



Mental Health Stepped Care Services Operational Guidelines

- » Intake, triage, assessment, and referral
- » Low intensity services – digital/telephone
- » Moderate intensity services – *Psychological Therapies* including place-based (remote) services
- » Severe and complex mental health needs
- » Psychological Therapies for people with mental illness in Residential Aged Care Facilities



p: (07) 4034 0300
e: hello@nqphn.com.au

w: nqphn.com.au



Northern Queensland Primary Health Network acknowledges the Traditional Custodians of the lands and seas on which we live and work, and pay our respects to Elders past and present.

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1. Program overview

1.1 Background

As a response to mental health reforms introduced by the Commonwealth Government from 2016 onwards, Northern Queensland Primary Health Network (NQPHN) is commissioning the following elements of a stepped care model of mental health services.

Low intensity needs for services

These are early intervention services that are targeted to people with mild mental illness, or who are at risk of developing a mental illness, but do not require acute clinical services.

Moderate intensity needs for services

These are *Psychological Therapies* providing short-term interventions for financially disadvantaged people with non-crisis, common mental health conditions of moderate severity, or to people who have attempted, or who are at risk of suicide or self-harm.

Severe and complex need for services

These are services that support people through care coordination and community-based support by qualified mental health professionals.

Youth mental health services

These are extending across the stepped care framework.

Aboriginal and Torres Strait Islander services

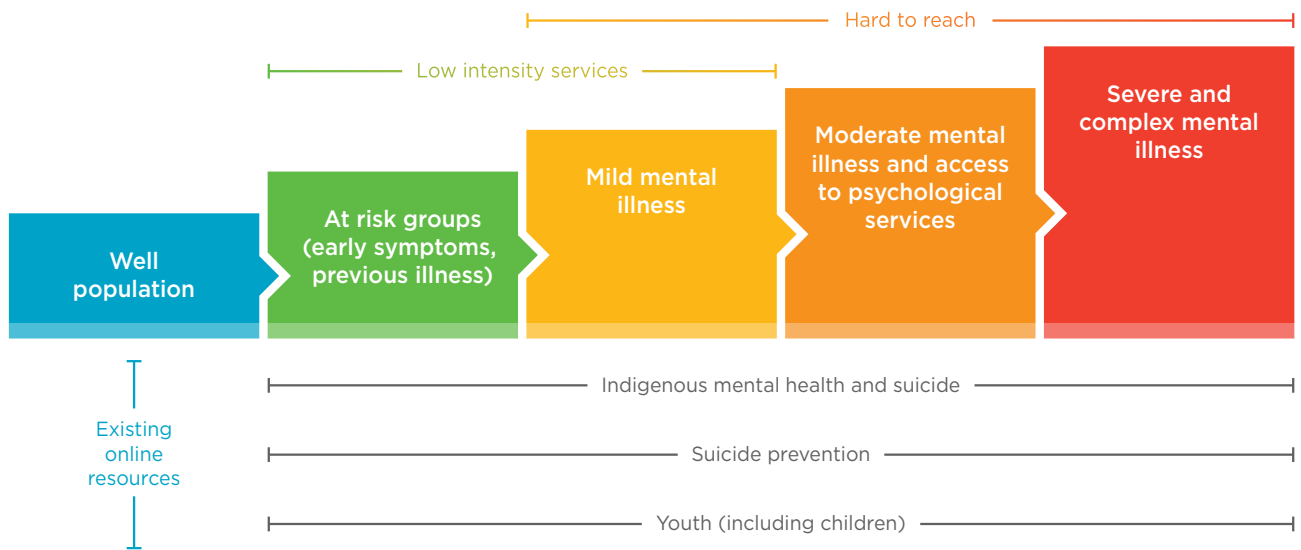
These are extending across the stepped care framework.

Suicide prevention – regional approaches

The Australian Government has tasked PHNs to take a lead role in planning community-based suicide prevention activity through a more integrated and systems-based approach, in partnership with Hospital and Health Services (HHSs) and other local organisations.

The NQPHN Stepped Care Framework is detailed here:

STEPPED CARE APPROACH



The focus of these operational guidelines is the following components of the stepped care model:

- » intake, triage, and assessment—including referral across stepped care
- » low intensity (digital and telephone-based) services
- » moderate intensity needs for services, *Psychological Therapies* including place-based (remote) services
- » severe and complex mental health needs.

Operational guidelines for Aboriginal and Torres Strait Islander services and suicide prevention—regional approaches will be developed in consultation with stakeholders.

2. Requirements of all stepped care providers

2.1 Quality requirements

The service providers must comply with the requirements of any relevant accreditations and standards and must be, or able to be, accredited within generic accreditation frameworks by a certified entity.

The service providers must be accredited, comply, or demonstrate alignment with the requirements of the National Standards for Mental Health Services (NSMHS) 2010, including implementation guidelines for private office-based mental health services and all other relevant standards and legislative/regulatory requirements. The national standards are available for downloading from the Department of Health publications website at: [www.health.gov.au u/internet/publications/publishing.nsf/Content/mental-pubs-n-servst10-toc](http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-servst10-toc)

Service providers must promote recovery from mental illness, in line with the National Framework for Recovery Oriented Mental Health Services 2013.

Safety and quality are critical to the successful delivery of all services to clients. The contracted organisation must consider the following core quality principles when considering strategies and approaches for the delivery of a safe, quality service.

These principles underpin the Australian Safety and Quality Framework for health care and are as follows:

- » **Principle 1:** Person-centred
- » **Principle 2:** Driven by information
- » **Principle 3:** Organised for safety and quality.

The contracted organisation is required to have a quality management framework which includes, but is not limited to, a process for continuous quality improvement including:

- » corporate and clinical governance
- » quality of care for patients
- » consumer and professional/employee satisfaction
- » safe working conditions and workplace health and safety
- » risk management and handling of incidents and complaints.

Clinical audits, where appropriate, may be undertaken from time to time as determined by NQPHN. Service providers must grant NQPHN and/or its authorised personnel access to complete the necessary requirements. NQPHN will give 14 days notice of audits to service providers.

2.2 Risk management

Service providers are required to have a risk management strategy within their organisation. The risk management strategy should:

- » identify and document clinical and operational risks
- » identify and document risk control strategies
- » have a documented critical incident process
- » have clear referral pathways
- » implement adequate and effective policies and procedures to manage and control risks.

2.3 Client consent

It is a requirement that all clients referred to NQPHN-funded stepped care services sign a consent form during their first appointment. A copy of the consent is to be given to the client and a copy filed in the client's clinical file. If a client is re-referred at any time, they will not be required to complete a new consent form.

If the contracted organisation wishes to use their organisational consent form, the following paragraph must be included:

I consent to my information being provided to Northern Queensland Primary Health Network and to the Commonwealth Department of Health to be used for statistical and evaluation purposes designed to improve mental health services in Australia. I understand that this will include details about me such as date of birth, gender, and types of services I use but will not include any details that would identify me such as my name, address, or Medicare number. I understand that my information will not be provided to the Commonwealth Department of Health if I do not give my consent.

2.4 Client data

As part of the mental health reform the Department of Health developed a Primary Mental Health Care Minimum Data Set (PMHC-MDS) which has been required to be collected by commissioned services from 1 July 2017. Collection of client data is mandatory for all contracted organisations. Further information regarding the PMHC-MDS can be found at www.pmhc-mds.com and a summary is in Appendix B of these guidelines.

Service providers providing funded NQPHN stepped care services are required to complete the PMHC-MDS via the NQPHN-funded RediCASE platform for all clients allocated to them.

Each individual who is accepted for funded NQPHN stepped care services is allocated a unique individual identifier through the RediCASE system. That identifier should be used for each referral and session of care for the individual and will assist in monitoring the number of services an individual has been provided and whether they are returning for treatment for the same or new conditions, as well as demographic and outcome data that is required to be collected under the PMHC-MDS.

Medicare numbers are not appropriate to be used for PMHC-MDS identifiers.

An outline of the NQPHN funded programs required to collect data for the PMHC-MDS is listed in Appendix B.

2.5 Outcome assessment tools

The contracted organisation is required to implement and report on patient outcomes as a result of their use of stepped care services.

Providers will be required to utilise the assessment tools as pre and post measures and will be required to record these scores as part of the PMHC-MDS data collection. Assessments should be undertaken at the initial (first) session and at completion of the episode of care at the final session of their allocated sessions. Additionally, assessments should be completed more often if clinically required and must also be recorded in the PMHC MDS. For group programs, assessments should be undertaken at the initial (first) session and at completion of the group program.

Minimum outcome measures to be used are:

- » Kessler Psychological Distress Scale (K5) for Aboriginal and Torres Strait Islander clients
- » Strength and Difficulties Questionnaires (SDQ) for children (0-14)
- » Kessler Psychological Distress Scale (K10+) for all other clients.

Contracted organisations can utilise additional assessment tools as required, however only the above measures will be recorded in the PMHC-MDS.

If using other outcome measures additional to the PMHC-MDS, NQPHN encourages the use of the following most commonly used outcome measures:

- » Beck Anxiety Inventory (BAI)
- » Behaviour and Symptom Identification Scale 32 (BASIS-32)
- » Beck Depression Inventory (BDI)
- » Depression Anxiety Stress Scales (DASS)
- » Global Assessment of Functioning (GAF)
- » General Well-Being Index (GWBI)
- » Hospital Anxiety and Depression Scale (HADS)
- » Health of the Nation Outcome Scales (HoNOS)
- » Edinburgh Postnatal Depression Scale (EPDS)
- » Modified Scale for Suicidal Ideation (MSSI).

2.6 Workforce requirements

As indicated in the NQPHN contract for services, the service provider will ensure that their employees (specified personnel) and contracted mental health providers (specified sub-contractors) listed in the special conditions of the NQPHN contract for services are adequately trained and qualified to perform the services. Evidence of qualifications will be provided to NQPHN upon request.

The service providers will need to ensure that all employees and sub-contractors comply with the relevant sections of the NQPHN conditions of contract and contract for services.

2.7 My Health Record

The NQPHN region was a pilot site for the introduction of the My Health Record personal electronic health record during 2016-17. With the exception of those who chose to opt-out of the scheme, most residents of the region have now been allocated a My Health Record.

Individuals who use the record are able to see their important health information in one consolidated view. They are able to share this information with trusted healthcare practitioners, who in turn will be able to access their patient's My Health Record to support the delivery of high-quality healthcare regardless of where and when it is needed.

The use of My Health Record is to be encouraged with service users of stepped care.

2.8 Translating and Interpreting Service (TIS) – National interpreting service

NQPHN has determined that financial assistance will be available for TIS National interpreting services directed to refugee populations accessing stepped care programs. NQPHN will advise on how service providers are to access this funding support.

