CESPHN Psychological Support Services (PSS) Guidance

EIS Health Limited trading as Central and Eastern Sydney PHN

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Version 2.0

CONTENT

Scope

MSA and associated Schedules take precedence over this document and this is for general guidance only.

1. Definitions

In this Document, unless the context otherwise requires:

- **Access** is defined as being unable to either physically get to an available service or afford to pay a fee for an available service

- **Children** means Persons under the age of 18 years as defined in the Child Protection (Working With Children) Act 2012 (NSW) and Child Protection (Working With Children) Regulation 2013 (NSW); however in context the following sub-definition may be used:

  - **Children (0-12)** means children age between 0 -12 years who have not yet graduated from primary school and have not commenced high school
  - **Young People** means youth aged between 12-25 years who have commenced high school.

- **CESPHN** refers to Central Eastern Sydney PHN.

- **Confidentiality** refers to the treatment of information that an individual has disclosed in a relationship of trust, with the expectation that it will not be given to other people or organisations without prior Consent.

- **Confidential Information** includes, but is not limited to, matters not generally known outside CESPHN, such as information relating to the general business operations with CESPHN including:
  - the Provider's Agreement;
  - trade secrets, know-how and specifications in respect of CESPHN's operations;
  - third party information disclosed to CESPHN in confidence;
  - medical records and health information;
  - any other information which by its nature could reasonably be expected to be regarded as confidential, including financial and funding information of CESPHN.

- **Consent** is defined as express Consent or implied Consent which has four key elements:
  - the Consent must be voluntary;
  - the individual must be adequately informed before giving Consent;
  - the Consent must be current and specific;
  - the individual must have the capacity to understand and communicate their Consent.

- **Clinical Incident** is any unplanned event which causes, or has the potential to cause, harm to a consumer.

- **Medical Practitioner (MP)** is defined in this document as a GP, Psychiatrist, Obstetrician-Gynaecologist and Paediatrician

- **Non-Medical Practitioner (NMP)** is defined as those referring to the programme who are not Medical Practitioners. This includes school counsellors, school principal/deputies, directors of early childhood services, headspace Clinicians, maternal and child health nurses, allied health professionals, lactation consultants, midwifery and neo-natal nurses, Aboriginal health workers, Aboriginal Care coordinators and Outreach workers, House parents of Kirinari Hostel (Sylvania), Aboriginal youth health and well-being coordinators, managers of Aboriginal

Community Controlled Health Services (ACCHS), multicultural community health liaison officers, Acute Mental Health Teams, and Psychiatric Emergency Care Centre.

- **Personnel** means managers, subcontractors, consultants, suppliers, employees, agents and other persons engaged by the Provider

- **Privacy** refers to the right of individuals to control how their information is collected, stored and used.

- **Provider/s** means the organisation commissioned by CESPHN to provide PSS

- **Qualified Mental Health Professionals (MHP)** means: Psychologists (general and clinical), mental health nurses, mental health accredited social workers, mental health accredited occupational therapists and Aboriginal and Torres Strait Islander mental health workers.

- **Work Health and Safety (WH&S)** means, as relevant:
  - the Work Health and Safety Act 2011 (NSW) and the Work Health and Safety Regulation 2011 (NSW); and
  - the Work Health and Safety Act 2011 (Cth) and the Work Health and Safety Regulation 2011 (Cth).

2. Primary Health Networks

Primary health networks (PHNs) have been established with the key objectives of increasing the efficiency and effectiveness of medical services for individuals, particularly those at risk of poor health outcomes. They also aim to improve coordination of care to ensure people receive the right care in the right place at the right time.

PHNs are not for profit, regionally based organisations which aim to strengthen primary care by redirecting frontline health services to improve health outcomes of the community.

Primary health care may be viewed as the first point of contact an individual has with the health system. This is often visiting the local GP but may include a range of health professionals such as nurses, psychologists, pharmacists, dentists, physiotherapists or Aboriginal health workers. Primary health care services address not only the immediate problem, but also include prevention and screening, chronic disease management and health promotion.

Our Vision

Our vision at Central Eastern Sydney Primary Health Network (CESPHN) is better health and wellbeing of the people who live and work across our region. We work to achieve this by working directly with all key players including general practitioners (GP), allied health, nurses, secondary care providers, local health districts (LHD) and specialty health networks, local communities and non-government organisations to ensure improved health outcomes for people living and working in our region.

Our Activities

Each year we undertake a comprehensive needs assessment to identify the key health and health service needs of people in our region. This information is used to identify opportunities and to prioritise our activities.

We provide programmes and services that strengthen general practice and allied health services. We also provide a range of programmes focused on delivering integrated care with our LHD and specialty

health networks including: Aboriginal health, antenatal shared care, aged care, HealthPathways, immunisation, mental health , drug and alcohol and sexual health.

CESPHN identifies health needs in the region and procures the provision of services from external providers. Apart from exceptional circumstances, for example, where there is market failure or market limitations, CESPHN will serve as a commissioning organisation and develop quality primary health care services and associated interventions that deliver better health outcomes for individuals, meet population health needs and reduce inequalities within the resources available.

Our Region, Our Community

The Central and Eastern Sydney catchment spans 626 square kilometres. Our region stretches from Strathfield to Sutherland, as far east as Bondi, and also includes Lord Howe Island and Norfolk Island. We are the second largest of the 31 primary health networks across Australia by population, with more than1.6 million individuals residing in our region. Our boundaries align with those of South Eastern Sydney LHD and Sydney LHD. Pdf Click here (78 KB) for a complete list of postcodes within the CESPHN catchment area.

3. Psychological Support Services (PSS)

CESPHN is funded by the Commonwealth of Australia, Department of Health (DoH), to commission organisations to provide short term psychological therapy services targeting the needs of people experiencing mild to moderate mental illness in underserviced groups, where there are barriers to accessing Medicare Benefits Schedule (MBS) based psychological intervention.

Psychological Support Services (PSS; formerly known as ATAPS) provides FREE evidence based, structured, short term, low or medium intensity psychological intervention to people with a diagnosable mild to moderate mental health concern and who are identified as an underserviced group. It also offers evidence based psychological interventions for people who have attempted, or are at risk of, suicide or self-harm where Access to other services is not available or appropriate.

Services are delivered by appropriately trained and qualified Mental Health Professionals (MHP) including: Psychologists (general and clinical), mental health nurses, mental health accredited social workers, mental health accredited occupational therapists and Aboriginal and Torres Strait Islander mental health workers.

CESPHN commissions four consortia in the community that employ MHPs to provide PSS to eligible individuals in the region, across the lifespan. CESPHN also commissions five headspace sites across the region, and each of these headspace sites are provided with funding to deliver PSS services to headspace and eligible individuals.

3.1 PSS Eligibility

PSS is for people who live, work or study in the Central and Eastern Sydney region with diagnosable mild to moderate mental health concerns, who may benefit from short term treatment, are unable to Access other available services including Better Access (Medicare subsidised psychological services) due to financial hardship (**Individual income < $55,000; family income < $130,000**) AND who fit into one of the below underserviced and/or hard to reach populations:

1. Children (who are aged between 0-12 years who have not yet graduated from primary school) with, or who are at risk of developing a mild to moderate mental, emotional or behavioural disorder
2. Young people (12-25 years)

3. Adult
4. Individuals who identify as Lesbian, Gay, Bisexual, Transgender, Intersex and Queer/Questioning (LGBTIQ)
5. Individuals experiencing perinatal depression and their partners
6. Individuals who identify as from an Aboriginal and Torres Strait Islander background
7. Individuals who identify as from a Culturally and Linguistically Diverse (CALD) background
8. Individuals who have attempted, or who are at risk of suicide, or self-harm
9. Individuals at risk of becoming homeless;
10. Individuals living within the following areas, based on internal analysis on individual to PSS MHP ratios, have been identified as experiencing high levels of psychological distress and/or low Access to any psychological services: SA3 Botany, Canterbury, Eastern Suburbs – South, Hurstville, and Marrickville;
11. People with severe mental health concerns who may benefit from short term focused psychological intervention as part of their overall care.
12. People with mild Intellectual disability who may benefit from short term psychological intervention when co-occurring mental health concerns are diagnosed.

PSS is NOT a:

- crisis service;
- drug and alcohol service;
- sexual assault service;
- domestic violence service;
- couples or family counselling service;
- homelessness support service;
- dementia, delirium, and tobacco use disorder are not regarded as mental health disorders for the purposes of this activity.

PSS is not appropriate for Individuals who are in current domestic violence situations as other more appropriate services exist. Children living where the perpetrator still resides should be referred to more appropriate services.

PSS will not:

- duplicate or replace existing services provided by other organisations, including state and tertiary government services, disability support services or workers compensation.
- provide a low intensity service involving self-referral;
- provide psychosocial support, unless the individual is referred under **Suicide Prevention Service** (SPS);
- provide a service which could be provided through the Better Access (MBS) Initiative in the same location for the same population group.

This guidance is to be read in conjunction with the
DoH guidance for Psychological Therapies for Underserviced Groups.

4. PSS Service Delivery

The model of service will adopt the following key principles:

- Person centred
- Trauma informed
- Recovery focused
- Inclusive of family, carers, and significant others as identified by the person
- Safety and care planning
- Culturally responsive for Aboriginal and/or Torres Strait Islander peoples
- Culturally responsive for Culturally and Linguistically Diverse communities
- Inclusive of diverse genders and sexualities

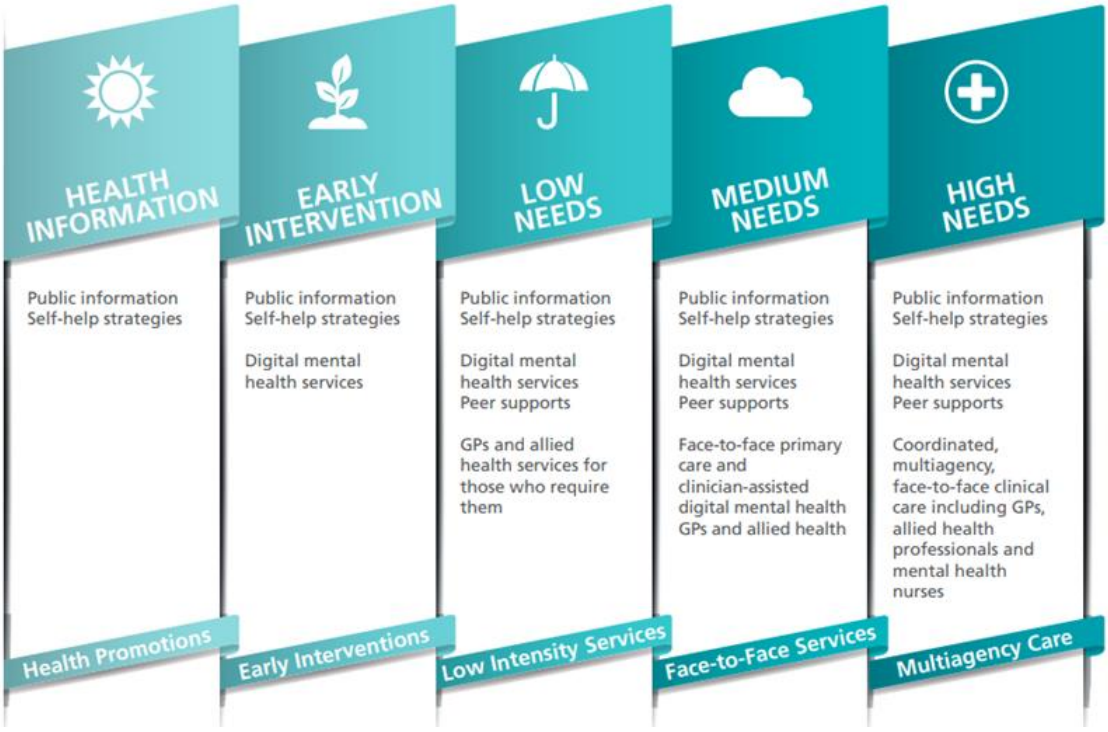
Essential elements of the CESPHN PSS Programme includes:

- Providing a level of service commensurate with the clinical needs of the individual;
- Providing services to complement the role the MBS plays in funding psychological services on referral from Medical Practitioners; GPs, psychiatrists and paediatricians;
- Delivery of individual or group programmes using specified psychological treatments;
- Providing referral and/or links to other services within a stepped care approach to ensure services are matched to individual needs and considered as needs change over time;
- Ensuring smooth transfer between services for individuals as needed, in conjunction with involved parties;
- Requiring each individual to have a Mental Health Treatment Plan (MHTP) or in the case of a child an appropriate care plan, with some flexibility for interim referrals to enable service provision to commence while arrangements are made for the individual to see a MP;
- Compliance from MHP that sessions cannot continue until the MHTP or MHTP Review has been sent by the MP and approved by the CESPHN Mental Health Central Intake team;
- Offering flexibility where needed, including the format of delivery of services, which could include:
    - face-to-face individual consultations (primarily), as well as telephone and internet-based services as clinically indicated and agreed with the Provider's clinical lead;
    - discussions with parents of young people accessing services (where Consent has been obtained as appropriate);
- Being consistent with standards articulated in the National Standards for Mental Health Services 2010 and other relevant standards & legislative/regulatory requirements (**See Attachment A. Legislation**);
- Ensuring all MHPs develop a plan for treatment, prepared in consultation with the individual and any family, carers or significant others as requested by the individual, identifying goals for their treatment and recovery;
- Supporting carers, especially where services are provided to Children and young people;

- MHP complete training in CIMS and that all required data, including PMHC-MDS data items, is entered into the CIMS within 5 days of each month end;
- Ensuring MHPs maintain adequate and legible records of all services provided as part of PSS Programme. Such records by law must be kept for 7 years following completion of treatment or in the case of minors until they reach age 25;
- Ensuring that no co-payment, gap fee, cancellation fee or claim to Medicare is charged to the individual. CESPHN will not reimburse for 'no shows' or any travel costs. CESPHN define a 'no show' for the purposes of the MDS as an individual not giving 24 hours' notice of non-attendance.

