental health nurses and Aboriginal and Torres Strait Islander health workers). An allied health professional may not refer someone to themselves or to someone operating in the same practice
- school psychologists/counsellors or deputy principals/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 12 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.

The mental disorders and contextual factors relevant to children under 12 years of age that can be treated under PTS - Children are outlined below.

Table 1: List of disorders and contextual factors (ICD-10) for treatment under PTS - Child Mental Health

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[1]
10	Eating disorders
11	Encopresis[2]
12	Enuresis[3]
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 (F93)
20	Mental disorder, NOS
21	Contextual factors- including but not limited to: (a) problems related to upbringing (Z62) (b) problems related to negative life events in childhood (Z61) (c) other problems related to primary support group, including family circumstances (Z63)

1,2,3 - In cases where children (e.g. with behavioural/toileting/feeding difficulties) can competently be treated by GPs, paediatricians, maternal and child health nurses, and/or mental health nurses etc. (and where these services are available), it is recommended that the child should not be referred to PTS - Child Mental Health as a first option. However, an exception may arise when families live in remote areas and do not have access to a range of primary care services.

* Note - Although prevalence rates for some disorders listed in this table are less commonly observed in childhood (marked*), they have been retained under PTS - Child Mental Health to be inclusive and for PTS - Child Mental Health to benefit children at risk of developing these disorders - in line with an early intervention approach to mental health service delivery.

17.7 Interventions Children PTS

Children under 12 years with mental health issues require, specific age related, psychological treatment options. The most common treatment option available is cognitive behavioural therapy (CBT). However, in its standard form, it requires a level of cognitive development which is generally not achieved until adolescence. Consequently, CBT for children under 12 years, needs to be specially modified to suit their development level.

Often, appropriate psychological treatment options for children under 12 years, can involve therapies which involve the whole family. This may include family-based therapies such as behavioural therapy, and parent training in behaviour management, which entail working closely with parents and families.

The interventions that can be provided through this service shall be consistent with the following treatments as these are considered to have a strong evidence base:

- attachment intervention family-based intervention (where expertise is available)
- behavioural interventions
- cognitive behavioural therapy (CBT) Interventions (including individual child and family/parent based)
- family-based interventions (behaviour or CBT based intervention only)
- parent-child interaction therapy (PCIT) for attachment and behavioural disorders (where expertise is available).

The following interventions are **not** included under PTS - Child Mental Health:

- art therapy
- mindfulness-based cognitive therapy (MBCT)
- play therapy
- family therapy (other than behavioural/cognitive behavioural treatments).

Service providers should ensure service delivery mechanisms underpinning PTS - Child Mental Health contribute to the overall PTS objectives, as well as PTS - Child Mental Health objective through:

- establishment and maintenance of appropriate referral pathways and linkages with government and non-government stakeholders at the community level (including those outside of the clinical mental health system)
- provision of efficient and effective services, that are managed within the overall capacity of the service provider to meet demand for services
- provision of a high-quality standard service, that is clinically appropriate for children under 12 years of age and delivered by a trained and appropriately skilled allied health professional qualified.

18. Working with children requirements

There are professional and ethical considerations to be made when working therapeutically with children.

Caution is recommended around the risks associated with subjecting children to incompetent or unsuitable mental health care with potentially damaging consequences to their ongoing mental health.

High recruitment standards must be maintained and guidelines around professional practice put in place to ensure that staff are only practicing within their area of competence and relevant scope of practice.

Service providers are to ensure PTS - Child Mental Health allied health professionals are familiar with all issues that are specific to working with children and families. In addition, service providers must ensure clinical awareness and support is available to allied health professionals in areas such as forensic and legal topics, mandatory reporting of abuse, confidentiality, managing risk and safety issues.

Service providers and staff are required to comply with the appropriate commonwealth and state legislation around working with children.

19. PTS in Residential Aged Care Facilities

Mental health services have not been readily accessible to older people living in Residential Aged Care Facilities (RACFs), nor had they been within scope of services that RACFs provide. There is evidence that RACF residents have had very high rates of mental illness presentations. It has been put that 39 per cent of all permanent aged care residents are living with mild to moderate depression (DoH, 2018: p.7). The experience of other services, such as Better Access, indicates that up to half of this population group residing in RACFs and presenting with mild to moderate depression may wish to receive mental health services if they were available to them (DoH, 2018: p.7).

19.1 Workforce

All clinicians delivering RACF PTS services will be require mental health credentialing/accreditation and must have previous skills and experience in working with older persons mental health:

- psychologists (clinical and general)
- mental health social workers
- mental health occupational therapists
- credentialed mental health nurses
- Aboriginal health workers.

19.2 Client eligibility

People living in residential aged care facilities (RACFs) presenting with mental illness.