2.9 Client complaints and feedback

The service providers are required to put in place a complaints mechanism for people who access stepped care services in accordance with section 1.16 of the National Standards for Mental Health Services.

This mechanism must be:

- » documented in a plain English brochure and in other languages as appropriate
- » provided to all people who receive services under stepped care
 - the contracted organisations must provide a copy of this brochure to NQPHN with its annual plan and budget.

Client satisfaction surveys are also to be employed. The Department of Health is currently developing a primary mental health care version of the Your Experience of Service (YES) survey instrument, with a working party of PHN representatives. It is expected this will be available to stepped care providers in 2019.

Interim surveys can be utilised and electronic or internet options for client satisfaction surveys may also be made available. A sample client satisfaction survey is to be provided to NQPHN with the annual plan and budget.

2.9.1

A number of providers of stepped care services are sub-contracted by larger host provider organisations across the region.

A complaint or issue from a sub-contracted professional or service should be directed to the contracting organisation in the first instance.

The complaint or issue should be referred to NQPHN only if it cannot be resolved between the sub-contractor and the contractee.

2.10 Crisis support mechanism

Where it does not already exist, the service provider is to establish a crisis support mechanism for individuals being provided with treatment to cover their needs after hours and for the mental health professionals who provide treatment. All mental health professionals engaged to provide stepped care services should be provided with details of who to contact, under what circumstances they should be contacted, and the details of how to contact them. Appropriate after-hours crisis support contact numbers and details are also to be provided to each individual being provided with services.

A copy of the crisis support mechanism is to be provided to NQPHN with the annual plan and budget.

2.11 Reporting and evaluation

Performance reporting is detailed in the service provider's contract for services. Milestone dates indicate required times for submission of data, reports, and invoices for payment.

The stepped care service providers are required to participate in the evaluation of the program through the PMHC-MDS, NQPHN performance reports, ad hoc surveys and interviews, and other methodology as determined by NQPHN from time to time.

2.12 Promotion of stepped care services

To ensure that accurate information is provided to GPs, primary health care, and other referrers, NQPHN will promote the service provider to referrers.

If the service provider identifies that referrers require additional information regarding the mental health stepped care services, the service provider should provide this feedback to NQPHN to support additional communication strategies.

NQPHN encourages the service provider and any contracted or sub-contracted providers to maintain current entries in the National Health Services Directory.

Stepped care services will be included in local Health Pathways referral models.

3. Central intake, assessment, triage, and referral (IATR) services – stepped care

3.1 Referral, assessment, and triage process

As stepped care is tasked to deliver innovative services for priority groups and regions, it is important that those who are referred will be appropriately served by stepped care services or that they are referred to the right service at the right time within the stepped care model and broader community and mental health services.

The service provider is to have mechanisms in place to ensure people are:

- » referred to appropriate services
- » resources are effectively targeted
- » duplication is avoided
- » expected levels of unmet demand are managed.

The service provider is expected to use triage and assessment systems that best suit local conditions which could include, but are not restricted to:

- » a panel arrangement
- » a salaried staff member with appropriate qualifications and clinical expertise
- » a specialist contractor with appropriate qualifications and expertise
- » a quality assurance model to review referral processes and decisions on eligibility and access to services.

Assessment services are to be performed by mental health professionals (including psychologists, appropriately trained nurses, occupational therapists, social workers, and Aboriginal and Torres Strait Islander health workers). Where there is a need for a face-to-face session, the one triage/assessment session is not to be considered a treatment session, and this does not count towards the individual's allowed *Psychological Therapies* or Low Intensity treatment sessions in a calendar year.

The organisation may use a number of different intake processes depending on their service delivery model. In all cases, the service provider needs to have arrangements in place to ensure that clients are referred to appropriate services and liaise with the stepped care direct service providers to ensure demand is managed within available resources and that referrals are accepted throughout the financial year.

A system of monitoring the triage/assessment process will be useful for the service provider in identifying where a GP or other referral source may be consistently making inappropriate referrals. Where this occurs, NQPHN encourages the service provider to work with the referrers and educate them on the service.

A strategy on how to manage the demand for services should be incorporated in the organisations' strategic and financial planning. Strategies to manage demand should include:

- » ensuring an amount of funding is allocated for each month of the financial year
- » prioritising access to appropriate stepped care services and priority populations within those groups
- » promoting appropriate referral practices to GPs and other mental health and primary health providers
- » ensuring a seamless transition for individuals whose needs change and require access to different components (steps) of stepped care
- » ensuring alternative referral pathways are established for those for whom the services cannot be provided.

Referrals may be made face-to-face, by telephone, electronically, or by a written referral. It is suggested that IATR services developing a referral form use a proforma based on the format suggested by the Royal Australian College of General Practitioners (RACGP).

3.2 Service linkages

The intake, assessment, triage, and referral (IATR) service provider will facilitate patient access and referral to appropriate existing health and community services, as required, and where such services are available particularly for individuals who are not eligible for stepped care services.

The service provider should maintain an accessible and up-to-date service matrix of mental health, social and community services, and groups for the NQPHN region.

The service provider is expected to work with NQPHN, other health and community services, and funders to further enhance the northern Queensland service system to meet the needs of the targeted population.

3.2.1 Utilisation of Head to Health – web-based/telephone therapy and resources

Many digital and telephone-based services and programs are able to be accessed through the new Commonwealth Government mental health gateway, the Head to Health portal (www.headtohealth.gov.au). These services may particularly benefit people in rural and remote areas who face barriers in accessing face-to-face services. Available activities include the provision of general psychosocial telephone helplines, online counselling, online self-help and peer support resources, and self-directed online treatment modules. There is sound evidence supporting online therapies for people with anxiety and depression, both nationally and internationally.

The services, in the majority of cases, do not require a referral and clients can access them in their own time and in the privacy of their own home. The programs have built-in screening and/or triage capability and provide clear information for practitioners and clients alike as to who will benefit most from the programs and those for whom the program is not suitable.

The available online treatment programs are mainly self-guided and can be accessed by people while they wait for face-to-face appointments, as a follow up to face-to-face, or instead of, depending on the individual's needs and circumstances.

There is also capacity for mental health practitioners to be actively involved with clients as they complete online therapies, should this be desirable or considered necessary, however it is not mandatory.

3.2.2 Relationship with low intensity services

The programs and services available through Head to Health will be complemented by a range of separately contracted NQPHN funded services, providing low intensity services. Individuals referred to or contacting the service provider may be referred to low intensity services where the referral or triage results in agreement of the need for a less intensive intervention than a clinical referral.

The IATR service provider will need to ensure that:

- » Comprehensive information and guidelines are available for the low intensity programs and services, and that these are available for practitioners and clients. The service provider will need to liaise with low intensity providers (both NQPHN-funded and funded from other programs) to ensure that service details are current and accurate.
- » Referral pathways with low intensity service providers are established and regularly reviewed in a collaborative process with the service providers.
- » Low intensity services are utilised only when indicated by referral/triage and are appropriate to meet the individual's needs. Individuals requiring higher intensity services must be referred to the appropriate professional or placed on a waiting list and can be offered the opportunity access to low intensity services as an interim intervention until an appointment is available.

3.2.3 Relationship to services for moderate intensity mental health – *Psychological Therapies*

The programs previously provided under the Access to Allied Psychological Services (ATAPS) and Mental Health Services for Rural and Remote Areas (MHSRRA) have now been transitioned to stepped care.

Former ATAPS providers (now *Psychological Therapies* providers) will be re-contracted by NQPHN to continue service delivery of sessions consistent with their contract for services and funding. *Psychological Therapies* host organisations are required to maintain liaison with the IATR service regarding available sessions, staffing and staffing changes, as detailed in their contract for services.

MHSRRA providers were included in a request for tender process providing place-based services, and the Place-based (remote) services replaced the MHSRRA and remote ATAPS services from 1 July 2018. Place-based providers have flexible options for receiving referrals and are block-funded to provide flexibility in service provision, rather than the sessional-based structure of *Psychological Therapies*. The IATR can still provide referrals to the place-based services when appropriate.(See Section 6 for further details).

3.2.4 Relationship to services for severe and complex mental health

This program was formerly the Mental Health Nurse Incentive Program (MHNIP) and is transitioning to the new hub model of Mental Health Integrated Complex Care (MHICC) services. Referral pathways for MHICC are developed with the central IATR intake in both Cairns and Mackay and will be developed in Townsville in 2020.

4. Digital/telephone services – low intensity services

Low intensity mental health services will provide evidence-based psychological interventions that most appropriately support people with, or at risk of, mild mental illness (primarily anxiety and/or depressive disorders). These services will supplement the role of Head to Health, the digital mental health gateway which provides a central entry point for national low intensity telephone and web-based mental health services.

The low intensity service will also provide linkages, pathways, and service delivery to complement existing mental health and primary care services and be integrated with the intake, assessment, and triage service provider for the other tiers of the stepped care framework for NQPHN.

Low intensity services are targeted to:

- » at risk groups (early symptoms, previous illness)
- » mild mental illness.

4.1 Eligibility criteria – Low intensity services

To be eligible to receive a low intensity service the client must:

- » experience symptoms or be at risk of a mild mental health condition (primarily anxiety and or depressive disorders that present a small number of symptoms, and have a limited effect on the person's daily life)
- » meet age requirements — the service is available to people who are 15 years and older (for those younger than 15 years services are available via Kids Helpline 1800 551 800 — if a face-to-face service is required please refer to NEAMI National)
- » reside in the NQPHN catchment area.

4.2 Exclusion criteria

Activities that are not considered in scope for low intensity health service include those which:

- » are not supported by an empirical evidence base
- » do not provide a structured form of psychological intervention to address a mental health problem or illness
- » primarily provide social support services
- » provide services to those residing outside of the NQPHN catchment region
- » provide activities that duplicate other services more appropriately provided through NQPHN or other organisations, including state and territory government services, or through the Medicare Benefits Schedule (MBS) and other national initiatives
- » activities targeted to those under the age of 15 years.

4.3 Priority groups

Low intensity services are targeted to give priority to the following vulnerable groups:

- » Aboriginal and Torres Strait Islander (ATSI)
- » Culturally and Linguistically Diverse (CALD)
- » Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning (LGBTIQ)

4.4 Service delivery model

Essential features of the low intensity services are outlined below.

- » Targeted at lower intensity mental health needs, within a stepped care approach.
- » Focusing on early intervention for people with, or at risk of mild mental illness.
- » Provide evidence-based psychological intervention (e.g. cognitive behaviour therapy (CBT) to people with, or at risk of, mild mental illness (primarily anxiety and/or depressive disorders).
- » Provide a high-quality service that people can access easily and directly, with or without needing a referral, while noting that it is best practice to involve a general practitioner (GP) on overall health and mental health care.
- » Draw from a broad workforce, whilst ensuring workforce skills, qualifications, and supervision arrangements are appropriate for the level of service commissioned.
- » Address the low intensity needs of the region, including those in under-served population groups.
- » Are consistent with relevant standards and legislative/regulatory requirements and align with standards articulated in the National Standards for Mental Health Services 2010.
- » Promote recovery and align with the National Framework for Recovery Oriented Mental Health Services 2013, where relevant.
- » Provide links to other services within a stepped care approach to ensure people are matched to a service commensurate with their mental health need.
- » Provide an easy to access service that may not require a referral.