4.1. Stepped Care Approach

- Primary mental health care service delivery is moving towards a stepped care approach as part of the reforms implemented by the Commonwealth Department of Health. This approach will support people to access services based on their needs, at the right time.
- Stepped care is an evidence-based approach comprising of interventions, from the least to the most intensive based on the level of mental health needs.
- CESPHN provides a stepped care approach to meet the needs of individuals being referred to the service of PSS, including suicide prevention service (SPS), at no cost to people in the Central East Sydney region. An experienced clinician will review and assess referrals and allocate each referral to an appropriate service in accordance with each person's individual's choice and the level of their mental health needs applying a stepped care approach.
- The PSS and SPS programme sit in line with low needs to medium needs. Individuals who require more or less support should be referred appropriately.



Stepped Care Principles

The Stepped Care Principles are the foundation of the stepped care approach in mental health services.

Under the Stepped Care Principles, services are focused on a person's choice as well as matched to the individual's needs and recovery goals. Needs are reflected on a continuum and interventions are matched to the severity and complexity of needs and preferences. Individuals do not have to start at the least intensive level of intervention to progress to the next level. They can enter the system and have their individual requirements and needs met.

Services should be connected, easy to access, flexible and responsive to changing needs. In addition, services commissioned by CESPHN are expected to be informed by evidence and accountable with a key focus on the underserviced groups, including Children, young people, people who identify as Aboriginal and/or Torres Strait Islander and people from culturally and linguistically diverse backgrounds in the CESPHN region.

The Stepped Care Model and Principles can be found on the CESPHN website Stepped Care Model and Principles .The community guide represents current funded services at CESPHN ranging from early to high needs services, applying a Stepped Care approach.

Rational for Stepped Care

In the DoH guidance (PHN Mental Health and Suicide Prevention Implementation Guidance), the reasons why stepped care is considered a priority activity for PHN's was outlined and has been summarised below:

- preventing underservicing and over servicing of need;
- shifting focus to self-care and early intervention and away from costly face to face high intensity interventions;
- improving community access to mental health services so that a person who experiences mental illness does not have to wait until their situation worsens by implementing early intervention approaches;
- encourage more efficient and effective use of primary mental health services, including Medicare subsidised psychological services and the use of clinician moderated self-help digital services;

4.2. Psychological Treatment

Psychological treatments are limited only to evidence based Focused Psychological Strategies (FPS) indicated by the DoH, under the "Better Outcomes in Mental Health Care Initiative".

These are:

- **Cognitive behaviour therapy (CBT)** – Is a focused approach based on the premise that cognitions influence feelings and behaviours, and that subsequent behaviours and emotions can influence cognitions. CBT has two aspects: behaviour therapy and cognitive therapy. Behaviour therapy is based on the theory that behaviour is learned and therefore can be changed. Cognitive therapy is based on the theory that distressing emotions and maladaptive behaviours are the result of faulty patterns of thinking

- **Interpersonal psychotherapy (IPT) –** Is a brief, structured approach that addresses interpersonal issues. The underlying assumption of IPT is that mental health problems and interpersonal problems are interrelated. The goal of IPT is to help individual understand how

these problems, operating in their current life situation, lead them to become distressed and put them at risk of mental health problems

- **Narrative therapy –** This has been identified as a mode of working of value to Aboriginal and Torres Strait Islander people, as it builds on the story telling that is a central part of their culture. Narrative therapy is based on understanding the 'stories' that people use to describe their lives. This therapy regards problems as being separate from people and assists individuals to recognise the range of skills, beliefs and abilities that they already have and have successfully used (but may not recognise), and that they can apply to the problems in their lives

- **Family therapy and family-based interventions –** Defined as any psychotherapeutic endeavour that explicitly focuses on altering interactions between or among family members and seeks to improve the functioning of the family as a unit, or its subsystems, and/or the functioning of the individual members of the family

- **Mindfulness-based cognitive therapy (MBCT) –** This is a group treatment that emphasises mindfulness meditation as the primary therapeutic technique. MBCT was developed to interrupt patterns of ruminative cognitive-affective processing that can lead to depressive relapse. In MBCT, the emphasis is on changing the relationship to thoughts, rather than challenging them

- **Acceptance and commitment therapy (ACT) –** Is based in a contextual theory of language and cognition known as relational frame theory and makes use of several therapeutic strategies, many of which are borrowed from other approaches. ACT helps individuals increase their acceptance of the full range of subjective experiences, including distressing thoughts, beliefs, sensations, and feelings, in an effort to promote desired behaviour change that will lead to improved quality of life

- **Solution-focused brief therapy (SFBT) –** Is a brief resource-oriented and goal-focused therapeutic approach that helps individuals change by constructing solutions. The technique includes the search for pre-session change, miracle and scaling questions, and exploration of exceptions

- **Dialectical behaviour therapy (DBT) –** is designed to serve five functions: enhance capabilities, increase motivation, enhance generalisation to the natural environment, structure the environment, and enhance therapist capabilities and motivation to treat effectively. The overall goal is the reduction of ineffective action tendencies linked with deregulated emotions. It is delivered in four modes of therapy

- **Schema-focused therapy –** focuses on identifying and changing maladaptive schemas and their associated ineffective coping strategies. Schemas are psychological constructs that include beliefs that we have about ourselves, the world and other people, which are the product of how our basic childhood needs were dealt with. Schema change requires both cognitive and experiential work

- **Eye Movement Desensitisation and Reprocessing Therapy (EMDR) (Trained MHP only)** - is based on the idea that overwhelming emotions during a traumatic event interfere with normal information processing, In EMDR, the person is asked to focus on particular aspects of the traumatic event while tracking the movement of the therapist's finger. It is proposed that the dual attention helps the individual to process the trauma and integrate the memory with existing memory networks.

- **Psychodynamic psychotherapy –** Short-term psychodynamic psychotherapy is a brief, focal, transference-based therapeutic approach that helps individuals by exploring and working through specific intra-psychic and interpersonal conflicts. It is characterised by the exploration of a focus that can be identified by both the therapist and the individual. Long-term psychodynamic psychotherapy is open-ended and intensive and is characterised by a framework in which the central elements are exploration of unconscious conflicts, developmental deficits, and distortion of intra-psychic structures

- **Emotion-focused therapy (EFT) –** This combines a client-centred therapeutic approach with process-directive, marker-guided interventions derived from experiential and gestalt therapies applied at in-session intrapsychic and/or interpersonal targets. These targets are thought to play prominent roles in the development and exacerbation of disorders such as depression

- **Psychoeducation –** This is not a type of therapy but rather, a specific form of education. Psychoeducation involves the provision and explanation of information to individual about what is widely known about characteristics of their diagnosis. Individuals often require specific information about their diagnosis, such as the meaning of specific symptoms and what is known about the causes, effects, and implications of the problem. Information is also provided about medications, prognosis, and alleviating and aggravating factors

  For further information, please see: Australian Psychological Society - Evidence-based Psychological Interventions in the Treatment of Mental Disorders: A Literature Review

4.3. Documentation

Documentation in health care records must provide an accurate description of each individual's contact with health care Personnel. CESPHN requires that a health care record is available for every individual accessing PSS (**See 19.3. Access to Information**). MHP must maintain adequate and legible records of all services provided as part of the PSS services.

All entries in an individual's records must be:

- Contemporaneous
- Up to date
- Accurate
- Legible and in English
- Be sufficiently clear and detailed to allow other members of the health care team to assume care of the individual or to provide ongoing service at any time
- Include only that information that is relevant to the intervention provided
- Written in an objective way and not include demeaning or derogatory remarks
- Only include personal information about other people when relevant and necessary for the care and treatment of the individual

An entry must be made in the health care record for each individual, including attempts to contact the individual. Entries should reflect the level of assessment and intervention undertaken. Issues of significance must be sufficiently detailed. This includes issues relating to:

- Decisions about treatment
- Referral decisions and actions
- Critical information
- Risks
- Reassessment outcomes
- Changes to the care plan

4.4. Client Information Management System (CIMS)

The CIMS chosen by CESPHN is called rediCASE. **See Attachment C. rediCASE Manual & Clinically Closed Episodes**

- CIMS is used to support central intake, triage and allocation, session data and financial management of PSS. CIMS also supports the National Primary Mental Health Care Minimum

Data Set (PMHC-MDS) reporting to the DoH and its use is a mandatory requirement of MHPs delivering PSS;

- MHPs agree to use the CIMS as determined by CESPHN and agree to attend training in the use of this system;
- MHPs will need be trained in the use of the CIMS. Access to, and training in, the CIMS system will be provided to Providers by the CESPHN Mental Health Team and the Provers will need to train all new MHPs. CESPHN will provide short webinars to assist in this training, and the CIMS user guide is available (see Attachment C);
- CESPHN may, at its absolute discretion, change or amend the existing record management system, or introduce a replacement record management system. CESPHN will provide training on any newly developed management system which replaces CIMS;
- All data is to be entered by the MHP into CIMS within 5 days of each month end.

Please note:

- CESPHN CIMS is not to be used for the purpose of MHP PSS clinical case notes
- CESPHN triage will write clinical notes in the Notes section for review by the Provider and MHP
- Case notes to be kept by MHP as directed by the Provider
- Notes can be added to CIMS for the purpose of communicating relevant information or actions related to the referral. E.g. reason for declining a referral, MHP gender preference, area of service, out of area.
- Take care to record date correctly, as two assessments recorded on the same date will be picked up in MDS as one Assessment, hence creating an error
- GP and other referrers DO NOT have access to rediCASE.

4.5. Referral to Initial Appointment

- MHP are recommended to view CIMS daily for new referrals and review notes on each referral.
- Referrals should be accepted or declined by the MHP within 72 hours.
- The first appointment needs to be booked within 4 weeks of accepting the referral.
- It is recommended that at the first appointment the following documents are provided to the individual:
    - Consent form signed
    - PSS Flyers
    - Example of Statement Rights and Responsibilities (**See Attachment B for example)**
    - Australian Charter of Healthcare Rights
- Emergency contacts are **essential** and must be noted in CIMS on the first appointment.
- All individual call attempts are to be logged into CIMS. This allows CESPHN Intake Admin to respond to referrers when enquiring about individual(s).
- Please be aware to update the CIMS of any changes in the individual's details or MDS.

4.6. Communication Between CESPHN and Providers

- The Notes section of the CIMS (rediCASE) is used by CESPHN Mental Health Intake Team to make any relevant notes during the intake, triage and allocation process. This ensures that the individual's journey through the centralised intake system can be tracked and information shared.
- The Note section should be viewed by the Provider to assist in appropriate MHP allocation as requests such as gender, location, availability and preferred MHP will be documented in this section.
- If the MHP does not think a referral that has been allocated can be serviced by them in a **timely fashion**, then a note should be written in the rediCASE Note section and declined immediately for reallocation by the Provider clinical lead.
- If the Provider does not feel the referral is appropriate for the programme, they are to provide reasoning in the Note section of rediCASE (including recommendations of alternative referral pathways) and decline the referral in rediCASE immediately.
- Once an individual is allocated to a MHP the duty of care rests with that MHP and the Provider. MHPs with clinical issues relating to current PSS individuals, should address their concerns with the Provider clinical lead.
- MHP can contact CESPHN at mentalhealth@cesphn.com.au for any administrative questions relating to new referrals or current PSS individuals.
- The CESPHN Mental Health Central Intake team will copy (cc.) the Provider into a response email when there is any communication with the MHP related to individuals care.
- MHP can contact CESPHN for CIMS related correspondence (rediCASE), at redicasefeedback@cesphn.com.au **Please note:** No clinical request should be sent to this email address.

4.7. Referrer Communication

- The CIMS generates an email to the referrer once a referral is accepted by the MHP.
- On the PSS referral form we have indicated if the referrer's preferred MHP is not available would the referrer consent to the client being allocated to another MHP. If the referrer has indicated "yes" then it is the responsibility of the Provider clinical lead to allocate to another MHP. If the referrer has indicated "no" the Provider is to write a note in rediCASE with the reason and indicate other MHP options for this individual referral. Please decline the referral for CESPHN central intake and triage to contact the referrer and re allocate.
- CESPHN will keep referrers informed of all processes and any changes to the PSS programme.
- **Please note referrers, including MPs, do not have access to CIMS, hence correspondence must be direct to the referrer. They cannot see your notes in rediCASE.**

4.7.1 Medical Practitioner (MP) Referrer Communication

- The MHP is to communicate to the referring MP by providing a timely and comprehensive written report to the MP after every 6 sessions. Please ensure a copy of all correspondence including MP reports and letters are uploaded into CIMS, otherwise delay will occur in processing reviews. Correspondence is required after:
    - **initial consultation** - to outline assessment and planned treatment strategy;

- **completion of allocated sessions or after every sixth session**, whichever comes first, as a review of progress against treatment plan;

- **episode end or point of discharge** to outline treatment outcomes, relapse plans and any further referral recommendations;

- **stepping up or down of an individual from PSS ↔ SPS**, once approval has been obtained from the Provider clinical lead.