19.2 Interventions

- in-reach services on location at RACFs
- targeting residents with a diagnosed mental illness or who are assessed as at risk of mental illness if they do not receive services
- provide evidence-based, time-limited psychological therapies which are adjusted to be responsive to the needs of older people – delivered either as individual or group-based therapy approaches;
- provided within a stepped care framework with a particular focus on meeting the needs of older people with mild to moderate mental illness
- implemented collaboratively, in close communication with RACFs and other key stakeholders, including consumers and family members
- locally developed assessment and referral arrangements which ensure services are matched to need for mental health services
- be equitable and efficient, to enable access to services to be offered across the region to RACF residents over time
- up to five service contacts per client, can be extended to 10 based on clinical review recommendation.

20. Number of PTS service contacts and clinical case reviews

The number of PTS General and Specialist service contacts* (except suicide prevention) that can be accessed by an individual in one year across all streams (except suicide prevention) are limited to 12 per year, with a clinical review required evidencing the need for continuation of services after the first six service contacts are completed. This is information is then to be provided to the referring medical practitioner is required.

If special circumstances present from a clinical review that there is a need for additional service contacts to be provided, i.e. it is identified that an extension beyond 12 service contacts is needed to arrange for a smooth step up or step down action to occur, and that it is in the best interests of the client, additional service contacts beyond 12 can be requested from Murray PHN.

PTS service contact extensions, approved by a clinical review, are a continuation of the original episode of care and is not to be recorded as a new episode of care. It must be factored that PTS is for a mental health disorder diagnostic range of mild to moderate clinical presentations and is not a longer-term approach. So, at the second review (after 12 service contacts), the focus will need to be on completing a recovery-oriented goal plan or planning a 'step-up' option as per the Stepped Care approach.

A clinical case review involves an all of team review (including the individual, any nominated supports, the GP/psychiatrist and other team members).

Clients that are inactive for 12 months must be provided a clinical review immediately for forward planning and potential discharge.

*A service contact is a minimum of 30 minutes to a maximum of 60 minutes clinical interaction with a client, or regarding a client. The service contact can be provided face to face, by telephone and/or digital and can be in group or individual mode.

21. Exit criteria PTS Generalist and Specialist

Support provided under PTS Generalist and Specialist for individuals with severe and persistent mental illness experiencing periods of significant disability.

Individuals should exit the program when they no longer require the level of support as outlined in this document.

An individual's episode of care will conclude when:

- he or she has achieved the recovery goals and/or is not presenting with mental illness signs and/or symptoms that are significant disabling social, personal and occupational functioning
- no requirement for clinical services of the program.

22. Low Intensity Mental Health services for Children to 15 years

Short term targeted therapeutic services that support children with low intensity mental health presentations up to the age of 15 years, within a primary care setting, specifically general practices in local communities. These services can include:

- psychoeducation for clients, other services (schools, welfare services etc), carers, parents and significant others
- referral pathways to more intensive mental health services
- short term interventions that are less costly than psychological services available through the Medicare-based Better Access initiative
- the provision of evidence based psychological intervention (e.g. CBT)
- services that can be accessed easily and directly without a referral (although it is best practice to involve a GP in overall health and mental health care)
- draw from a broad workforce, whilst ensuring workforce skill, qualification and supervision arrangements are appropriate for the level of service provided.

22.1 Client eligibility

Children presenting with mental health issues or at risk of developing a mental health disorder and are aged to 15 years.

22.2 Functions of the service

Develop an integrated model of care between general practice and specialist providers for children presenting with a mental health related issues, or at risk of developing a mental disorder, and is aged up to 15 years.

22.3 Workforce

A credentialed mental health nurse with the Australian College of Mental Health Nurses is recommended to be a team member for the provision of Low Intensity Mental Health Services programs, however alternate clinical disciplines are also acceptable, as appropriate to client needs.

Clinicians working in this program must have current professional registration, mental health credentialing /accreditation/endorsement.

Other disciplines, as required to address identified client need, can be added to the client's intervention plan in keeping with the Stepped Care approach.

Specialist training requirements must be met for the provision of mental health services to children. This can be child specific training provides by the Australian Psychological Association (i.e. Children's Mental Health Service Professional Development Training – Fundamentals and Enhanced) or equivalent as accepted by Murray PHN, or they must have a minimum of two years' experience in working therapeutically with children.

22. National Disability Insurance Scheme (NDIS) and PTS

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

23. Better Access

PTS is different to the Better Access Program. The Better Access initiative to psychiatrists, psychologists and general practitioners through the Medicare Benefits Schedule (Better Access) includes a range of Medicare rebate-able services for people with a diagnosed mental health disorder. It includes providing rebates for services provided by appropriately qualified psychologists, social workers and occupational therapists.

PTS is delivered through a federal government fundholding arrangement where allied health professionals are salaried or subcontracted to provide mental health services. PTS also offers a broader range of service providers compared with Better Access, such as credentialed mental health nurses (CMHN) and Aboriginal and Torres Strait Islander health workers.

The referring clinician decides whether to refer a client to Better Access or PTS. It is preferred, not mandatory, that individuals should only be referred to one of these programs in any single calendar year.

24. Cancellation and did not attend

If a client cancels an appointment 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 client's non-attendance.