4.5 Low intensity mental health counselling services

The low intensity mental health services counselling services will have three components:

- » intake and assessment
- » counselling and support
- » post intervention follow up .

Intake and assessment

- » Is available 24 hours a day, seven days a week and accessed via a 1300 free call number.
- » The counsellor will undertake a preliminary social health assessment. Eligible clients will be referred into the counselling and support service.
- » The service provider will ensure that there is strong primary care integration, ensuring that all clients have a GP. If the client does not have a GP, the counsellor will assist the client to find local practitioners in the client's area.
- » The service provider will work with the NQPHN funded service provider for intake, assessment, and triage, to step up clients where clinically indicated to a higher tier of service delivery in the stepped care program. Alternately the service provider will accept direct referrals from the intake, assessment, and triage service in a step-down approach where clinically indicated and appropriate.
- » Referrals to other local service providers can also be made.
- » If the client is in severe and immediate distress and or/at risk of suicide the counsellor will undertake a suicide risk assessment, provide immediate counselling and support, working to develop of safety plan with the client, and/or escalate to emergency serviced if required.

Counselling and support

Will be available seven days a week from 9am to 9pm.

Up to six short-term call back (phone, web chat, or video) psychotherapy sessions (e.g. CBT, DBT, PST, motivational interviewing) will be provided with the same counsellor, where possible. Support will be tailored to client needs and include further assessment, counselling, and referral.

To ensure seamless service delivery, those clients who are still experiencing difficulties and requiring further attention after three sessions, will be referred to allied health practitioners to step up to the NQPHN-funded *Psychological Therapies* program, or Better Access under a provisional referral.

Clients can also be stepped down into this low intensity service at the conclusion of their high intensity Better Access or NQPHN-funded *Psychological Therapies* program.

Post service follow up

Follow up will be undertaken at six weeks after the final session, and will include:

- » clients who have used the counselling and support sessions will be contacted to determine the impact of the support sessions on their ongoing mental health
- » clients who need to re-enter the counselling and support sessions may do so at this point or be stepped back up to higher intensity services as required.

4.6 Outcome assessment tools

The contracted organisation is required to implement and report on patient outcomes as a result of their use of low intensity services. Providers will be required to utilise the assessment tools as pre and post measures and will be required to record these scores as part of the PMHC-MDS data collection. Assessments should be undertaken at the initial (first) session and at completion of the episode of care.

Minimum outcome measures to be used are:

- » Kessler Psychological Distress Scale (K5) for Aboriginal and Torres Strait Islander clients
- » Kessler Psychological Distress Scale (K10) for all other clients.

The additional assessment tool that will be utilised is the Outcomes Rating Scale (ORS). This will not be reported in the PMHC-MDS, however will be reported on in the service provider's quarterly reports.

5. Psychological Therapies – moderate stepped care

5.1 Eligibility criteria – Psychological Therapies.

To be eligible for *Psychological Therapies* individuals need to meet all of the following criteria:

- » Individuals must hold a current Health Care Card, Low Income Health Care Card, or Pension Card. Individuals who do not have these concessions but are experiencing financial difficulties and cannot access Medicare-funded services such as Better Access, will be assessed by the IATR provider on a case-by-case basis, where the referrer identifies exceptional circumstances apply in relation to the individual's financial situation.
- » have a non-acute moderate mental health condition. The short-term, goal-oriented focused psychological strategies that *Psychological Therapies* provides are of most therapeutic value to individuals with common disorders of mild to moderate severity.
- » individuals with more severe illness whose conditions may benefit from short-term interventions may also be provided with *Psychological Therapies* services. People who generally require longer term treatments or support can be referred to other options, such as public mental health services, community-managed mental health services, or the support services available through the social and community services sector and the National Disability Insurance Scheme (NDIS).
- » have a mental health treatment plan (MHTP) or a Child Treatment Plan (CTP) or be accepted as a provisional referral until these can be arranged.
- » reside in the NQPHN catchment area.

Suicide prevention services have different criteria. See Appendix C for details.

5.2 Priority groups – moderate (*Psychological Therapies*)

The service delivery model enables GPs, state health funded services, and primary health workers to refer eligible individuals to primary mental health professionals. The mental health services to be provided are restricted to focused psychological strategies, which are time-limited, evidence-based psychological treatments.

Moderate needs services are targeted to give priority to the following groups:

- » people living in rural and remote communities (see Section 6 of these guidelines)
- » children under the age of 12 years, who have or are at risk of developing a mild to moderate mental illness, childhood behavioural or emotional disorder. Children may be referred to *Psychological Therapies* by a GP, paediatrician, or psychiatrist. Children diagnosed with a mental disorder or assessed as being at risk of developing a mental disorder where this causes 'significant dysfunction in everyday life' are eligible for *Psychological Therapies* services.
- » young people aged 12–25 years
- » people experiencing, or at risk of, homelessness
- » women experiencing perinatal depression and/or anxiety
- » people at risk of suicide or self-harm. People who are referred under this priority area do not require a diagnosis of a mental disorder to be eligible for *Psychological Therapies* services
- » people who identify as lesbian, gay, bisexual, transgender, intersex, and questioning
- » people of Aboriginal and/or Torres Strait Islander descent
- » people from Culturally and Linguistically Diverse (CALD) backgrounds
- » other groups with specialised needs such as people with other disabilities.

5.2.1 People who are affected by extreme climatic events

Priority may also include people impacted by extreme climatic events such as floods, cyclones, and bushfires which may cause ongoing psychological symptoms resulting from trauma or loss that require provision of medium-term psychological treatment, as advised by NQPHN. Support from PHN-funded services will be provided consistent with local disaster plans and referral mechanisms.

5.3 Exclusion criteria – *Psychological Therapies*

Individuals not eligible for *Psychological Therapies* include individuals who:

- » have acute mental health needs, or are under the care of public mental health (i.e. Acute Care or Continuing Care Team, Child Youth Mental Health Service)
- » live in a government-funded aged care facility
- » have dementia, delirium, tobacco use disorder, and/or mental disorder, except where the mental disorder co-exists with a mental health disorder
- » have long term chronic, complex mental health issues, except where a GP or referrer has identified they can benefit from the short-term nature of *Psychological Therapies*
- » are in a crisis requiring acute care
- » are involved in workers compensation or motor vehicle compensation proceedings.

Using a ‘no wrong door’ approach, the service provider receiving the initial referral (in most cases the intake, assessment, triage, and referral [IATR] provider) must refer individuals in the above categories to more appropriate mental health services (e.g. Better Access, acute mental health services, etc.).

5.4 Relationship with Better Access

Psychological Therapies is delivered as a complementary program to Better Access and is not designed to offset or top up services delivered under Better Access.

While gap payments can be a barrier for accessing Better Access for some patients, PHN funding cannot be used to cover gap payments. **Medicare and PHN funding must not be used for the payment of the same psychological therapy session.**

Where a person has received the full allocation of sessions under the Better Access initiative and is considered to clinically benefit from some additional services, the person may be eligible for additional PHN-funded *Psychological Therapies* **if they meet relevant eligibility criteria, which are listed in Section 5.2 of these guidelines.**

An example where a person may meet eligibility requirements could include changed financial circumstances whereby they are no longer able to meet the co-payments associated with Better Access services.

For the purposes of NQPHN-funded *Psychological Therapies* the combination of sessions accessed in the calendar year by the client through Better Access plus their allocated sessions for *Psychological Therapies* should not exceed the *Psychological Therapies* sessions limits specified in these guidelines. For example, a client who is eligible for *Psychological Therapies* who has received 10 sessions under Better Access can only receive an additional 2 sessions, and a further 6 in exceptional circumstances if an appropriate referral is made for exceptional sessions by a GP.

From 1 November 2017, Better Access is available through telehealth to remote areas Modified Monash Model (MMM) 4-7 throughout the NQPHN region. These regions are available as a map on the following website: www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/MMM_locator

5.5 Response times and priorities

Once a client has been referred and accepted for services with a *Psychological Therapies* provider they should be provided with the number of sessions they clinically require, consistent with these operational guidelines, and consistent with short-term psychological interventions.

Within three working days following receipt of a referral, the *Psychological Therapies* service provider must contact a client and an initial appointment must be offered within two weeks.

For clients requiring services for suicide prevention and/or self-harm, contracted organisations must contact the client within 24 hours (business days) of the date of referral and offer an appointment within 72 hours.

If the service provider is unable to either contact or provide an appointment as per the above timeframes, they must then return the referral to the intake, assessment, and triage provider who will either (i) allocate the referral to another contracted organisation who has capacity to meet the required timeframes or (ii) if the client is unable to be contacted, the IATR organisation will notify the referring GP.

Clients need to access *Psychological Therapies* within one month of the referral and utilise all referred sessions (the initial six-session block), including group programs, within four months. Unless sessions are extended for a further six or twelve sessions, any sessions not utilised after four months will no longer be valid and services should not be provided to the client by the contracted organisation. Referrals will be closed by the *Psychological Therapies* service provider on the date, or close to the date, following four months from the date of referral. This clause does not apply to services that are place-based (remote).

Additionally, the intake assessment and triage service provider must liaise with NQPHN when they experience delays or waitlists for clients where the above timeframes are unable to be met.

5.6 Occasions of service – *Psychological Therapies*

The service must include the following components:

- » provision of evidence-based, short-term psychological intervention to achieve positive outcomes for the client including:
 - psychoeducation
 - cognitive behavioural therapy (including behavioural and cognitive interventions)
 - relaxation strategies
 - skills training
 - interpersonal therapeutic strategies
 - narrative therapeutic strategies
 - interventions for children, as part of the above interventions
 - parent management training
 - family therapy
- » timely access to services—the preferred maximum time between appointments is 2.5 weeks where possible and appropriate
- » provision of flexible service approaches to engage and meet the needs of the client including format of delivery, which could include face-to-face, telephone, or internet-based
- » provision of services that consider the cultural and social diversity of the clients to meet their needs
- » provision of individual and/or group-based services to best meet the individual needs of the client to achieve positive outcomes
- » facilitation of referral via the IATR provider to an alternative *Psychological Therapies* provider in the event of a request from a client for a change of therapist
- » facilitation of referrals to other health services within the stepped care approach to ensure people are matched to services commensurate with their needs

- » facilitation of referral or access to an appropriate range of agencies, programs, and/or interventions to meet the client's needs for leisure, relationships, recreation, education, training, work, accommodation, and employment in settings appropriate to the individual consumer. Depending on the person and their circumstances, this may be facilitated by the IATR provider at the point of initial referral, or the *Psychological Therapies* provider during the course of treatment
- » unused sessions from one calendar year may be rolled into the next calendar year, however unused sessions will be deducted from the allocation for the new year. For example, a client who has used four sessions in one year may use the remaining two sessions in the following year, but these will be counted towards the allocation of six sessions in the new calendar year.