- This individual is required to return to their MP after the initial 6 sessions to complete a MHTP review. This needs to occur before the 7th session is delivered. MHP are NOT to provide sessions beyond the 6th appointment without approval.

- A MHTP does not expire. A referral is valid until the referred number of sessions have been completed, regardless of whether a patient chooses to change their allied mental health provider.

- Sessions 13-18 are only provided under *exceptional circumstances* and require the individual to see their MP following the 12th session for review. These reviews will be re-triaged by the CESPHN Central Mental Health Intake team. MHP are NOT to provide sessions beyond the 12th appointment without approval.

- Notification of an approval for the exceptional circumstances will be sent to the Provider to communicate to their providers.

- If session 13-18 are not approved, CESPHN will contact the MP and the Provider to advise of the outcome and reason. The Provider will communicate the outcome to the MHP.

- MHPs are not to contact MPs requesting PSS referrals for their individuals, this is always at the MP's discretion to determine the most effective treatment options.

4.7.2 Non-Medical Practitioner (NMP) Referrer Communication

- When a referral has been sent by a Non-Medical Practitioner (NMP) the MHP is required to send the correspondence to the **MP** at the following times:

  - **MHP assists individual to request a MHTP from MP following their initial interim sessions**. The MHP will correspond to the MP to outline recent contact, details of assessment and planned treatment strategy moving forward;

  - **completion of allocated sessions or after every sixth session**, whichever comes first, as a review of progress against treatment plan;

  - **episode end or point of discharge** to outline treatment outcomes, relapse plans and any further referral recommendations;

- **Please note** you are not expected to send an initial communication to the NMP Referrer.

- If the individual does not have a GP, please assist in linking them to a GP asap.

4.8. Mental Health Standards

All services provided under PSS must comply with the National Standards for Mental Health Services 2010. The Standards are available for downloading from the Mental Health Standing Committee website at **National Standards for Mental Health Services**

4.9. Mandatory Reporting

Reporting must be in accordance with the legislative requirements of mandatory reporters. The mandatory reporter guide can be found at:

https://www.facs.nsw.gov.au/families/Protecting-kids/mandatory-reporters/what-when-to-report/chapters/mandatory-reporter-guide

4.10. Minimum Data Set (MDS)

The **Primary Mental Health Care MDS (PMHC MDS)**, mandated by the DoH and updated from time to time, outlines the requirements for data collection and reporting for each Primary Health Network (PHN). This is designed to monitor the progress of mental health reforms being led by Primary Health Networks (PHNs). It is the responsibility of the PHNs to ensure that these collection and reporting requirements are met by all contracted Providers of client mental health services. The PHN provides regular reports to the DoH based on this data. This data is used by DoH to evaluate the services commissioned by the PHN and determine future funding to mental health.

Data from the CIMS is linked directly to the MDS. It is therefore imperative that all data entered in the CIMS is accurate. Data from the CIMs is also directly linked to the PHN contract management processes including invoicing, hence a further need for this data to be entered accurately and in a timely manner. **MHPs must enter accurate data to the MDS via the CIMS in the Assessment field**. The link to the PMHC- MDS can be accessed here.

- MHP must entered MDS into the CIMS **within 5 days of each month end.**
- The DoH has identified target areas against which the PHN has to report. In order to ensure that the data is accurate please ensure that you select the correct "Principal Focus of Treatment Plan" for each individual on the episode commencement page in the CIMS. Please see "Access to Services" in **Table** 1: MHP Guide for data entry to accurately capture the DoH Mental Health Indicators
- Table 1 below summarises the DoH mental health indicators embedded in the CIMS.
- The "Appropriateness of Service" section in Table 1 ensures that individuals receive the correct level and quality of support for their presentation. It stipulates that all MHP delivering services to Aboriginal or Torres Strait Islander individuals have completed appropriate training. It also is in line with the timeframes stipulated in the SPS guidance **(see Attachment E. SPS Guidance)** for Provider and MHP contact when receiving a SPS referral.
- The "Clinical Outcomes" section in Table 1 refers to the collection of pre and post clinical data. The DoH relies on the completion of this data to determine the effectiveness of the service provided. All MHPs need to ensure that they enter an appropriate clinical tool, i.e. K10+, K5 or SDQ at the first session, every 6th session, and at the last session when they close the episode of care. The first and last session outcome measures are paired in the MDS. Only PAIRED data is reviewed in the MDS. It is imperative that MHP enter this data into the CIMS. **Please refer to Section 13 Outcomes and Satisfaction** for more information
- The "Suicide Referral Flag" option on the Episode Commence page should only be selected if the individual has been referred under the PSS Suicide Prevention Service (SPS). Selecting this option indicates that the individual has acute needs and MUST be seen within 7 days of the referral date received by CESPHN. Please DO NOT select this flag for individuals that are under the General PSS program and have some suicidal risk. The DoH has mandated that ALL clients under this SPS program MUST have their initial consultation (face to face or over the

phone) with a MHP within this time period and mandate a 100% adherence rate. **See Appendix E** for more information about the SPS program.

- **Paired Outcomes:**
  - If a K10 is not administrated at the last session, a **previous K10** score can be entered for the last session **ONLY IF the K10** was administered within 30 days of the date you are clinically closing the episode/file.

  - If a K10 score was only administrated in the initial session, you CANNOT enter the same initial K10 score when clinically closing an episode/file. Entering the same initial K10 score on closure will show no outcome from your sessions. No outcome will be recorded in the MDS for this situation and will affect out DoH targets.

- If for some reason an outcome measure score is not available when the episode is clinically closed, e.g. lost to care, not requiring final sessions, individual cancelled final appointment, then the most RECENT outcome measure score needs to be entered into the CIMS.
- Please note that the episode of care needs to be closed CLINICALLY with the attached outcome score, not ADMINISTRATIVELY in order for the paired outcome score to be generated.
- Once an episode has been ***closed it must NOT be reopened*** under any circumstances as this causes data errors in the MDS. Once an episode of care is closed, a new episode must be started regardless of the number of sessions provided under the previous episode.
- To CLINICALLY close an episode of care, it must be closed when entering an occasion of service and selecting “No Further Episodes are planned under this Episode of Care), and then select the outcome tool and enter the score.
- If you close the episode of care without opening an occasion of service, i.e. via the “Actions” tab, then this will not be counted in the MDS.
- MHPs are responsible for updating any MDS information that may change during their time with the client. This is the information that is contained in the case file tab in the clients file. All MHPs have access to this and are able to edit this tab at any time

To clinically close an episode a service contact will need to be created indicating no further sessions are planned and the most RECENT outcome score recorded

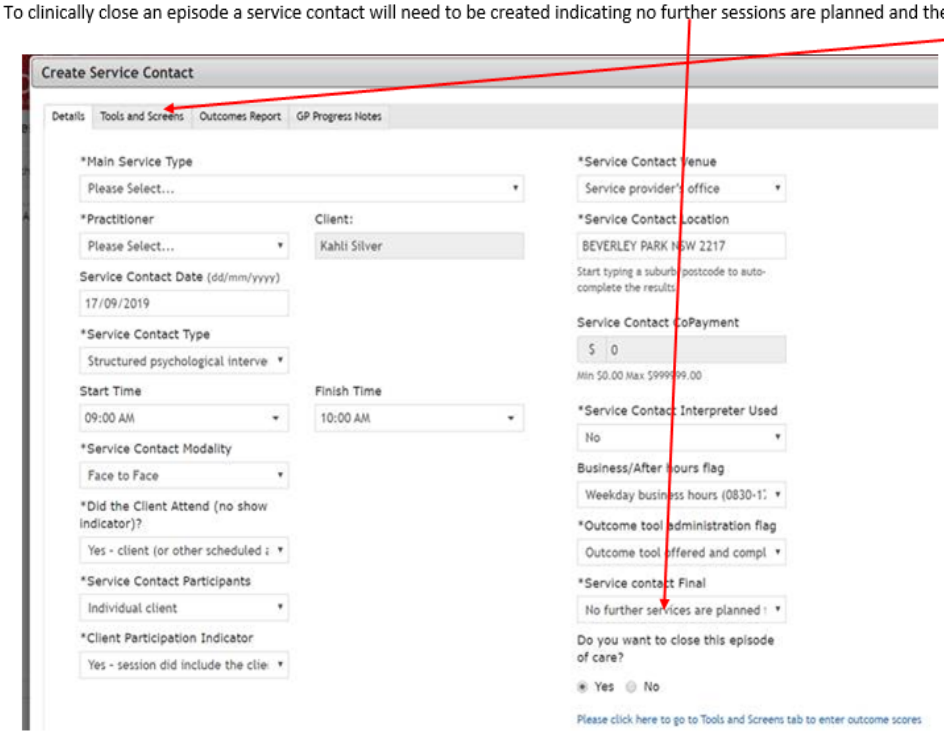


Table.1. MHP Guide for data entry to accurately capture the DoH Mental Health Indicators

DoH MENTAL HEALTH INDICATORS	SUB INDICATORS (PSS = YELLOW)	MEASURED BY	TO BE COMPLETED	CESPHN SERVICE? DoH TARGETS
Access to services. **Principal Focus of Treatment Plan** **Selected at episode commence.**	1. Low Intensity Psychological Intervention	*Number of **persons, based on Episodes** accessing low intensity services*	**Select:** **Low intensity psychological intervention**	NewAccess, CALD Mindfulness Groups
	2. Psychological Therapies delivered by MHP	*Number of **persons, based on Episodes** accessing psychological therapies*	**Select:** **Psychological therapy.**	PSS Underserviced Groups (CALD, SPS, PND, LBGTIQ)
			Select: **Indigenous-specific mental health services**	Aboriginal and Torres Strait Islander People
			Select: **Child and youth-specific mental health services**	For Children and a Young People, up 25years of age with a **"youth referral"**
	3. Severe and complex services	*Number of **persons, based on Episodes** accessing severe and complex services*	**Select:** **Clinical care coordination**	PICS only
Appropriateness of services **(Suicide referral flag elected at episode commence)**	1. Service to Aboriginal and Torres Strait Island People	***Service contacts counts** delivered by a MHP who has completed recognised cultural competency training or recorded as of Aboriginal or Torres Strait Islander origin*	Cultural Competency Awareness training needs to be completed and CESPHN notified to be entered into rediCASE	Target 100%
	2. Suicide Prevention Services	***Number of Episodes** that are followed up within 7 days of referral*	Service contact needs to be entered into rediCASE within the 7 days of **date of referral**. Completed via face to face, Skype or Telephone session.	Target 100%
Clinical Outcomes	1. Low Intensity Psychological Intervention	***Number of completed Episodes** with valid outcome measure between baseline and follow-up for low intensity services*	**Select: K5** for Aboriginal and Torres Strait Islander People (18+yrs) **Select: K10+** for Adults (18+yrs)	Target 70%
	2. Psychological Therapies delivered by MHP	***Number of completed Episodes** with valid outcome measure between baseline and follow-up for psychological therapies*	**Select: K5** for Aboriginal and Torres Strait Islander People (18+ yrs) **Select: K10+** for Adults over 18+ **Select: SDQ** for Children (up to and including 17yrs) **SEE SECTION 13**	Target 70% **Please note:** For person under 18 years, clinician-discretion is allowed, for use of K10+/ K5
	3. Severe and Complex Services	***Number of completed Episodes** with valid outcome measure between baseline and follow-up for severe and complex*	**Select: K5** for Aboriginal and Torres Strait Islander People (18+ yrs) **Select: K10+** for Adults (18+ yrs)	Target 70%

5. Who Can Deliver PSS?

5.1. MHP Qualifications and Standards

- To ensure a high-quality standard of service delivery MHP must be appropriately trained and qualified health professionals who are to deliver the services.
- The MHP are expected to hold Australian Health Practitioner Regulation Agency (AHPRA) registration or Mental Health Social Work Association Registration.
- Only PSS-approved MHPs are able to deliver PSS services/treatments.
- MHPs need to complete the Provider Information Form. Signing this form confirms you have completed training, have relevant qualifications and are eligible to deliver specific PSS streams. **See Attachment D. PSS Mental Health Provider Information Form.**

The MHP is required to:

- be fully qualified according to the requirements of their profession and credentialed in the field of Mental Health;
- be members of a professional body with ethical and professional guidelines, and accountability and disciplinary procedures for dealing with malpractice, incompetence and unethical behaviour and agree to abide by their profession's Code of Ethics;
- be adequately experienced in the field of mental health, and trained in delivering psychological therapies; currently or recently engaged in clinical practice in that field and **2 years** of experience working in the field;
- be involved in continuing relevant professional development and for MHPs providing SPS services, that their professional development activities include suicide prevention (see Table 2 for approved training to be a SPS MHP);
- have sufficient insurance cover in place for malpractice, public and products liability;
- have had a National Police Check undertaken before commencement.
- be appropriately trained and experienced to deliver services to the identified target group(s). Provisionally registered allied health professionals or students are **not** eligible to provide suicide prevention services, services for Children and services for people with a severe mental illness.
- promote recovery from mental illness, in line with the National Framework for Recovery Oriented Mental Health Services 2013 **(See Attachment A. Legislation)**
- obtain and provide the new Working with Children Check (WWCC) from NSW Office of Communities https://www.kidsguardian.nsw.gov.au if the MHP is providing PSS Services to or is likely to come into contact with young people and Children less than 18 years of age. CESPHN encourages all MHPs to have an up to date WWCC as there is always potential for incidental contact with children and young people.

5.2. Specific Training

Requirements

Specific training and/or experience is also required when working with the following individual groups: See Table. 2.

Table.2.

Groups	Mandatory Training Requirements
Aboriginal and Torres Strait Islander Peoples	▪ Cultural Competency training – recognised training programmes include those provided or endorsed by the Australian Indigenous Psychologists Association (AIPA).
Culturally and Linguistically Diverse Backgrounds	▪ Cultural Awareness, bilingual and/or experience working with interpreters when working with people from Culturally and Linguistically Diverse Backgrounds ▪ Recommended training Framework for Mental Health in Multicultural Australia
Children and their Families	▪ Post graduate experience working with Children (minimum 3 years) ▪ Training in Child Mental Health, for example Attachment Theory and the Neurobiology of Trauma training provided by the Australian Childhood Foundation ▪ Information about Child Mental Health is also provided by Emerging Minds
Perinatal	▪ Training and experience with Attachment Theory ▪ Recognised training includes APS Perinatal Non-Directive Counselling Training V2 APS Perinatal Non-Directive Counselling Training V2 ▪ FREE on-line training course for health professionals from COPE https://www.cope.org.au/course/basic-skills-in-perinatal-mental-health/
Individuals at risk of suicide	▪ Postgraduate experience a minimum of 2 years ▪ Recognised **initial** training includes Suicide prevention: A practitioner's guide online training provided by the Australian Psychological Society (APS) ▪ Recognised **ongoing** training includes Advanced Training in Suicide Prevention training provided by the Black Dog Institute

*** Please note** if you have equivalent or extensive training in these areas please discuss with your Provider. It is a requirement that these mandatory training requirements are vetted by the Providers.

It is also highly recommended that the following training be completed for:

- People with co-occurring mental health and drug and alcohol needs: due to the high prevalence of co-occurring mental health and drug and alcohol needs, MHPs are expected to review the

National Comorbidity Guidelines and complete the associated online training at https://comorbidityguidelines.org.au/

- LGBTIQ individuals to be able to assist with Gender Dysphoria and associated mental health issues. There are a number of organisations that provide relevant training including The Gender Centre, Twenty10, and ACON.

5.3. Location of PSS Service

- Services must be delivered within the CESPHN catchment area and from locations that are easily accessible to individuals, including those with a disability
- MHP services are to be delivered from a professional setting.
- MHP are to make services accessible to underserviced populations and hours of operation should reflect this.
- MHP must provide their Provider clinical lead with updated lists of consulting location or any changes to location
- The Provider and MHP warrants that the location complies with all relevant Work Health and Safety (WH&S) Policies **(See Attachment A. Legislation**) and appropriate insurance coverage is in place.

6. PSS Referral Process

- Referrals to the PSS programme can be made by:
  - **Medical Practitioner**: GPs, Psychiatrist, Pediatricians, Obstetrician-Gynecologist (peri-natal only)
  - **Non-medical Practitioners**: **See 13. Non-Medical Practitioner Referrals**
- All referrals and reviews must come through CESPHN Mental Health Central Intake team via:
  - Online Service Referral Form
  - Healthlink/ GP Integrator
- Referrals **will not** be accepted via email due to privacy concerns,
- GPs continue to play the central role in the provision and coordination of physical and mental health care within the primary care setting. A Mental Health Treatment Plan (MHTP) from a MP is required.
- NMP referrals are accepted for the following underserviced or hard to reach groups including: Aboriginal and Torres Strait Islander peoples, Children and young people, individuals experiencing perinatal depression, individuals from culturally and linguistically diverse backgrounds and individuals who identify as Lesbian, Gay, Bisexual, Transgender, Intersex and Queer/Questioning (LGBTIQ).

- These NMP referrals will allow MHPs to carry out up to three sessions to do an assessment and facilitate a MP Mental Health Treatment Plan when appropriate. NMP referrals are valid for a period of three months only and sessions must commence before expiration of this period.

6.1. Individual Sessions

- PSS is for mild to moderate mental health issues and clients can access **up to 18 sessions** within a 12-month period from the date of the referral.

- Sessions are allocated from CESPHN in blocks of six sessions. Initial 1-6 Sessions, followed by a MHTP Review for approval of sessions 7-12. In exceptional circumstances as defined by a "significant change in the individual's clinical condition or care circumstances'', a further 6 sessions may be requested by outlining the clinical benefit for 6 sessions 13-18.

- Sessions 13-18 are only provided under *exceptional circumstances* and require the individual to see their MP following the 12th session for review. These reviews will be re-triaged by the CESPHN Central Mental Health Intake team and are NOT guaranteed. MHP are NOT to provide sessions beyond the 12th appointment without approval.

- Notification of an approval for session 13-18 will be sent to the Provider to communicate to their MHP.

- If session 13-18 are not approved, CESPHN will contact the MP and the Provider to advise of the outcome and reason. The Provider will communicate the outcome to the MHP.

- If individuals require therapy beyond the 18 sessions (12 months) then this also needs to be approved by the clinical lead. There may be some clients that would clearly benefit from a "second round" of PSS, but this needs to be discussed with and approved by the Clinical Lead. A maximum of two "rounds" of PSS (totalling a maximum of 36 sessions) is permitted for each client. GP reviews must continue every 6 sessions and be sent to CESPHN Mental Health Central Intake for uploading.

- Face to face sessions are preferable

- Each session (face to face, telephone or Skype) shall be provided based on at least 50 minutes per individual, evidence based, FPS.

- Telephone and Skype sessions are recommended if face to face is not available in the **initial assessment**. If telephone or Skype is to continue past initial appointment, approval from the Provider clinical lead is required.

- MHP to follow the MDS requirements by requesting reviews from MPs at each set of six sessions. When intake notify the MHP of approval they will confirm what block of sessions have been approved to help MHP keep on track. MHP can check the total number of sessions provided in the **Service Contact** tab of rediCASE.

- Sessions delivered through a NMP referral are included in the total number of sessions allocated by the CESPHN Mental Health Central Intake team.

- *Sessions **cannot** commence or be booked in advance by the treating MHP without first being approved by the CESPHN Mental Health Central Intake team. This includes sessions before the review has been approved.*

- For more information regarding SPS sessions please refer to **Attachment E. SPS Guidance**

6.2. Time Frames

GENERAL PSS REFERRALS		
FROM	**TO (completion of task)**	**Days**
1. Referral sent to CESPHN	Triage and allocation	Up to 3 Days
2. Provider	To allocate to MHP	1 Days
3. MHP	Needs to accept referral	72 hours
4. MHP	Initial individual appt	4 Weeks

SPS REFERRALS		
FROM	**TO (completion of task)**	**DAYS**
1. Referral sent to CESPHN	Triage and allocation	24 hours
2. Provider	To allocate to SPS MHP	24 hours
3. MHP	View and accept the referral	24 hours
4. MHP	Initial contact with individual, which is counted as a service contact	7 days from referral

6.3. MHP Unable to Contact an Individual

- When a MHP has accepted a referral, it is reasonable that after 3 attempts to contact the individual that this is enough to assume the individual is unable to be contacted.
- The MHP must communicate to the referrer and their MP updating them of non-engagement with the individual and document in CIMS.
- The referral can then be closed by the MHP by declining the referral and adding a note in CIMS of the reason E.g. unable to contact the individual.

6.4. Definition of a No-Show

- A ‘no show’ is defined for the purposes of the MDS as an individual not giving 24 hours’ notice of non-attendance.

- No shows must be captured in rediCASE as - **Service Contact type: No service took place**. This automatically prepopulates the other responses. The session will not be taken away from the individual's approved set of 6 sessions.

6.5. Request for change of MHP

When a request comes through for a change of provider:

- CESPHN Mental Health Central Intake will record who the request has come from and the reason for the request to change provider.
- The Provider clinical lead will be notified of the request.
- It is the Provider's responsibility to contact the current MHP and advise them of the request for change.
- The Provider is responsible for ensuring the current MHP has been uploading MP reports and adding any necessary notes, MDS etc before re-allocating to a new MHP.
- If a new MHP is unavailable, then the Provider is to notify CESPHN Mental Health Central Intake for re allocation to another Provider organisation.

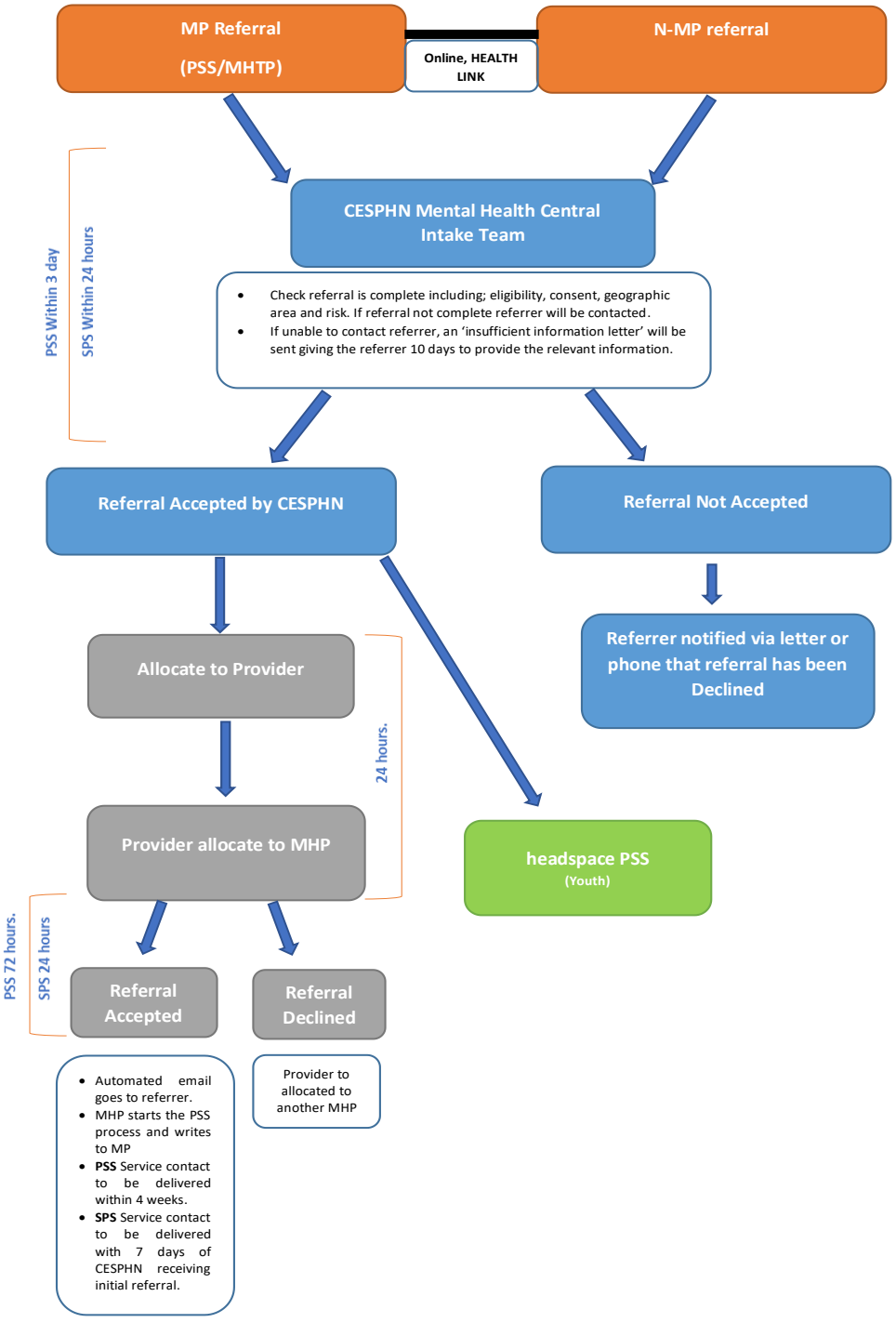
6.6. Limitations

- PSS Service is designed to provide short-term support for an individual for up to 12 sessions, with the possibility of an additional 6 sessions where there is a clinical benefit identified and the clinical lead has approved. The service is not designed to provide long term support or treatment.
- **Individuals Who Are Not Australian Citizens living or Working in Australia**
    - Non-Australian citizens including overseas students may access the service after the following is conducted:
        - If an individual does not have a current Australian Medicare card, then DoH recommends the other options must be investigated before a PSS referral can be made. Students on student visas may have their own private insurance arrangements in place and can access private services.
        - If an individual does not have access to other services, they may be appropriate for PSS. In which case, a Mental Health Treatment Plan must be in place for them to receive treatment.

7. CESPHN Mental Health Central Intake Process

- CESPHN have a Mental Health Central Intake Team that is staffed by both administrative and clinical staff. The team is responsible for all data entry, triage, and allocation of referrals to appropriate services and Providers. MHPs will only provide services to individuals under the PSS programme who are referred directly to the Providers by CESPHN.