Individual sessions – requirements

- 1-6
- Referral from a GP, psychiatrist, or paediatrician.
 - A mental health treatment plan is completed.
 - In some circumstances other clinicians may make a provisional referral.
While it is understood that GPs play a central role in the overall and ongoing care of clients, it is also understood that in some instances, a referral from a GP (or psychiatrist) may not be possible. The provisional referral pathways are in place to overcome barriers to access for those eligible for Psychological Therapies Services and allows identified service providers to refer clients. Provisional referrals to service may enable service delivery to commence while arrangements are made to see a GP and have a 'GP Mental Health Treatment Plan' developed.
 - A provisional referral can be made by the following professions and clinicians:
 - » Mental health professionals who are eligible to provide services under Psychological Therapies (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.
 - » Women with perinatal depression may be provisionally referred by a maternal and child health nurse.
 - » Public hospital ward clinical staff/nurses.
 - » Medical officers in non-government organisations (NGOs).
 - » Hospital and Health Service Mental Health Acute Care Teams.
 - » Stepped Care IATR Clinicians.

In the case of provisional referral or referral the mental health treatment plan should be completed within two weeks of the commencement of treatment, or four weeks in a rural and remote area, or as soon as practical where access to GPs is not readily available, please advise NQPHN if this is occurring regularly.

- Where there are difficulties in meeting the mental health treatment plan requirement for some groups of clients NQPHN will consider exemptions.

- 7-12
- On completion of the initial course of six sessions, the mental health professional is to provide a written report to the referring medical practitioner.
 - The written report is to include information on assessments carried out, treatment provided, the individual's outcomes, and recommendations on future management of the individual's mental disorder.
 - Following receipt of the report, the referring practitioner will consider the need for further treatment and if clinically required refer the individual to the IATR provider for allocation to an additional 7-12 sessions. This request may be arranged through telephone or email and does not require a face-to-face consultation. However, where referral for additional sessions is obtained by telephone, the IATR provider is to document the GP's agreement to the continuation of treatment.
 - Further allied mental health services may not be provided without referral or agreement by the GP for additional sessions.
 - Unless the individual under treatment is being provided with a new referral for a new course of treatment for a different condition, this is considered to be a continuation of the original course of treatment and is not to be recorded as a new course of treatment or as a new individual.
 - On completion of 12 sessions of treatment, the allied health professional must provide a written report to the referring medical practitioner. The written report is to include information on assessments carried out, treatment provided, the individual's outcomes and recommendations on future management of the individual's mental disorder.

-
- 13-18
 - In exceptional circumstances, the individual may require an additional six sessions above those already provided (up to a maximum total of 18 individual sessions per client per calendar year).
 - Approval of a further six sessions (to 18) is available, if this has been approved by a psychiatrist/specialist. This may be done via a private psychiatrist, a non-urgent bulk billing HHS psychiatrist, or via a telehealth psychiatrist.
 - Unless the individual under treatment is being provided with a new referral for a new course of treatment for a different condition, this is considered to be a continuation of the original course of treatment and is not to be recorded as a new course of treatment or as a new individual.
-

Group sessions – requirements

- 1-12
 - Up to 12 group therapy services within a calendar year involving 6-10 people. Group sessions do not count towards the 12 individual allied mental health services in a calendar year.
 - Referral from a GP, psychiatrist, or paediatrician (and for perinatal depression services, obstetricians, and maternal and child health nurses can refer patients).
 - In some circumstances other clinicians may make a provisional referral (refer to referral processes).
 - The referring practitioner should ensure the client's mental health treatment plan or referred psychiatrist assessment and management plan is completed.
 - In the case of provisional referral or referral by a maternal and child health nurse the mental health treatment plan should be completed within two weeks of the commencement of treatment, or four weeks in a rural and remote area or as soon as practical where access to GPs is not readily available.
 - Two facilitators are required to lead group sessions with each facilitator meeting the *Psychological Therapies* eligibility criteria to provide services.
 - Providers may include clients who are serviced by other programs, such as Better Access, however payment will only be available to providers for *Psychological Therapies* clients.
-

5.7 Continuity of care and discharge planning

The *Psychological Therapies* service provider is required to ensure continuity of care for the client through appropriate referral, communication, and liaison with other services involved in the clients care plan to maximise outcomes for the client.

On completion of all referrer requested individual and/or group sessions, the *Psychological Therapies* providers are required to agree to a discharge plan with the client that includes self-care information for patients and carers, any advice on maintaining their health, and referral or advice on other health and community services where required and this may also include access to e-health service options.

A copy of the discharge plan and session outcome report must be provided to the client and clinical referrer on completion of the episode of care, and where appropriate, referrals for ongoing support are completed.

5.8 Workforce

The *Psychological Therapies* service provider will be responsible for maintaining a register of mental health providers delivering assessment and treatment services and ensuring that they have completed the required training and maintained other professional eligibility requirements (see Appendix A). This will be provided to the IATR to facilitate appropriate referrals.

Appendix A provides detail of the qualifications and standards required for mental health professionals to provide *Psychological Therapies*.

Should the capacity or availability of employees/contractors within the service provider change, it is the organisation's responsibility to notify NQPHN and the IATR provider immediately. This includes holidays, extended sick leave, Christmas closure, etc.

Should an employee/contractor leave employment with the *Psychological Therapies* service provider, it is the responsibility of the organisation to transfer the client's case to another employee/contractor. Additionally, NQPHN must be advised within five working days.

Should a new employee/contractor join the organisation, it is the responsibility of the service provider to advise NQPHN so the employee/contractor can be included in the service provider's contract for services details. The employee/contractor cannot provide the service until the notification of inclusion is received by the service provider from NQPHN.

Service providers must demonstrate evidence that they have appropriately accredited mental health professionals working within their scope of practice—including psychologists, mental health nurses, occupational therapists, social workers, and Aboriginal and Torres Strait Islander health workers. Specialist skills, knowledge, and experience, and additional training in working with the nominated hard to reach groups is a prerequisite and must be demonstrated.

Examples of additional training could include:

- » child (0–12 years)
 - children's mental health training
 - post graduate tertiary qualification and/or advanced education in child health
 - note: provisionally registered mental health providers are not eligible to provide services to children under 12 years old
- » suicide prevention
 - specialist suicide and self-harm training
on-line training is available through the Australian Psychological Society Institute at www.psychology.org.au/Training-and-careers/APS-Institute
These courses are available to a range of professions and the Foundations of Suicide Prevention course is recommended for *Psychological Therapies* providers who wish to develop skills in the suicide prevention area
- » Aboriginal and Torres Strait Islander peoples
 - cultural competence training for non-Indigenous mental health practitioners
- » Culturally and Linguistically Diverse (CALD)
 - cultural competence training for working with people from culturally and linguistically diverse backgrounds
 - bilingual and/or evidence of skills and experience working with interpreters
- » LGBTIQ
 - evidence of inclusive practices and participation in increased awareness regarding LGBTIQ people and needs (i.e. attending training, networks, seminars, programs, etc.)
- » homeless
 - have evidence of skills and experience in providing a service in a non-traditional setting (i.e. ability to provide outreach services)

Service providers who sub-contract the services will need to ensure that the sub-contractor complies with the relevant sections of the NQPHN conditions of contract and contract for services.

5.8.1 Telephone and videoconferencing based Cognitive Behaviour Therapy (CBT).

- » mental health professionals must have undertaken specific training in CBT and be competent in the delivery of these therapeutic techniques when treating people with mental health issues via video conferencing or telephone
- » no additional funds will be provided to the service provider using videoconferencing or telephone CBT as a mode of service delivery
- » videoconferencing is only to be used by the service provider where IT infrastructure is already in place
- » signed consent must be obtained from clients for this mode of service delivery.

6. Place-based (remote) *Psychological Therapies*

6.1 Background

Place-based (remote) services are designed to provide flexible *Psychological Therapies* service delivery to remote areas of the NQPHN region, through a block-funded service provision model instead of session-based payments. This funding model also acknowledges the previous Mental Health Services in Rural and Remote Areas (MHSRRA) funding program that was provided in the Cairns and Cape Areas of the NQPHN region prior to the introduction of stepped care.

6.2 Relationship to the NQPHN Mental Health Stepped Care Operational Guidelines

6.2.1 Applicable sections

Sections 1 and 2 of these operational guidelines are applicable to place-based (remote) services and should be read in conjunction with the Conditions of Contract and the Contract for Services. These sections include:

- » Program overview
- » Stepped care provider requirements, including
 - Quality management
 - Risk management
 - Client consent
 - Client data
 - Outcome assessment tools
 - Workforce requirements
 - My Health Record
 - Translating and Interpreting Service (TIS)
 - Complaints and feedback
 - Crisis support mechanism
 - Reporting and evaluation
 - Promotion of stepped care services

Sections 3 and 4

- » These sections detail the responsibilities of (3) the intake, assessment, triage, and referral (IATR) and (4) low-intensity components of the stepped care model.
- » Place-based providers should familiarise themselves with these components of the stepped care model.
- » (3) Intake - Place-based providers are funded on the basis of providing intake for people in their regions, rather than through the IATR provider.
- » The place-based model allows for the IATR to provide limited Intake for people who reside in remote regions, where circumstances require such facilitation. This may arise for example, in a situation where a resident is hospitalised in Cairns and referred locally to the Cairns office of the IATR for follow-up, but is discharged back to their remote region of residence
- » Models should acknowledge the individual characteristics and needs of the local communities in which they will be delivered. Models should complement existing services, be geographically and culturally appropriate and suit the specific needs of the local population.
- » Place-based service providers should undertake individual, professional and community capacity building activities in their local area, in a manner that complements and enhances direct service delivery but does not detract from it.