- The Clinical Lead – Mental Health Central Intake Team monitors and oversees the process and workflow and manages any complex clinical issues or complaints.
- All relevant information obtained during the triage process is uploaded to the Notes or Document Sections of the CIMS, where Providers and MHPs can access these notes once they have been allocated.
- Please take any concerns about this process to your Provider clinical lead, who will feedback to the CESPHN Clinical Lead - Mental Health Central Intake Team.
- **See CESPHN Mental Health Central Intake Process Flow Chart below:**



8. Underserviced Groups

- Underserviced groups refer to those who:
    - experience financial hardship (Individual income < $55,000; family income < $130,000) including adults;
    - have been identified via CESPHNs Mental Health Needs Assessment for our local CESPHN region as well as underserviced groups defined by the DoH; **AND**
    - who fit into one of the below underserviced and/or hard to reach populations:

8.1. Perinatal

- The National Perinatal Depression Initiative of the DoH (2013) identified this group as requiring better Access to psychological services to improve prevention and early detection of antenatal and postnatal depression. CESPHN continue to support this initiative.
- Individuals with perinatal mental health concerns may be referred to PSS by MPs (GP, Psychiatrist, Paediatrician, Obstetrician-Gynaecologist), or by NMPs (Maternal and Child Health Nurses and Allied Health Professionals, Lactation Consultants, Midwifery and Neo-natal Nurse).
- Perinatal PSS services can be delivered as focused psychological services, group therapy, liaison with child/maternal nurses regarding referral pathways, family therapy, telephone and web-based services.
- MHP are to provide links appropriately to other services especially local Perinatal mental health services, within a stepped care approach to ensure people are matched to a service commensurate with their perinatal need.

8.2. Aboriginal and Torres Strait Islander People

- There are 13,489 individuals identifying as Aboriginal and/or Torres Strait Islander peoples living in the CESPHN region, with the largest numbers residing in the Inner Sydney City, followed by Eastern Suburbs - South.
- PSS support will assist Aboriginal and Torres Strait Islander people have access to mental health services that are integrated, culturally appropriate and safe, and designed to holistically meet the mental health and healing needs.
- Services are to support clinical evidence and delivered by an appropriately skilled MHP. Culturally appropriate services require cultural awareness, cultural respect, cultural safety and an understanding of the cultural determinants of health **See 5.2. Specific Training Requirements**

- In recognition of the difficulties in accessing MPs to obtain a MHTP, service provision can commence while arrangements are made to see a MP (**See 11. Non-Medical Practitioner Referrals)**

- Services are to complement and link with other closely connected activities, such as social and emotional wellbeing services, services provided by Aboriginal Community Controlled Health Services (ACCHS), the Aboriginal Medical Service (AMS), headspace, suicide prevention approaches, Local Hospital District (LHDs), and alcohol and other drug services.

- When providing treatment to underservices groups, or in some Aboriginal and Torres Strait Islander communities a MHP may encounter difficulties in meeting the requirement of a MHTP. If this occurs, the MHP should contact CESPHN to discuss further.

8.3. LGBTIQ

- The ABS has reported that the top ten suburbs for same sex couples are located within inner Sydney, which falls within the CESPHN region.

- CESPHN's Mental Health Needs Assessment (2018) identified a higher proportion of LGBTIQ young people accessing CESPHN commissioned headspace sites than the national headspace average.

- CESPHN recognises both the historical and ongoing risk factors affecting the mental health of LGBTIQ people, as well as the observed rise of stress and anxiety levels within LGBTIQ community during the marriage equality postal survey 2018 and subsequent commentary.

- CESPHN commissions services targeting this specific cohort, such as The Gender Centre, headspace and local PSS MHPs.

- CESPHN request Providers to approach and facilitate LGBTIQ-inclusive practice:
  - ensuring inclusive language on all materials and in discussions with individuals
  - linking to LGBTIQ resources in services and on website
  - being aware of and using referral pathways and options that include providers with expertise and experience with working with the LGBTIQ community

- CESPHN promotes links and coordination between mainstream health and community services and organisations with specialist expertise working with the diverse needs of the LGBTIQ community.

- Providing culturally safe and accessible services that value and affirm LGBTIQ people, their communities and their unique and shared experiences and avoids assumptions that all individuals are heterosexual and/or cisgender.

- It is also important to consider whether an Individual prefers to attend a LGBTIQ specific service

LGBTIQ services and Referral Pathways in the CESPHN Region

Services available	*Contact information*
Psychological Support Services (PSS) through CESPHN PSS provides FREE short term face-to-face psychological services to populations who have been identified as underserviced and/or hard to reach including the LGBTIQ population. PSS is funded through the Commonwealth Department of Health and is delivered through several CESPHN commissioned consortiums including One Door Health Care and Twenty10. The CESPHN website provides a link to PSS provider organisations and registered PSS mental health practitioners and their areas of expertise, including expertise/experience working with LGBTIQ people.	For more information on how to make a referral visit www.cesphn.org.au/programs/pss Or call the CESPHN PSS intake team on 9330 9999
QLife Free national telephone and online counselling service.	www.qlife.org.au 1800 184 527 3pm to midnight, daily
Twenty10 Provides a range of community and health services to LGBTIQ young people, their families and communities in NSW.	www.twenty10.org.au 8594 9555
The Gender Centre Provides a range of health and welfare services to the transgender gender diverse and gender questioning community including counseling and psychological support housing outreach and youth support	www.gendercentre.org.au 9569 2366
ACON ACON is a NSW based organisation specialising in HIV prevention and support, and LGBTIQ health. ACON provides HIV, LGBTIQ and AOD counselling and care coordination.	www.acon.org.au 9206 2000
Beyond Blue National phone support 24 hours, 7 days a week and online support 3pm to midnight daily and online information and resources.	www.beyondblue.org.au 1300 224 636
Life Line Access to 24-hour crisis support and suicide prevention services.	13 11 14

8.4. Culturally and Linguistically Diverse (CALD) Background

- CESPHNs Mental Health Needs Assessment (2018) identified that Access to psychological intervention for CALD communities within the CESPHN region may be impacted by low English language proficiency, cultural stigma, and limited support networks.

- The highest proportion of CALD persons based on low English proficiency are Canterbury, Hurstville, and Kogarah-Rockdale. These regions with the lowest utilisation rates for Medicare psychological intervention, indicating barriers to Access psychological services.

- All MHP must complete cultural awareness training (**See 5.2. Specific Training Requirements**).

- Mental Health Australia has developed training modules for services and providers as part of the Framework for Mental Health in Multicultural Australia.

- Translating/interpreter services must be made available. Individuals requiring this service need to have access facilitated by the Provider. Ensure MDS is correctly filled out to record use of interpreter.

8.5 Child PSS

- Child PSS refers to children who are aged between 0-12 years, who have not yet graduated from primary school and who have, or are at risk of developing a mental, childhood behavioural or emotional disorder. These include:
  - a child assessed as having definite or substantial signs and symptoms of an emerging mental disorder, where this causes "significant dysfunction in everyday life"; and
  - a child at risk of developing a mental disorder, where the child shows any number of signs or symptoms (social-emotional-behavioural) of developing a mental disorder and/or where the child's developmental pathway is disrupted by their mental health condition (i.e., not limited to disruptive disorders).

- MHPs working with this cohort need to have completed relevant training and post-graduate experience working with children of minimum 3 years. (**See 5.2. Specific Training Requirements)**

- Appropriate psychological treatment options for Children often involves therapies which involve the whole family, or which in other ways do not fit the parameters of FPS. Child PSS allows for family-based therapies such as behavioural therapy, and parent training in behaviour management, which entail working closely with parents and families. It is acknowledged that some of these sessions may or may not include the child.

- The DoH recommends that sessions where parents, guardians or other family members are present and the child is not present, do not exceed the number of services with children present.

- Those sessions where parents, guardians or other family members are present, and the child is not present will count towards the total number of individual Services.

- If parents of a child require more sessions, they should be considered as separate individuals and referred individually to PSS. It is recommended that in these situations, the parent be referred to a different MHP.

8.6 Young People 12-25 Years of Age

- PSS targeting young people is provided in headspace centres across the region, The Gender Centre, as well as through other MHPs in the CEPSHN region.
- CESPHN commissions five headspace sites in its region: Ashfield, Bondi Junction, Camperdown, Hurstville and Miranda.
- NMP referrals can be made by the headspace Youth Access Clinician (YAC), school counsellors and school Principals/Deputies.
- A CESPHN PSS Guidance for headspace centres has been written detailing the referral process, eligibility and data reporting requirements.

8.7 Individuals experiencing severe Mental health conditions who may benefit from short term PSS

- PSS targeting individuals experiencing severe mental health conditions is available for individuals who would clearly benefit from **short term** FPS. The PSS programme does not offer long term psychotherapy.
- PSS would form part of an individual's overall care and is not provided as the sole primary care option for the individual
- Mental health must be stable
- PSS is only available for individuals whom are not receiving psychological therapy from any other service
- Individuals referred to PSS cannot be an active client within the mental health services of the Local Hospital Network.

8.8. Mild Intellectual disability who may benefit from short term PSS

- Intellectual disability must be mild and co-occurring with a diagnosed mental health problem to be eligible for this service.
- PSS is available for individuals who would benefit from **short term** FPS only. This program does not offer long term behavioural therapy or psychotherapy.
- Individuals receiving psychological services through other government initiatives such as NDIS are not eligible for PSS. There will be no duplication of service.

9. Suicide Prevention Support (Non-Acute)

- This service provides priority access to the PSS initiative for individuals who have self-harmed, attempted suicide or who have suicidal ideation and are **already** being managed in the primary health care setting. A person does not need to have had a mental disorder diagnosed before referral to the SPS and is not required to have a MP MHTP completed to start support.
- SPS is limited to individuals referred by:
  - Medical Practitioners
  - Acute Care Team (ACT)
  - Psychiatric Emergency Care Centre (PECC)
  - Current PSS MHPs stepping up from PSS
  - headspace clinicians with clinical lead approval
- DoH has mandated time frames for the SPS programme, which need to be strictly adhered to by the MHP.
- This programme is only available to MHPs who meet eligibility requirements and have done the mandated training.
- Please see **Attachment E. SPS Guidance** for specific details about this programme.

10. Residential Aged Care Facility (RACF)

- Residents of aged care facilities do not have the same Access to mental health services like those available in the community through the MBS Better Access Initiative. PSS services to RACFs will help to address the current service gap for this group of people by offering access to psychological services which are like those available to people in the community.
- The current programme for PSS RACF is currently under review and this guidance will be updated should there be any changes to the model of care. The guidance below refers to the programme as it currently stands.
- The PSS programme aim is the delivery of psychological support services to target the mental health needs of people living in residential aged care facilities (RACF) across the CESPHN region. The services to be provided are evidence-based, time-limited psychological therapies which are adjusted to be responsive to the needs of older people experiencing mild to moderate mental illness
- The benefits for RACF residents from accessing needed psychological services are expected to include mood improvements, reduction in anxiety and stress, and increased ability to cope with life changes. Residents experiencing mental illness will be more likely to engage in activities and social connections at the facility if they receive treatment appropriate to their needs.

10.1. Eligibility Criteria

- Residents of Aged Care Facility experiencing mild to moderate mental health illness. This includes:
    - Residents who are having significant transition issues and experiencing adjustment disorders or abnormal symptoms of grief and loss, for whom early treatment may avert descent into a more serious mood disorder. This group does need to be differentiated from residents who are exhibiting normal sadness and/or transition issues;
    - Residents experiencing mild to moderate anxiety and/or depression – as above, this is expected to be the largest group requiring services through the measure, given almost half of all residents are likely to experience depression;
    - Residents with past history of mental illness for which they received services before being admitted which could not be continued – particular issues of continuity of care and understanding individual's history apply; and
    - Residents who, in addition to their mental illness, have a level of comorbid cognitive decline and/or dementia. The AIHW reported that 40% of residents with dementia were likely to have a mental health or behavioural problem.
- Dementia and delirium are not regarded as mental illness. This is because these conditions require medical and/or other specialised support which is not within scope of this initiative.
    - People with dementia are not excluded from treatment if they also have a comorbid mental illness such as anxiety or depression.
    - Delirium may present with symptoms similar to those associated with a mental illness although it will not respond to psychological therapies and requires urgent medical assessment.
    - Please refer to **2.2. Provision of mental health services to residents with comorbid dementia: The Department of Health Guidance**
- A medical diagnosis of mental illness by a MP is important to ensure that symptoms of cognitive decline, dementia or delirium are not mistaken for mental illness, and to ensure that physical illness, and medication needs are considered in the overall care plan of the individual. However, there may be some circumstances where it is not possible to get a timely medical diagnosis and provisional referrals to commence service provision in anticipation of a formal diagnosis, may be important to get timely care.
- The services may in some instances also target people who are assessed as 'at risk' of mental illness. The 'at risk' group is defined for this measure as individuals who are experiencing early symptoms and are assessed as at risk of developing a diagnosable mental illness over the following 12 months if they do not receive appropriate and timely services.

10.2. Referral processes

- Residents of RACFs can be referred for PSS via the CESPHN Online Referral form.
- Requests for services can come from a variety of sources including self-referral, family and friends, or RACF staff; followed by a formal referral.

- Formal referral may come from a GP, RN, psychiatrist, geriatrician, psychologist, Older Adults team LHD, or other providers who are able to confirm a diagnosis of mental illness or reliably identify individuals who would benefit from the service

- It is recommended the individual's GP is advised that they have been referred to mental health services if the GP is not the referrer, and that the GP is regularly updated about the Resident's presentation and progress in treatment.

- For NMP referrals, the MHP must facilitate a mental health diagnosis to ensure that symptoms of cognitive decline, dementia and delirium are not mistaken for mental illness and to ensure that physical illness, and medication needs are considered in the overall care plan.

- Residents of RACFs can access up to 12 sessions of FPS. These sessions are provided in sets of 6 sessions. When the MHP has delivered the 6th session, they are required to complete a review letter which needs to be uploaded into rediCASE documents and a copy placed in the Resident's file.

- If a Resident requires more than 6 sessions, the MHP needs to clearly articulate in this review letter the reasons for the additional 6 sessions and the treatment plan. This needs to be discussed with the referrer, and a mutual decision be agreed on that a further 6 sessions be granted.