Section 5: *Psychological Therapies* applicable sections include:

- » 5.1 Priority groups
- » 5.2 Eligibility criteria
- » 5.3 Exclusion criteria
- » 5.4 Relationship with Better Access
- » 5.5 Response times and priorities; see table below for response times to place-based services.
- » 5.6 Occasions of Service - requires amendments for place-based services – see below.
- » 5.7 Continuity of care and discharge planning
- » 5.8 Workforce
- » All sections of 5.6 of the NQPHN Mental Health Stepped Care Services Operational Guidelines apply to place-based services, with the following not applicable:
 - The table of Individual Sessions and Groups (page 19–20) is not applicable. The following table below applies:

5.6 Place-based (remote) *Psychological Therapies* services**Individual sessions**

- Place-based remote *Psychological Therapies* providers will provide services to individuals with a mild to moderate diagnosable mental illness.
- There is flexibility in referral source, and referrals can be received from numerous sources, including RNs, Primary Health Clinics, NGOs, etc. however a medical/general practitioner should have responsibility for clinical assessment and management of the client through a comprehensive mental health treatment plan.
- Many remote locations will have difficulty in accessing a medical/general practitioner and flexibility in obtaining a treatment plan is permitted. The client can be engaged with up to four sessions prior to obtaining the treatment plan.
- Videoconferencing or teleconferencing should be utilised for client contacts where circumstances do not permit regular face-to-face access or may delay contact with a general practitioner.
- As a guide, sessions numbers should be consistent with those specified for general *Psychological Therapies* providers, with flexibility of the period of time in which these contacts occur. *Psychological Therapies* are intended as a short-term intervention and time-limited.
- Initial assessments for all clients except suicide prevention referrals, should occur within a fortnight of receipt of referral. Sessions should be delivered within a six-month period.
- Clients should be reviewed after eight *Psychological Therapies* sessions to determine progress and ongoing requirements for therapy.
- Suicide prevention referrals should be initially contacted (by phone, videoconferencing, or face-to-face if possible) within three days of referral.

Group sessions

- It is acknowledged that group programs are difficult to resource in remote locations, and there is no expectation of providers being able to conduct group programs.
- If there is scope for group program delivery, place-based providers may include clients who are serviced by other programs, such as Better Access.

Section 7: Mental Health Integrated Complex Care (MHICC)—severe and complex services

- » Place-based services need to familiarise themselves with this section of the operational guidelines, although severe and complex services will be difficult to access in remote regions.

Appendix A: Eligible requirements for mental health providers under Psychological Services—Please note special recommendation regarding qualified staff servicing remote areas.

7. Mental health integrated complex care – severe and complex mental health services

The previous Mental Health Nurse Incentive Program (MHNIP) is transitioning into the Stepped Care – Mental Health Integrated Complex Care (MHICC) program, which is targeted to the severe and complex component of the stepped care model for NQPHN. The transition has occurred in Cairns and Mackay and will progress in Townsville in early 2020. Individuals referred to the MHICC program will require a referral from a GP, which is to be directed to the central IATR.

7.1 Eligibility criteria

Consistent with the Commonwealth Guidelines, the clients of MHICC will be individuals who:

- » experience severe mental illness with complex needs, including severe episodic illness
- » have at least two or more aspects of their life significantly impacted by mental illness (e.g. relationships, employment, education, housing, community inclusion, physical health, etc.)
- » have experienced a hospitalisation for mental health issues in the past or be at risk of hospitalisation if not supported
- » are best supported in primary health care
- » are not current clients of HHS mental health services
- » are expected to need ongoing treatment of their disorder over the next two years, at which time a review of ongoing needs will be conducted.

7.2 Exclusion criteria

The following exclusion criteria apply to clients of the program:

- » clients who do not live in the NQPHN area
- » clients whose sole requirements are psychosocial supports
- » clients whose situation has resolved and is no longer significantly disabling.

7.3 Service delivery

The new severe and complex program will ensure that individuals are placed at the centre of their own health and wellbeing, and experience improved care and mental health. The services will ensure that:

- » individual Mental Health Treatment Plans are in place, including recovery planning
- » services are provided at little or no cost to the patient (this would preferably include access to bulk-billed GP services where applicable)
- » there is improved client mental health literacy and awareness of services
- » there is improved self-management/self-reported status of mental health
- » individuals can access the service when they need it
- » individuals report increased satisfaction on their experiences of service
- » there is improved coordination of care and improved access to clinical and non-clinical services
- » there is a reduction in mental health in-patient unit admissions for the patient group
- » family and significant others are supported
- » services can be provided in modes that suit the patient (while face-to-face is preferred, group programs, video links, or telephone support, can be utilised where required)
- » support can be provided in clinical or community-based settings, depending on needs and staff requirements.

7.4 Service types

As part of delivery of a person-centred and holistic service, the following service types will be required. These can be provided individually, or in group programs for MHICC clients where appropriate.

- » complex care coordination and referral to appropriate services
- » psychoeducation and support to self-manage illness
- » family support
- » recovery planning—the National Framework for Recovery-oriented Mental Health Services (2013) provides resources for providers at www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde
- » physical health care monitoring and metabolic monitoring
- » medication management.

7.5 Referrals

- » referrals for MHICC services will be received from GPs and private psychiatrists by the intake, assessment, triage, and referral (IATR) provider
- » the IATR provider will allocate eligible patients to an area hub where MHICC services are available and there is capacity in the caseload. The IATR will provide the referral details to the hub within a week of receiving the referral
- » non-availability of MHICC services may require the IATR provider to seek interim alternative services or instigate referral of the individual back to the GP/psychiatrist
- » MHICC service providers will regularly liaise with the IATR provider regarding availability of places and current caseloads.

7.6 Caseloads

MHICC mental health nurses should carry a caseload not exceeding 35 patients per 1 FTE position at any one time.

7.7 Workforce

MHICC services will be staffed by Credentialed Mental Health Nurses. See Appendix A for credential requirements.

8. Psychological Therapies for people with mental illness in Residential Aged Care Facilities

This section provides information specific to the Psychological Therapies pilot project for people with mental illness in Residential Aged Care Facilities (RACFs). As per 5.3 of these Operational Guidelines, people who live in a government-funded aged care facility have been excluded from Psychological Therapies under the Mental Health Stepped Care Services. In response to the evidence that RACF residents have very high rates of common mental illness, PHNs have been resourced to commission services to address this gap via a staged approach.

Client eligibility

- » Residents of RACFs who have a diagnosed mental illness with mild to moderate symptoms.
- » Residents of RACFs with severe mental illness who are not more appropriately managed by Older Person's Mental Health Service and would benefit from psychological therapy are not excluded.
- » People who are assessed as 'at-risk' of developing a mental illness over the next 12 months may be eligible.
- » Residents who are experiencing significant transition issues, adjustment disorders, or grief or loss issues may be eligible if it is deemed that early treatment may prevent progression to a mood disorder.
- » Residents who in addition to their mental illness have cognitive decline or dementia may be eligible.

Not in scope

- » Services that duplicate the role of Older Person's Mental Health Service, Dementia Behaviour Support Services, or other aged care services such as the Community Visitors Program.
- » Services currently provide by RACFs such as social and recreational support.
- » Services for families or carers who are not residents.
- » Disability Support services.
- » RACF staff or services.

Referral

- » Referrals can come from a wide variety of sources including: RACFs, GP, self, family, ACAT, Older Persons Mental Health Service, Geriatricians.
- » The MBS item GP Mental Health Treatment Plan is not available in RACFs and is therefore not required as indicated by 5.1 of the Operational Guidelines.

Interventions

Some adjustment and tailoring of psychological therapies may be required to meet the particular needs of RACF residents:

- » It may take longer to engage with clients, because of hearing problems or cognitive decline.
- » Cognitive behaviour therapy may need to be adapted to the particular capabilities and needs of the individual and will not be appropriate for residents with significant cognitive decline.
- » Evidence-based therapies include reminiscence therapy, validation therapy and adjusted cognitive behaviour therapy.
- » The mental health terms used will need to match the cohort and attitudes of older people. For example, the term 'mental wellbeing' may be better than depression or mental illness.
- » Group sessions may be appropriate for some residents.
- » Interventions will be generally be provided on location at RACFs (in-reach services).

Intervention Period

As with other psychological therapies, it is intended that the focused Psychological Therapies in RACFs are short-term and goal oriented.

For the reasons outlined in this section, there is some flexibility in the number of sessions required. It is expected that this will range from 6 to 12 sessions. After the initial course of six sessions the mental health professional would provide a report to the intake officer as to the requirement for further sessions. In exceptional circumstances, the individual may require a further six sessions to a maximum of 18 sessions.

In line with 5.5 of Operational Guidelines, upon receipt of a referral, the Psychological Therapies service will contact the client within three working days to make an appointment offer within two weeks.

Outcome measures

In line with evidence-based practice to date the recommended outcome measures are:

- » K5
- » QoL AD.

Documentation/data systems

- » The rediCase system will be utilised via direct input for MDS.
- » RACF resident data system.

Training will be provided to contracted mental health professionals in these data systems.

Appendix A

NQPHN stepped care–eligibility requirements for clinical mental health providers

The following table defines the eligibility requirements for mental health providers who are contracted to provide *Psychological Therapies* as part of the NQPHN stepped care model.

Mental health social worker	Accredited mental health social workers with the Australian Association of Social Workers (AASW) and that they therefore: <ul style="list-style-type: none">• maintain current membership of the AASW• maintain accreditation as a mental health social worker• meet the ongoing requirements of the AASW Continuing Professional Development (CPD) program• meet the AASW practice standards for mental health social workers.
Mental health nurse	Current general registration as a nurse (Division 1) or as a registered nurse (Division 1) with a sole qualification notation (mental health nursing) with the Australian Health Practitioners Regulation Agency (AHPRA) and that they therefore meet all the following registration standards: <ul style="list-style-type: none">• criminal history registration standard• English language skills registration standard• registration standard: Continuing professional development• registration standard: Recency of practice• registration standard: Professional indemnity insurance arrangements. <p>Credentialed by the Australian College of Mental Health Nurses Inc., that they therefore have demonstrated evidence of:</p> <ul style="list-style-type: none">• a specialist or post-graduate mental health nursing or psychiatric nursing qualification• twelve months' experience since having undertaken a specialist or postgraduate qualification, or a minimum of three years' experience as a registered nurse in mental health• recent practice in mental health.
Psychologist	General registration as a psychologist with AHPRA and that they therefore meet all the following registration standards: <ul style="list-style-type: none">• continuing professional development registration standard• criminal history registration standard• English language skills registration standard• professional indemnity insurance arrangements registration standard• recency of practice registration standard.

Occupational therapist	<p>General registration as an occupational therapist with AHPRA and that they therefore meet all the following registration standards:</p> <ul style="list-style-type: none"> • continuing professional development registration standard • criminal history registration standard • English language skills registration standard • professional indemnity insurance arrangements registration standard • recency of practice registration standard.
Aboriginal and Torres Strait Islander health workers	<p>General registration as an Aboriginal and Torres Strait Islander health practitioner with AHPRA and that they therefore meet all the following registration standards:</p> <ul style="list-style-type: none"> • continuing professional development registration standard • criminal history registration standard • English language skills registration standard • professional indemnity insurance arrangements registration standard • recency of practice registration standard. <p>Aboriginal health workers who are not required by their employer to use the title 'Aboriginal and Torres Strait Islander Health Practitioner', 'Aboriginal Health Practitioner', or 'Torres Strait Islander Health Practitioner', are not required to be registered, and can continue to work using their current titles (for example, 'Aboriginal Health Worker', 'Drug and Alcohol Worker', and 'Mental Health Worker').</p>
Provisional/intern Psychologists and graduate social workers.	<p>Providers of services should be adequately experienced in the field of mental health or (to allow for entry of newly trained persons in the field) under the approved and direct professional supervision of a fully qualified and registered professional expert in that field who meets the criteria set out above.</p> <p>Supervision must meet the requirements of the relevant professional organisations.</p> <p>Suicide prevention service, and services to children under 12 cannot be provided by provisional/intern or new graduate staff.</p>
Remote area workers	<p>Due to the difficulties in recruiting professionals to remote areas, suitably experienced applicants who lack credential criteria will be assessed on a case-by-case basis by a NQPHN subject matter expert panel.</p>

Additional to the registration requirements the following knowledge, skills, and experience is required by all practitioners.

- » demonstrate knowledge, skills, and experience in the area of focused psychological strategies, including:
 - psychopathology
 - counselling theory and practice
 - evidenced-based interventions
 - minimum two years' experience practicing their profession in the field of mental health
 - be currently engaged in professional practice in other areas of work (that is, private practice work, employed part time by public mental health service, etc.)
 - specific training in providing services to people at risk of suicide which is culturally appropriate
 - local cultural capability training.

If providing services to children under 12 the practitioner requires:

- » extensive child development knowledge (post graduate level)
- » relevant training and experience in working clinically with children, parents, and families.

Qualifications and training should ensure that all non-Indigenous providers delivering Psychological Therapies—Aboriginal and Torres Strait Islander have completed appropriate training and evidence of cultural competency to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people.

Appendix B

Primary Mental Health Care– Minimum Data Set (PMHC-MDS)

The PMHC-MDS is designed to capture data on PHN-commissioned mental health services delivered to individual clients, including group-based delivery to individual clients.

Initially this will include, but not be restricted to:

- » *Psychological Therapies* delivered by mental health professionals (as per previous ATAPS/MHSRRA programs)
- » services delivered by mental health nurses, formerly captured through the Mental Health Nurse Incentive Program (MHNIP) session claim process maintained by the Department of Human Services
- » mental health interventions delivered by the new 'low intensity' workforce
- » care coordination targeted at people with severe and complex mental illness
- » suicide prevention services delivered to individuals
- » services delivered to Aboriginal and Torres Strait Islander peoples.

The intent is to ensure that the PMHC-MDS has capacity to collect data and report on a broader range of services than the previous ATAPS/MHSRRA MDS, covering the full spectrum of individual client-centred services expected to be delivered through PHN commissioning processes.

The scope of coverage does not extend to services targeted at communities, such as the community capacity building activities previously funded under projects sourced from National Suicide Prevention Program funding. Collection and reporting of activities of this type requires a different approach to 'counting' and identification of the client. A national MDS covering suicide prevention activities of this type has been in place for several years and is currently being considered for the future. PHN commissioning activities of this type will have flexibility to establish local data reporting arrangements that suit their requirements.

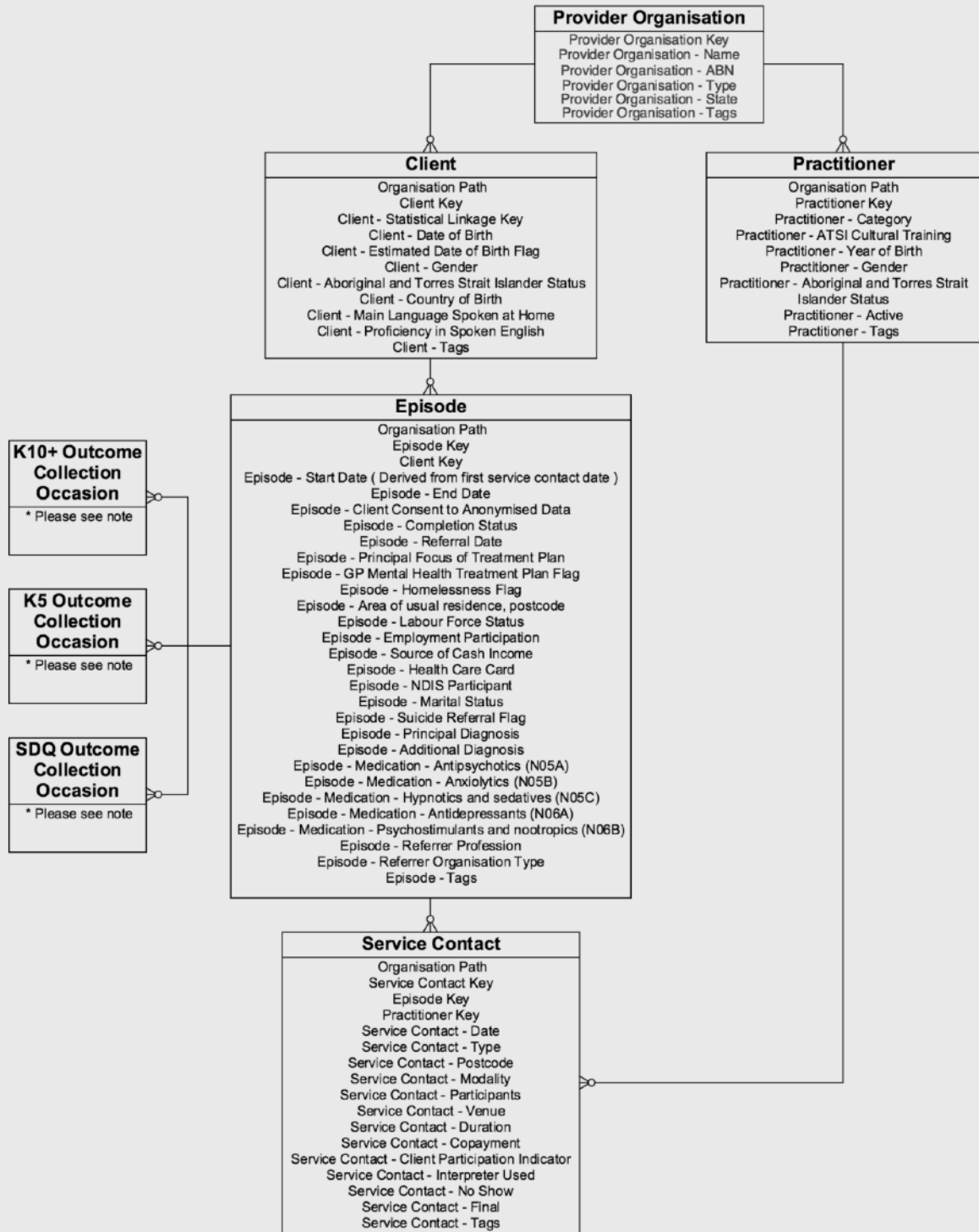
First stage development of the PMHC-MDS does not include existing youth-specific services (headspace, Early Psychosis Youth Services) that currently, and will continue to, collect and report a standardised dataset to headspace National Office. Pending the future of these arrangements, and access to data by PHNs, the PMHC-MDS may be expanded at a future stage to allow incorporation of headspace and Early Psychosis Youth Services should this be required.

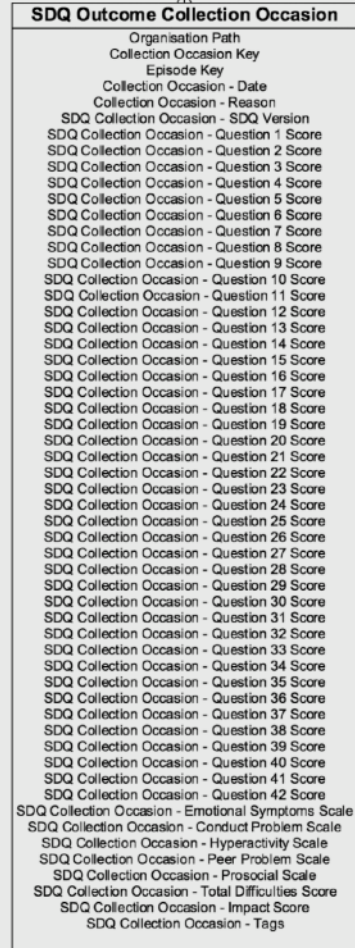
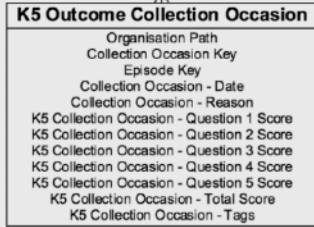
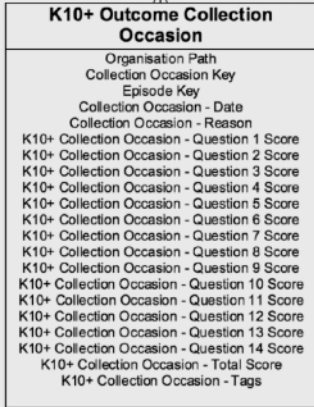
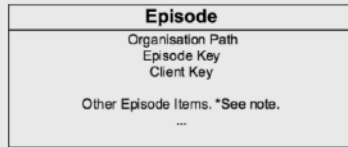
A User Guide for the PMHC-MDS is available at www.pmhc-mds.com/resources/

The data model for the PMHC-MDS is detailed on the following page.

PMHC-MDS data model

(See notes regarding episode on the following page)





Appendix C

Suicide prevention services (SPS)

1. Objectives

The suicide prevention service 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).

The service is not intended to increase the number of high-risk people being managed in the primary health care setting or to divert people from the care of the state or territory mental health services, but to better support those people already being managed in the primary health care setting. 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 patients. This service is also not designed to reduce the responsibilities of acute mental health services, but to ensure support for people whose care is usually in the primary health setting.

2. Eligibility

The suicide prevention service is primarily designed for the following four groups of people:

- » people who, after a suicide attempt or self-harm incident, have been discharged into the care of a GP from hospital or released into the care of a GP from an emergency department
- » people who have presented to a GP after an incident of self-harm
- » people who have expressed strong suicidal ideation to their GP
- » people who are considered at increased risk in the aftermath of a suicide.

Consideration should be given to the short-term nature of the suicide prevention service and whether the individual is more appropriately supported by the state or territory acute mental health service.

3. Ineligible clients

This service is not designed for people 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 accident and emergency department
- » people who have been discharged from a psychiatric accident and emergency department (these are not available in North Queensland but may be relevant for people who have moved from another state or country).