- Sessions beyond 6 will require a PSS review. MHP must:
    - Uploads a review report to rediCASE which states the rationale, plan etc
    - Send that report to the facility to add to the resident's file for the team there, including the resident's GP, to have access
    - If the resident is experiencing severe mental illness and needs further support, then the clinician will need to arrange a referral to the local hospital network's Older Peoples Mental Health (OPMH) team

Referral and assessment process	By whom	Description
Request for services	By self, relatives, RACF workers, former service providers, ACAT, dementia services or other service.	Resident identified to RN or GP as potentially being in need of low intensity services or assessment for mental health needs.
Formal referral to trigger the service	GP, psychiatrist, psychologist, RN or other provider who can reliably identify individuals who would benefit from the service.	Confirms diagnosis or identifies that person is at risk. Considers physical health needs relevant to mental health. Reviews likelihood of delirium. Identifies whether history of dementia exists.
Assessment/triage to identify level and type of service	CESPHN Mental Health Central Intake team	Assessment aims to identify which treatment is most suitable, and to inform individual approach to services.

- Referral time frames as per **section 6.2 Time Frames**

- Beyond Blue has a further guide of appropriate therapy choice for older people which can be found here: http://resources.beyondblue.org.au/prism/file?token=BL/1263A

- For Further information please refer to The Department of Health Guidance

11. Non-Medical Practitioner Referrals

- NMP can refer, with approval, for a limited number of sessions (depending on the referral type, **See Table.3. below**) for commencement of service with a PSS registered MHP **prior** to the development of a MP Mental Health Treatment Plan.
- Should sessions continue after these initial session(s) have been completed, the individual will need to see their MP for an initial PSS referral and MHTP before further sessions can be approved.
- Further sessions conducted without a MHTP, should not be remunerated.

Table.3.

PSS Categories	Non-Medical Practitioner Referrers Included	Provisional Sessions Allowed with a MHTP
Child (0-12 year and under)	▪ School counsellors ▪ School principal/deputies ▪ Directors of Early Childhood Services	▪ 3
Adolescents (12-25 years)	▪ headspace YAC ▪ School counsellors, school principal and deputies	▪ 3
Perinatal	▪ Maternal and child health nurses and allied health professionals ▪ Lactation consultants ▪ Midwifery and neo-natal nurse	▪ 3
Aboriginal and/or Torres Strait Islander	▪ Aboriginal health worker/ Care coordinator/ Outreach worker ▪ House parents of Kirinari Hostel (Sylvania) ▪ Youth health and well-being coordinators ▪ Managers of Aboriginal Community Controlled Health Services (ACCHS)	▪ 3
Culturally and Linguistically Diverse (CALD)	▪ Multicultural community health liaison officers	▪ 3
Suicide Prevention	▪ Acute Mental Health Teams ▪ Psychiatric Emergency Care Centre ▪ headspace centres **(Sessions are capped at either 12 FPS or 10 FPS +2 Care Coordination session within a 2-month period)**	▪ Facilitate access to a MP for a MHTP as soon as possible (preferably within 2 weeks.

12. Group Sessions

Prior to commencement of PSS Groups

- MHP must consult with the Provider's Clinical Lead and seek **approval** by CESPHN prior to delivering any group activity.
- Groups cannot duplicate existing groups already running in the community unless otherwise agreed to by CESPHN.
- Two facilitators must be available to facilitate a PSS group. Facilitators must be registered as PSS MHPs, be trained in delivering the proposed therapeutic modality and have completed the relevant qualifications and standards to deliver a service to that particular underserviced group.
- Groups must have at least 8 participants to commence. The maximum number of participants will depend on the room capacity and available facilitators. It is recommended that 2 facilitators have no more than a maximum of 14 participants.
- All Group Referrals must be completed using the Online PSS form. Referrer is to select **Group referral** under **Reason for Referral***. If the group name is not visible on the list, please select **PSS Group Referral** and add the name of group
- All group individuals must be registered in CIMS **minimum 1 week** before group commencement.

Eligibility

- Individuals will need to meet PSS eligibility for Group sessions including NMP referrals from approved referrers.
- Group Sessions are to be face to face evidence-based FPS only. These have been identified by the Australian Psychological Society **(See 4.2. Psychological Treatment)**
- PSS individuals may access group sessions up to 12 group sessions within a od from date of referral unless otherwise as agreed by CESPHN.
- Group participants are also able to access PSS Individual sessions during the referral period.
- Individual and Group sessions:
    - People who are accessing Better Access *individual* sessions under a MHTP may be able to access PSS *group* sessions if PSS eligibility applies.
    - People who are accessing PSS *individual* sessions can access Better Access *group* sessions, using their existing MHTP.

MDS Group Sessions

- All group sessions must be recorded in the CIMS including pre and post outcome tools and an individual's experience of care questionnaire. **See Section 13. Outcomes and Satisfaction**

- Group sessions are **not** to be included in the individual session target numbers but should be entered as a group session in CIMS
- Group sessions are to be entered in the same episode of care (that is, CIMS Referral ID number) as individual sessions. A new episode of care will only be open for clients where the MHP differs from the one providing individual sessions

13. Outcomes and Satisfaction

Outcomes

It is a mandated KPI requirement from the DoH to use specified outcome tools pre and post service delivery with a target of 70% completion over the entire programme.

- MDS requires the use of outcome tools:
    - K5 for Aboriginal and Torres Strait Islander Peoples (18+ years) only
    - K10+ for Adults over 18+
    - SDQ for Children (up to and including 17 years)
    - Please note: For young people, clinician-discretion is allowed, and that the K10+ or K5 (Aboriginal and Torres Strait Islander People only) may be used, even though the person is under 18 years

These outcomes tools can be downloaded from CESPHN website or from here for the SDQ

- MHPs are expected to enter an outcome tool at both the start of an episode and at its completion. If your client does not complete an outcome tool at the last session, please enter the score for the last completed tool.
- MHPs should then 'clinically' close the episode of care by selecting the message 'no further sessions required'.
- It is imperative the MHPs enter outcome data and close the episode of care according to these instructions as the DoH evaluates the effectiveness of the PSS programme based on these scores.
- **See 4.10 Minimum Data Set (MDS)**

Your Experience of Service (YES) survey

- CESPHN will use a measure of effectiveness of PSS services by asking Providers to implement the individual rated Your Experience of Service (YES) Survey.
- At the time of writing this guidance a PHN specific YES-Survey tool is under development and due for release, at which point CESPHN will instruct Providers to implement this version. However, those Providers who may already implement the CMO version of the Yes-Survey may use this version in the interim.
- Once the PHN YES-survey is released this guidance will be updated with clear instructions for MHPs.

- Implementation of this tool across the PSS program will enable CESPHN to assess how the service is being received and whether the service has a positive impact on individuals' daily lives.

14. Discharge/Closing an Episode

- Individuals who have reached the maximum number of sessions or have completed treatment will be exited from the PSS programme.
- Before closing the episode please ensure you have entered all MDS, outcome tool, relevant notes and have uploaded all correspondence sent or received by the original referrer.
- Once an episode is closed it is NOT to be reopened or sessions to be entered. In an event it has been closed and the individual returns to the programme, a new episode of care (new ID) will be created. Re-opening a file causes a major error with data extraction.
- When an episode of care is closed MHP will be able to search the individual by filtering the referral status as closed and filtering for the individual name or ID number. The individual will no longer be on their active client list.
- If individual requires a referral to another organisation for ongoing care and support, the MHP will make recommendations to the individual and gain Consent to refer to the other service after receiving Consent. It is essential that the MP is advised of this plan. It is also essential that all documentation is uploaded into rediCASE e.g. in the Notes section, before the individual is discharged to the other service.
- The MHP should 'clinically' close the episode of care by selecting the message 'no further sessions required' AND enter the final outcome score when closing the episode of care.
- **See Attachment C. rediCASE Manual and Clinically Closed Episodes**

15. Better Access and PSS

In the instance where an individual has received the 10 psychological therapy services available under Better Access through the MBS initiative and is considered to clinically benefit from additional services, the person may be eligible for PSS, **if they meet the relevant eligibility criteria**.

To access these additional services, the following applies for the CESPHN region:

- Individual must be eligible for PSS;
- Sessions can only be delivered by PSS registered MHP only;
- Referrals are to include the original Mental Health Treatment Plan used to access Better Access, with a review from the MP outlining the clinical benefit for a further 6 sessions;
- CESPHN Central Intake will triage eligibility and will notify the MP of the outcome of the referral.

Please note:

- Gap payment cannot be charged for these services.
- Expiring MBS sessions do not automatically qualify eligibility into the PSS programme.

PSS to Better Access

- Once an individual has exhausted their PSS sessions, please consult with the MP to consider moving the individual to alternative pathways of care such as Better Access or other primary health care initiatives.
- Please note individuals can only access 10 sessions via Better Access, per CALENDAR year.

16. Consent, Privacy, Confidentiality and Complaints

16.1. Consent

- Consent must be obtained prior to any services being delivered to the individual. Ensure an informed Consent form is given, **explained** and signed.
- On the first delivery of service the MHP must explain rights and responsibilities.
- An Individual's Consent is also required prior to undertaking any collaborative conferencing.
- If an individual requires referral to another organisation for ongoing care and support, the MHP must make recommendations to the individual and gain Consent before referring to another service.
- Consent must be voluntary, current and specific. Individuals have the right to withdraw Consent at any time.
- It is important to reconfirm Consent on an ongoing basis and make access for individuals to withdraw Consent as simple and straightforward as possible.

16.2. Confidentiality and Privacy

- Individual Confidentiality is paramount and is **always** to be maintained.
- As a general principle, personal information is to be used for the primary purpose for which we collect the information, or a secondary purpose related to the primary purpose for which it would be reasonable expect us to use the collected information.
- Personal information will not be used for an unrelated secondary purpose unless the individual's written Consent is obtained or in exception applies, such as it is impracticable to obtain Consent and we believe that collecting, using or disclosing personal information is necessary to lessen a serious threat to life, health or safety of any individual.
- Emails should never include individuals name – only rediCASE referral ID's are to be used.

- CESPHN, Provider, and MHP must undertake to observe all Privacy requirements when engaging in activities under this Providers Agreement in accordance with the **(See Attachment A. Legislation)**

    - Privacy Act 1988 (Cth) (Privacy Act)
    - Australian Privacy Principles 2019 (APPs)
    - Health Records and Information Privacy Act 2002 (NSW) (HRIP Act)
    - Privacy and Personal Information Act 1998 (NSW)
    - Privacy Amendment (Enhancing Privacy Protection) Act 2012 (Cth)

- The terms "personal information" and "health information" have the same meaning as is given to them in the Privacy Act and the HRIP Act. **(See Attachment A. Legislation)**

- The Provider or MHP undertakes to inform CESPHN immediately on becoming aware that any breach of Privacy or security relating to information under its control has occurred.

- The MHP must:

    - ensure that all Confidential Information is kept confidential and is not copied, published, disclosed or discussed with any person other than its Personnel who have a need to know and its authorised representatives;

    - not use any Confidential Information except as required for the purpose of the Providers agreement and providing the services;

    - not disclose any Confidential Information except as required by law.

16.3. Access to Information

The following principles apply:

- individuals are entitled to request access to their own personal information. Access will be provided unless there is a sound reason under the Privacy Act 1988 or other relevant law to withhold access;

- best practice must be used for the management of records and recognises the statutory requirements of the Health Records & Information Privacy Act 2002 and State Privacy Manual;

- the collection and use of personal and health information must relate directly to the individual's health care;

- individual must be aware of, or informed of, the purposes for which personal and health information is obtained;

- personal and health information received and held is up to date and records shown to be incorrect will be amended

- personal and health information is stored securely;

- third party access to personal and health information may only be granted in accordance with the Australian Privacy Principles (APPs);

- the APPs and the Privacy Act 1988 will be observed;

- individuals registered with My Health Record (MHR) can choose whether they would like information regarding their mental health care be uploaded to their MHR.

- retention and destruction of health records will be in accordance the Health Practitioner Regulation (NSW) Regulation 2010;
- Any request to access records is to be made in writing to the CESPHN CEO or CESPHN Clinical Services General Manager.

16.4. Storing Information

- MHP will need to take care to protect and hold securely personal information whether electronic or on paper. All personal information held by the MHP:
  - If in paper form, received and stored in a secure, lockable location with reference the Health Records and Information Privacy Act 2002 (NSW) **(See Attachment A. Legislation)**
  - If in electronic form, adequately protected according to best practice
  - Accessible by staff only on a "need to know" basis only and that access is purposeful, appropriate and legal; and
  - Not taken from the offices unless authorised and for a specified purpose.
- Securely destroy or permanently de-identify personal information that is no longer required to be held. Records are kept in accordance with the record-keeping obligations that apply to the category of record.