4. Referrals

Referrals for Suicide Prevention Services are limited to one referral per calendar year. However, should an individual require multiple referrals, consideration should be given to whether that individual is more appropriately managed by an alternative service.

Referrals must be cognisant with existing policies and protocols relating to the way in which people who have attempted or are at risk of suicide and self-harm are managed within the state mental health system. The service needs to ensure that existing pathways are complemented and not interrupted.

Referrals can be received from:

- » GPs
- » accident and emergency departments
- » hospital wards
- » state acute mental health support teams where the person has been identified as not at acute or immediate risk and is best supported by the service post assessment.

Individuals referred to the service do not need to have in place a diagnosed mental health disorder or a completed GP mental health treatment plan.

People referred directly from the hospital setting or acute mental health support team should visit their GP or Aboriginal medical service within two weeks of the first service to ensure all their health care needs are being addressed.

5. Crisis and other referral arrangements

In order to provide services through the suicide prevention service, the service provider must have formal arrangements in place with the acute mental health team (or equivalent) for the referral of individuals who are at acute and immediate risk of suicide, self-harm, or harm to others. These arrangements must be in place prior to the provision of services.

The service provider will also have a formal liaison role with other services, including local GP practices and emergency services in the local hospitals, to ensure optimal and timely referral of individuals to allied health providers.

The service provider will work with state mental health services to clarify the roles of each service and develop working arrangements for the referral of people from one service to the other.

See Section 7: Support services.

6. Intervention timing

The suicide prevention service is designed to provide immediate and short-term support for people 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 under this service will have priority access and the mental health provider is to contact the person within 24 hours of referral.

The first session with the mental health provider must occur within 72 hours of referral or earlier if clinically indicated. If this is not possible due to limited availability of the allied health professional due to the weekend or public holidays, or for other factors, arrangements must be made for the after-hours suicide support line (see below) to contact the person and provide support until the allied health provider can contact the individual and/or deliver a service.

The number of sessions is limited to 18 in the initial period of contact (generally two months), and the number of sessions provided has no impact on Better Access sessions or further referrals for *Psychological Therapies*. Individuals should be reviewed by their GP when a 12-session block is completed. Repeated requests for sessions should be considered in terms of appropriateness of acute care services or *Psychological Therapies*. The service is not intended to provide long-term support.

Clinical service delivery should be primarily face-to-face consultations with a series of follow-up phone calls to promote ongoing therapeutic contact.

The mental 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 mental health provider will retain responsibility for the clinical suicide prevention intervention services.

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

When a client, during a course of current sessions with a provider, presents as possibly requiring suicide prevention services, the *Psychological Therapies* provider may have two options depending on the client's situation and assessed risk:

- » if possible, consider rescheduling general *Psychological Therapies* sessions, such that they are more responsive/more frequent as appropriate to the client's presentation. The *Psychological Therapies* provider should then provide a review to the GP at end of the course of six sessions making a recommendation for further sessions (if necessary). Completion of further general sessions or an SPS referral (one SPS referral per calendar year) by the GP can be recommended as part of the end of sessions review if necessary.

OR

- » immediately refer the person to their GP for review, or to the Hospital and Health Service Acute Care Team (ACT) service for review, who may then consider referral to the SPS program as appropriate.

7. Support services

The service provider must ensure appropriate support arrangements are in place for mental health providers working in the suicide prevention service, for example clinical supervision. Providers can also contact their own professional membership bodies to access any member services that may be available to them for these purposes, as well as individual supervision with the service.

All Hours (AHS) suicide support line—On the Line

On the Line is a professional social health business providing counselling support, anywhere and anytime. On the Line's highly trained counsellors provide professional, quality telephone, web chat, and video counselling services to more than 75,000 people each year.

The AHS suicide support line is a suicide prevention telephone service provided by On the Line to PHNs and replaces the previous ATAPS suicide prevention service.

The AHS suicide support line can be accessed in two ways:

- » Mental health providers may contact the line directly and request that a call is made to a client. This may be particularly important when the provider is unable to see the client immediately, may have been referred outside business hours, or needs additional support outside business hours. Contact by telephone 1800 859 585 or email ahs@ontheline.org.au

A client may directly contact the AHS suicide support line on 1800 859 585 when they feel they need additional support.

Appendix D

Psychological Therapies—children under 12 (PTC-U12)

1. Eligibility

These services are primarily designed for children under 12 years of age who have, or are at risk of developing, a mild to moderate mental, childhood behavioural, or emotional disorder, and who could benefit from short term focused psychological strategies services that *Psychological Therapies* provides, that are of most therapeutic value to individuals with common disorders of mild to moderate severity. However, individuals with more severe illness whose conditions may benefit from focused psychological strategies as part of their overall treatment may also be provided with the services.

The eligibility criteria for services include:

- » A child assessed as having definite or substantial signs and symptoms of an emerging mental disorder (including conduct disorder), where this causes 'significant dysfunction in everyday life'.
- » A child at risk of developing a mental disorder, where the child shows one or more signs or symptoms (social-emotional-behavioural) of developing a mental disorder and/or where the child's developmental pathway is considered to be disrupted by their mental health condition (i.e. not limited to disruptive disorders). Signs of disruption to functioning in one or more settings are included in some circumstances.
- » Children between the ages of 12 and 15 can also access the services. In such circumstances, a child must have the clinical need and no other suitable mental health services exist in the region that the child could be referred to.

2. Mental disorders and contextual factors

Mental disorder definitions are 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 mental disorders and contextual factors relevant to children under 12 years of age that can be treated under *Psychological Therapies* are outlined in Table 1 below.

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

Table 1: List of childhood disorders (continued)

8	Neurasthenia (Chronic Fatigue Syndrome)	
9	Eating Disorders	
10	Feeding Disorders	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.) it is recommended that the child should not be referred to Psychological Services 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
11	Encopresis	
12	Enuresis	
13	Bereavement Disorders	
14	Childhood behavioural disorders, limited to:	
	(a) Conduct Disorder	
	(b) Attention—Deficit/Hyperactivity Disorder (ADHD)	
	(c) Oppositional Defiant Disorder	
	(d) Disruptive Behaviour Disorder not otherwise specified (NOS)	
15	Tic disorders (e.g. Tourette's syndrome)	
16	Substance use disorders (e.g. glue sniffing, alcohol and drugs)	
17	Sexual disorders—including but not limited to Gender Identity Disorder of Childhood	
18	Dissociative (conversion) Disorder*	
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)	

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

3. Access to PTC-U12 by parents and family

PTC-U12 is also available to parents and family members or to other persons having responsibility for the child (i.e. guardians or persons having custodial responsibility) to assist them to better support the child. It is important that parents or other responsible adults who have a mental disorder themselves and require psychological strategies services be referred to the adult services rather than receive services under the child.

References in this document to persons having responsibility for a child accessing *Psychological Therapies* include parents, guardians, or persons having custodial responsibilities for the child.

4. Eligibility of children at risk of suicide or self-harm

Where children are at risk of suicide, the service provider may choose to refer to the *Psychological Therapies* suicide prevention service subject to an individual's clinical need and available expertise within the service to manage children at risk of suicide. Treatment and referral in crisis situations must be supported by the local protocols to ensure crisis referral arrangements are in place for children under 12 years of age and clinicians are to work in conjunction with other professionals (e.g. child psychiatrists and paediatricians) on a case-by-case basis depending on the availability of other clinicians and parent consent.

Children who are at acute or immediate risk of suicide or self-harm or who have a severe and persistent mental illness should be referred to the emergency department or relevant state government acute mental health service or a child psychiatrist. *Psychological Therapies* is not designed for individuals who are already being managed by state government mental health services and is 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 patients in the primary care setting.

5. Referral requirements

Infants and children can be referred to the PTC-U12 service by their GP, paediatrician, or psychiatrist. Infants and children do not need to have a mental or childhood behavioural or emotional disorder diagnosed in order to access the PTC-U12 service. 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, in order to access the service. In cases where there is no diagnosis the referring GP, paediatrician, or psychiatrist should record symptoms which indicate that the child is at significant risk of developing a mental disorder or childhood behavioural or emotional disorder.

Stakeholders and referring practitioners should be made aware, that referrals to PTC- U12 are only for individuals that require short term support, and in some cases, individuals may be more appropriately referred to another local service, such as the Child and Youth Mental Health Services (CYMHS).

6. Provisional referral

In some instances, a referral from a GP, paediatrician, or psychiatrist may not be possible. Provisional referrals to the PTC-U12 service may enable service delivery to commence while arrangements are made to see a GP and have a 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 PTC-U12 (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 the parents).
- » Directors of early childhood services.
- » Medical officers in non-government organisations (NGOs).

Other provisional referral arrangements apply for the different target groups, which may be appropriate for some children.

7. Child Treatment Plan (CTP)

Clients must have an assessment conducted and a CTP developed to be eligible for PTC-U12. Provisional referrals do not require a CTP to be provided at the time of referral to the service.

Where referrals are made by professions other than a GP, patients must have a CTP 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 there is no ready access to GPs.

It is recognised that in some communities or for some individuals a GP may not be the primary provider responsible for the overall care of the person. Where an individual is receiving primary care from an Aboriginal Medical Service (AMS) for example, the parent/guardian should be encouraged to visit this alternate primary health care provider in order to ensure other health care needs are being managed. There may also be difficulties in meeting the CTP requirement in very remote areas without ready access to GPs, with providing treatment to homeless people including homeless children, or in some Aboriginal and Torres Strait Islander communities.

7.1 Format of the PTC-U12 CTP

Referrals may be made face-to-face, by telephone, electronically, or in writing using a referral proforma based on the format suggested by the Royal Australian College of General Practitioners (RACGP).

GPs can access Medicare Benefit Scheme (MBS) items to develop the treatment plan or another MBS item where appropriate.

Where there is no diagnosed mental disorder the referring medical practitioner should document in the CTP that there is evidence that a child is at a significant risk of developing a mental, childhood behavioural or emotional disorder and would benefit from short term focussed psychological strategies services.

8. Number of sessions

As outlined in the NQPHN Mental Health Stepped Care Operational Guidelines, currently the total number of sessions the client can access under the PTC-U12 is up to 12 in a calendar year (up to 18 in exceptional circumstances), as outlined in Table 2 on the following page.

In the case of children, referral for up to an additional six sessions under exceptional circumstances, could be extended to include specific clinical situations where ceasing treatment would lead to a detrimental outcome for the child (determined on a case by case basis).

The assessment of the child plays a pivotal role in determining the nature and severity of the disorder, the type of intervention required and the number of sessions required and hence, the referral pathways. PTC-U12 clinicians have the option of referring children out for a developmental/cognitive assessment (with parental consent) to a suitably qualified professional (e.g. school psychologist or private practitioner) as deemed necessary.

Parents can be present at all sessions where clinically appropriate. Clinicians can determine how many services to provide to parents or relevant others without a child being present, however they should ensure that the child receiving treatment must always be the focus of services and support, and that there is maximum capacity for treatment of children within the total available sessions.

It is a requirement of PTC-U12 for the child to attend for regular review and monitoring by the clinician during treatment (e.g. estimated as every third session).

Table 2: Sessions

Sessions 1-6

Sessions one to three may contribute to the initial assessment to identify if the PTC-U12 is appropriate for the individual or inform the most appropriate treatment.

Sessions will be subject to appropriate referrals and Child Treatment Plan (CTP) requirements and timeframes. Where there is no diagnosis of a mental disorder, the referring medical practitioner should document in the CTP that the child is at a significant risk of developing a mental disorder/childhood behavioural or emotional disorder and record the presenting symptoms.

Sessions 7-12

On completion of the initial course of six sessions, the allied health professional is to provide a written report to the referring medical practitioner. Following receipt of the report, the referring practitioner will consider the need for further treatment and if clinically required issue a referral for an additional 7-12 sessions.

Sessions 12-18

In exceptional circumstances, the individual may require an additional six sessions above those already provided (up to a maximum total of 18 individual sessions per client per calendar year).

Following receipt of the allied health professional' report, the referring practitioner will consider the need for further treatment and issue a referral for an additional six sessions.

Further allied mental health services may not be provided without a referral for additional services.

Sessions with parents, family members, guardians, or other persons having responsibility for the child without the child present

Parents can be present at all sessions where clinically appropriate. The total number of services is up to 12 in a calendar year (up to 18 in exceptional circumstances) for both with and without child present. Clinicians can determine how many services to provide to parents or relevant others without a child being present, however they should ensure that the child receiving treatment must always be the focus of services and support and that there is maximum capacity for treatment of the child within the total available sessions.

Group sessions

1-Sessions 1-12

Up to 12 group therapy services within a calendar year involving 6-10 people, providing appropriate referrals have been made and CTPs are prepared.

It is envisaged that children and their parents or other responsible adults may participate in such groups depending on the clinical appropriateness.

9. Involvement of parent, guardian, and other family members in treatment

A comprehensive assessment always includes:

- » consideration of strengths and vulnerabilities that the parents and children bring to their current circumstances
- » a developmental focus (including the relational context)
- » attention to bi-psychosocial factors that help or hinder the child and family at this time of rapid developmental change.

A range of information needs to be gathered from a number of sources, determined at least in part by the setting in which the child and family are being seen and the purpose of the assessment.

Parents, guardians, family members, or other persons having responsibility for the child can also access the PTC-U12 to assist them to better support the child that has or is at a significant risk of developing a disorder and who has an CTP.

In circumstances where it is not clinically appropriate for the child to be present, parents, guardians, family members, or other persons having responsibility for the child can access sessions without the child present. Parents, guardians, family members and other persons with responsibility for the child may attend treatment sessions subject to the following:

- » the allied health professional is comfortable for clinical reasons with more than one person being in the room
- » this is not detrimental to the treatment of the child
- » the primary focus of the session is the treatment of the child.

Clinicians can determine how many services to provide to parents or relevant others without a child being present, however they should ensure that the child receiving treatment must always be the focus of services and support and there is maximum capacity for treatment of the child within the total available sessions.

It is important that parents, family members, and others who have custodial rights and who have a mental disorder themselves and require psychological services should be referred to psychological services—general, rather than receive services under the PTC-U12.

10. Interventions

The PTC-U12 should be tailored to meet the needs of infants and children under 12 years of age, who are experiencing or are at a significant risk of developing, a mental, childhood behavioural, or emotional disorder.

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:

- » behavioural interventions
- » parenting/family-based interventions
- » Cognitive Behavioural Therapy (CBT) interventions.

The specific interventions to be provided as part of the above treatments include:

- » attachment intervention—family-based intervention (where expertise is available)
- » behavioural interventions
- » CBT (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 were not included under the previous ATAPS program and are therefore not included for CTP-U12:

- » art therapy
- » Mindfulness-Based Cognitive Therapy (MBCT)
- » play therapy
- » family therapy (other than behavioural/cognitive behavioural treatments) including:
 - psychodynamic
 - structural
 - constructivist approaches (e.g. Milan)
 - narrative
 - solution-focused interventions.

10.1 Intervention period

The PTC-U12 is designed to provide short-term support for children and their families or others with responsibility for the child. The service is not intended to provide long term intensive support, and clients and other stakeholders need to be aware of the objective of the PTC-U12. Individuals with more severe illness whose conditions may benefit from short-term focused psychological strategies services as part of their overall treatment may also be provided with PTC-U12.

Appendix E

Aboriginal and Torres Strait Islander peoples

This Appendix provides information specific to *Psychological Therapies—Aboriginal and Torres Strait Islander*, to improve the delivery of culturally appropriate mental health and/or suicide prevention *Psychological Therapies*. It builds on the information available in other sections of the NQPHN Mental Health Stepped Care Operational Guidelines.

1. Aims of the service

The objective of *Psychological Therapies—Aboriginal and Torres Strait Islander* is to provide Aboriginal and Torres Strait Islander peoples with an increased level of access to evidence-based short-term focused psychological strategies services that are culturally appropriate, within a primary care setting. The psychological services and interventions must be relevant to Aboriginal and Torres Strait Islander people with mental disorders, and their families.

As such, where appropriate, the guiding principles which should underpin the design, establishment, and delivery of *Psychological Therapies—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 and 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.

Service providers for *Psychological Therapies* for Aboriginal and Torres Strait Islander populations must 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.

2. Eligibility for *Psychological Therapies*— Aboriginal and Torres Strait Islander peoples

The services are designed for Aboriginal and Torres Strait Islander people who have, or are at risk of developing, a mild to moderate mental disorder, and who could benefit from short term focused psychological strategies services. The short-term, goal oriented focused psychological strategies services that *Psychological Therapies* provides are of most therapeutic value to 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 clients and other stakeholders are aware of the intention of the services. Individuals with more severe illness whose conditions may benefit from short-term focussed psychological strategies services may also require *Psychological Therapies*—Aboriginal and Torres Strait Islander.

Aboriginal and Torres Strait Islander people who are at risk of suicide or self-harm should be considered for the mainstream *Psychological Therapies*—Suicide Prevention or to an HHS mental health service.

3. Interventions

Interventions shall be broadly consistent with those provided across *Psychological Therapies* however *Psychological Therapies*—Aboriginal and Torres Strait Islander should be tailored to meet the needs of Aboriginal and Torres Strait Islander people who are experiencing a mental disorder. The services should reflect cultural requirements including therapies which involve the whole family where necessary.

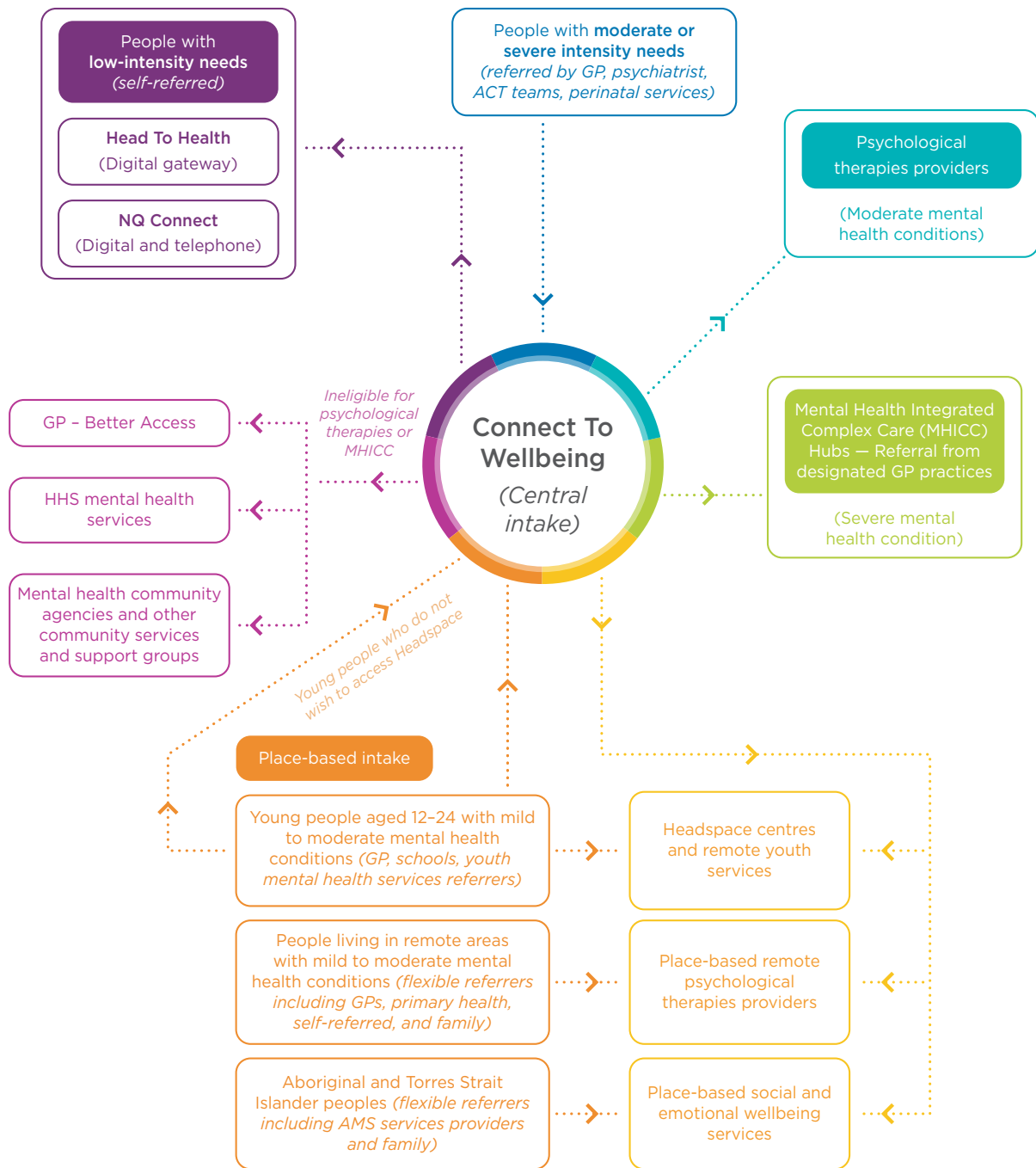
4. Qualifications and standards

Aboriginal and Torres Strait Islander health workers may deliver services under *Psychological Therapies*—Aboriginal Torres Strait Islander program stream in keeping with their qualification.

Appendix F

Referral Pathways Stepped Care

Referral Pathways Stepped Care



Torres and Cape | Cairns | Townsville | Mackay

e: hello@nqphn.com.au

w: nqphn.com.au