  MHP to maintain and retain adequate and prudent records of all services provided as part of the PSS services **(See 4.3 Documentation)**. Such records by law must be kept for 7 years for adults, and in the case of Children until the child reaches 25 years of age, from the date that the client was last provided with a Service
- Both CESPHN, and MHP undertake to observe all Privacy requirements when engaging in activities under the Providers agreement in accordance with the:
  - Privacy Act 1988 (Cth) (Privacy Act)
  - Australian Privacy Principles 2014
  - Health Records and Information Privacy Act 2002 (NSW) (HRIP Act)
  - Privacy and Personal Information Act 1998 (NSW)
  - Privacy Amendment (Enhancing Privacy Protection) Act 2012 (Cth)

16.5. Complaints

- It is not the role of CESPHN, or its staff, to become involved in complaints by outside parties (consumers, carers, other providers and organisations) about Providers or MHP.
- For complaints about Providers and MHPs, the complainant should, in the first instance, discuss their concerns with that organisation. The complaints policy of the Provider will apply beyond this step. However, CESPHN does require that Providers notify CESPHN of serious complaints, verbally and in writing as soon as practicable or within 24 hours.
- Notifiable complaints include complaints relating to:

- an unexpected death, suicide or major loss, permanent injury or disability after an assessment by or contact with a service delivered by a Provider and funded by CESPHN
- a breach of Individual rights
- any issue that is likely to or does lead to adverse media attention
- professional misconduct of a staff member involved in delivering a service funded by CESPHN
- a near miss where there was a reasonable likelihood of a death or major loss or disability occurring
- a change in service provision that results in loss of services for a community or priority population group

- Written reports to CESPHN relating to notifiable complaints must include:

  - Date/time of the complaint
  - Location and jurisdiction in which it occurred
  - Individual(s) (notify if third party involved)
  - Individuals age
  - Description of the complaint as known at that time
  - Any immediate action taken
  - Complaint reference number
  - Organisational contact details for follow up

- Providers are instructed to provide the written complaint to the CESPHN General Manager Clinical Services.

16.6. Clinical Incident

- CESPHN requires that Providers have incident management policies and procedures in place to handle Clinical Incidents.

- It is not the role of CESPHN, or its staff, to become involved in incidents that occur in services commissioned by CESPHN. However, CESPHN does require that Providers notify CESPHN of serious and major incidents, verbally and in writing as soon as practicable and within 24 hours.

- Notifiable incidents include:

  - an unexpected death, suicide, major loss permanent injury or disability after an assessment by or contact with a service delivered by a Provider and funded by CESPHN
  - Death or hospitalisation of a staff member related to work incident or suicide, in the course of an activity funded by CESPHN
  - a breach of individual rights
  - any issue that is likely to or does lead to adverse media attention
  - professional misconduct of a staff member involved in delivering a service funded by CESPHN
  - a near miss where there was a reasonable likelihood of a death or major loss or disability occurring
  - a change in service provision that results in loss of services for a community or priority population group

- This includes incidents involving individuals who are waiting for a service or those who have been discharged from an CESPHN - commissioned service in the last 3 months.

- Written reports to CESPHN relating to notifiable incidents must include:

  - Date/time of the incident
  - Location in which it occurred
  - Description of the incident as known at that time
  - Any immediate action taken
  - Incident reference number
  - Organisational contact details for follow up
  - CESPHN may request additional information

- Providers are instructed to provide the written incident report to the CESPHN General Manager Clinical Services.

- Depending on the nature and the severity of the incident, and the potential for learnings that may improve systemic changes or programme design, the CESPHN CEO or General Manager may request additional information from the Provider. This may include involvement in the RCA process.

16.7. Legal Matters and Subpoena's

- The PSS programme does not have the capacity to service Children and their families where the main area of concern is related to a current Family Law Court Matters.

- The PSS programme does not provide medico legal reporting as part of the programme.

- Subpoenas are the responsibility of the Providers. CESPHN Clinical Lead is to be notified by the Provider clinical lead of any subpoenas or significant legal matter related to the PSS programme.

17. Crisis Support Mechanism

- PSS is not a crisis service nor designed to replace an Acute Care Services.

- For individuals at risk and need:

  - **Assertive Follow-up Services**. Individuals who recently attempted suicide, and based on clinical judgement, requires assertive, community-based, case coordination to keep them safe. This requires referral to a local Acute Care Team via the Mental Health Line Ph 1800 051 511 or direct individual to the Local Hospital Emergency Department. The hospital team(s) may consider referring to SPConnect if appropriate.

  - **Imminent Risk** - The person is at imminent risk of suicide. Based on clinical judgement this person requires immediate / urgent assistance - Please call Emergency services 000

- Familiarise yourself with the following services:

  - **Suicide Call Back Service**

  - **All Hours Suicide Support Service**

17.1. All Hours Suicide Support Service

All Hours Suicide Support Service (AHS; formerly ATAPS) is funded by the DoH. This information is adapted from information received from All Hours Suicide Support Service.

- This free, specialised phone service is designed to support the individuals of allied health providers out of hours, whilst they are away, or when there is a long gap between appointments. It provides support to individuals at risk of suicide 24 hours a day to ensure these individuals have access to professional support around the clock.
- All individuals who are referred to this service must be assessed as **low to medium risk** and **15 years or over**.
- Individuals from a CALD background can access interpreter services through teleconference if an interpreter is needed.
- Individuals need to have an **ongoing treating practitioner** (Allied Health Practitioner) or should be in the process of being linked in with one.
- The Allied Health Practitioner (for example Psychologists, Social Worker, Mental Health Clinician etc.) must be registered with CESPHN and should have successfully completed the **SPS Training**.
- **Please note**, this service is not responsible for case management of the individual. Thus, outbound calls are check in calls for the individual and occur for up to **two weeks** at a time and **once** a day. Should additional calls be required, this will need to be reviewed by All Hours Suicide Support Service management before confirming.

How to make an individual referral to AHS

- If you are not registered with AHS as an Allied Health Practitioner, kindly fill out the **Practitioner Detail Form** https://ontheline.org.au/wp-content/uploads/2019/02/AHS-Practitioner-Details-Form-OP-FM-29.5.pdf and send it to ahs@ontheline.org.au

All individual referrals will now only be accepted via email.

- Download and complete the **Individual Referral Form** https://ontheline.org.au/wp-content/uploads/2019/02/AHS-Client-Referral-Form-OP-FM-31.5.pdf and email it to ahs@ontheline.org.au
- Please advise the individual of the scheduled first call and that the call will be from a private number. Please direct the individual to contact 1800 859 585 should they require additional support between appointments.

Incomplete forms may cause a delay in AHS' ability to support individuals at the required time

Accessing individual notes

- If Consent is provided individual information will be securely emailed to you as a PDF attachment following an individual contact with AHS, or attempted contact with the individual by one of the AHS counsellors. This is done immediately after each contact.
- The password protected PDF will be a snapshot of the information the counsellor collects on the call, including case notes. While meeting Privacy requirements, this will also be a more efficient way of providing you with the information you need.

What is the password for the new PDF of individual case notes?

- All PDF attachments containing individual call information and case notes will be password protected. The password for opening each PDF is **AHS** plus the **month** and **year** of the call record. The call received date will be in the email subject line. So, the password format is: **AHSMMYYYY**. For example, for an email notification received on 04 December 2018, the password would be **AHS122018**.
- If you require any further information, contact AHS Team on 1800 859 585 or ahs@ontheline.org.au

Client referral form.pdf

Practitioner Details Form.pdf

18. Psychiatry Support Line for GPs

Please encourage GPs to use this service to support your work with individuals.

For more information see the CESPHN website:https://www.cesphn.org.au/general-practice/help-my-patients-with/mentalhealth/psychiatry-support-line-for-gps

What is the GP Psychiatry Support Line and who can use it?

- The GP Psychiatry Support Line is a free service for GPs to help manage the care of mental health individuals, providing advice on diagnosis, investigation, medication and safety plan.
- The Psychiatry Support Line for GPs has been established in response to GPs indicating they would like timely access to psychiatry expertise.
- The service is not intended to be for triaging or referring individuals to a psychiatrist, but rather keeping individuals whose conditions are able to be treated within primary care under care of their GP.

Eligibility

- This service is exclusive to GPs who practice within the Central and Eastern Sydney PHN region.
- Other eligible PHN catchment areas includes South Eastern NSW PHN, Hunter New England and Central Coast PHN, Murrumbidgee PHN, Sydney North PHN and Western NSW PHN.
- The service is free, and is available Monday to Friday, 9 am - 5 pm. You can use it as many times as you wish. The service will respond to your enquiry within 24 hours.

How to access the service?

- To access this service, you will first need to register. To complete the registration, you will need your AHPRA Registration Number, and practice details. There are options to use Secure Messaging once you are registered.

This is NOT a triage or referral service, nor an emergency service.
In case of emergency or crisis, please ring 000.

Attachment A. Legislation

Legislation	Read
Australian Charter of Healthcare Rights	
Australian Privacy Principles	
Child Protection (Working with Children) Act 2012 (NSW)	
Child Protection (Working with Children) Regulation 2013 (NSW)	
Health Practitioner Regulation (NSW) Regulation 2010	
Health Records and Information Privacy Act 2002 (NSW) (HRIP Act)	
Mandatory Reporter Guide	
National Standards for Mental Health Services 2010	
Privacy Act 1988 (Cth) (Privacy Act) Section 16B of the Privacy Act	
Privacy Amendment (Enhancing Privacy Protection) Act 2012 (Cth)	
Privacy and Personal Information Act	
Work Health and Safety Act 2011 (Cth)	
Work Health and Safety Act 2011 (NSW)	
Work Health and Safety Regulation 2011 (Cth)	
Work Health and Safety Regulation 2011 (NSW)	
Working with Children Check from NSW Office of Communities	

Attachment B. Example of a Statement of Patient Rights and Responsibilities

PSS
PSYCHOLOGICAL SUPPORT SERVICES

Statement of Rights & Responsibilities

The *individual* agrees that they will:

- Attend scheduled appointments on time
- Inform the service of inability to attend within 48 hours
- Attend treatment free from intoxication from alcohol and/or non prescribed drugs
- Behave in a respectful, non-aggressive manner towards the clinician and auxiliary staff of the centre
- Make a genuine effort in treatment, including completing agreed homework tasks
- Provide the clinician with the necessary information to facilitate treatment
- Work in collaboration with your clinician to maximise your improvement
- Take responsibility for the outcomes of any decisions you make

The *clinician* agrees that they will:

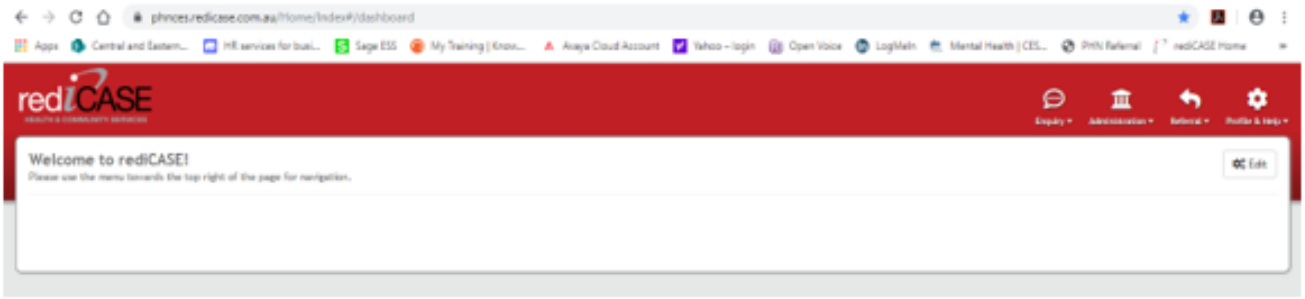
- Treat you in a professional, courteous and caring manner
- Provide you with verbal information regarding your diagnosis and explore with your treatment options
- Provide you with up to date focussed psychological therapies
- Communicate with your doctor regarding your treatment and progress
- Abide by the code of ethics as set out by the Australian Psychological Association (APS) and the Australian Health Practitioner Regulation Agency (AHPRA)
- Maintain your privacy and confidentiality within the bounds of ethical practice
- Maintain your safety and the safety of the community (especially children) as a high priority
- Keep relevant treatment notes in a secure/private environment for a period of at least 7 years as prescribed by law. (The clinician and notes can be subpoenaed by a court of law)
- Reserve the right to decline requests for legal reports and reports to Government Departments

Attachment C. rediCASE Manual & Clinically Closed Episodes

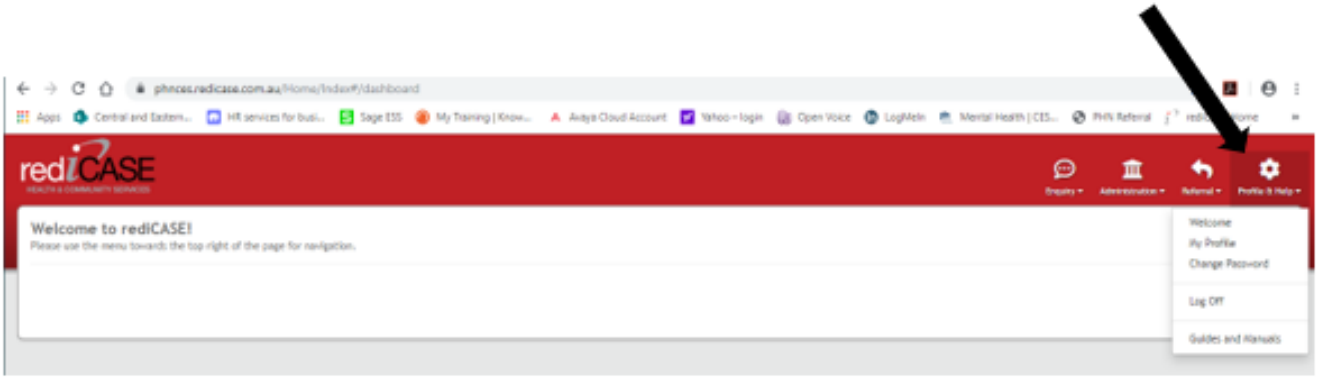
rediCASE Manual

To access the latest User Manual please follow the steps below:

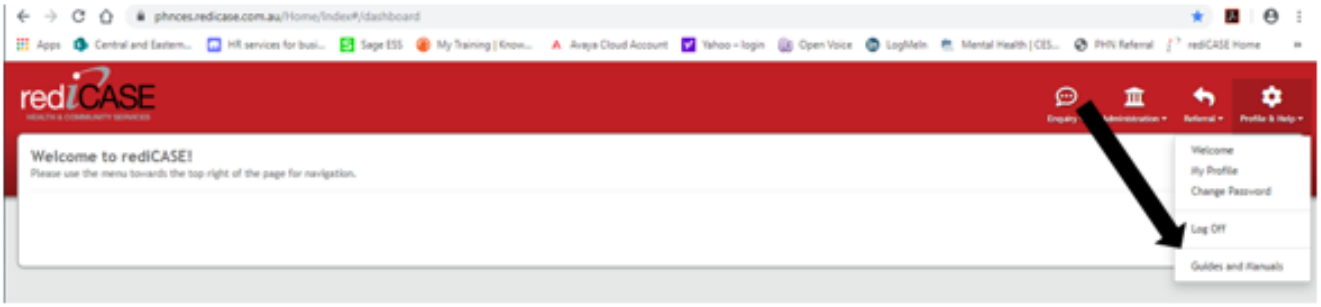
Step 1. Home page



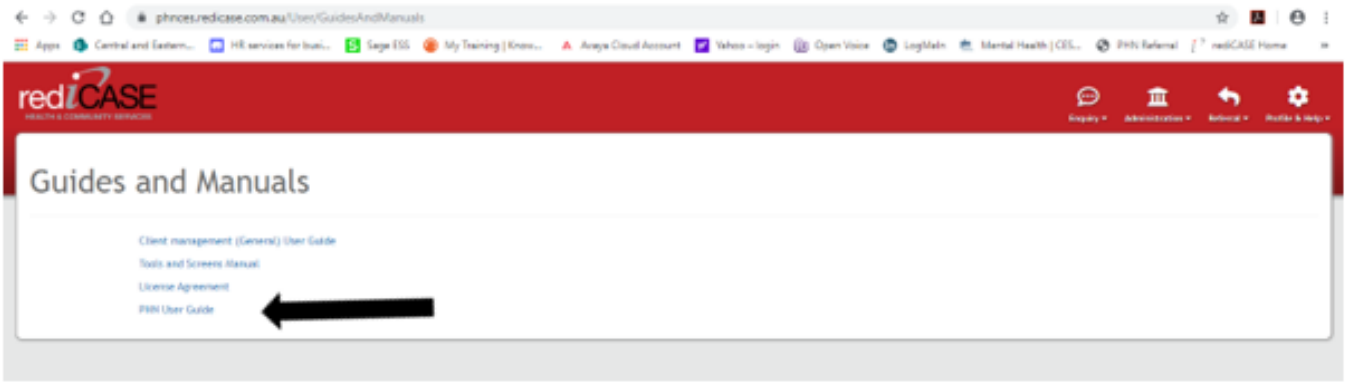
Step 2. Click on Profile & Help.



Step 3. Click on Guides and Manuals



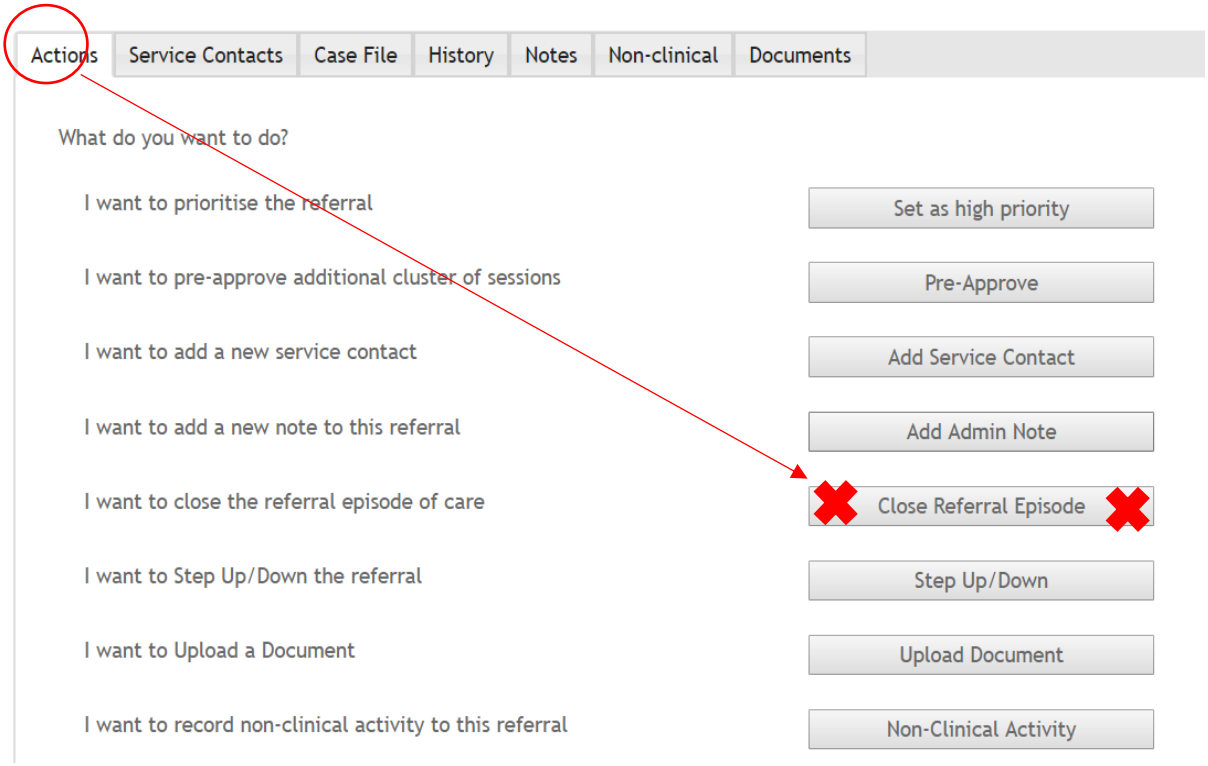
Step 4. Click on PHN User Guide



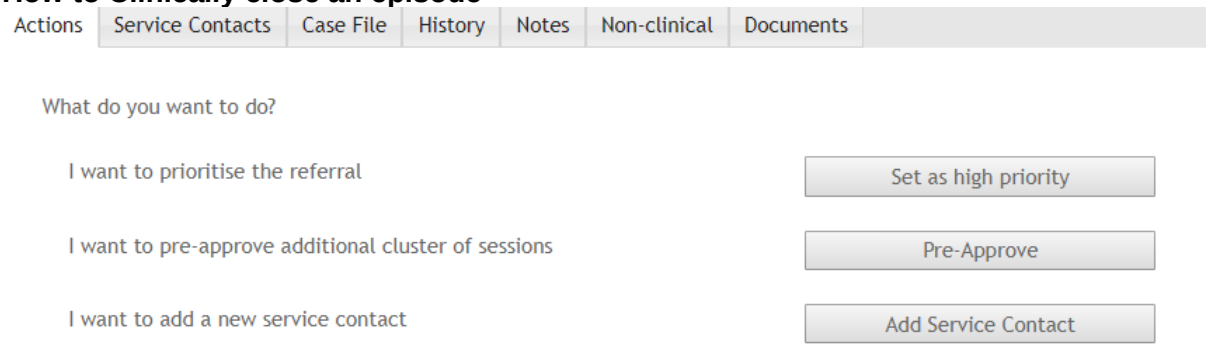
Clinically Closed Episodes

The department have now mandated that all episodes must be closed “Clinically” meaning that the episode must be closed at the final session with the client and have K10 scores recorded.
Outcome scores will be captured and measured as a “matched pair” meaning that an initial and final score must be captured for each client to be measured.

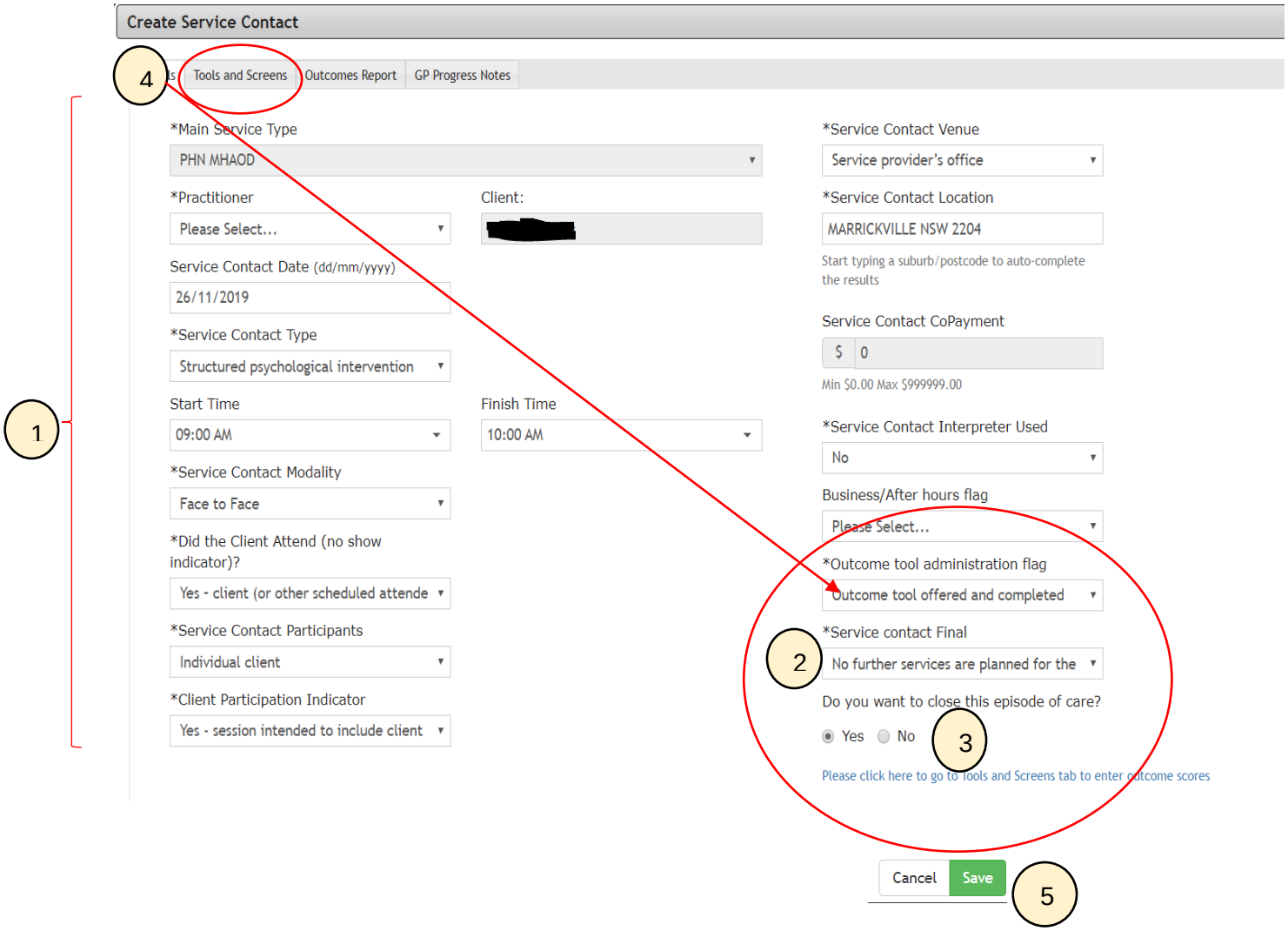
Episodes must NO LONGER be closed via the actions tab



How to Clinically close an episode



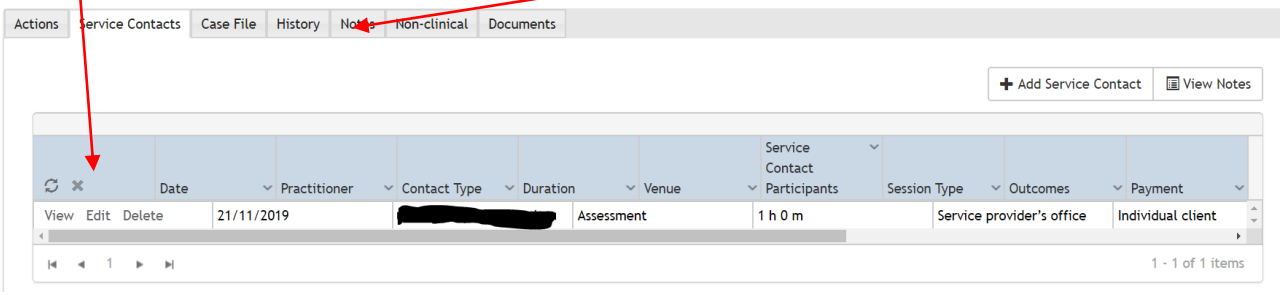
1. Add services contact
2. Enter session data as normal
3. On the final session ensure that "No further sessions are planned for this client is selected"
4. Select "YES" do you want to close this episode of care
5. Ensure that a K10 score has been administered and entered into rediCASE



Closing an Episode after a period of non-engagement

1. If you are closing an episode after a period of non-engagement you will need to (eg edit the last Occasion of service following the instructions above and enter the latest K10 score under tool and screens (Eg score collected at session 6)

2. Enter an admin note in the file of the ACTUAL date the K10 was administered.



Attachment D. PSS Mental Health Provider Information Form

PSS Mental Health provider information form

Please fill out one form for each consortium and practice that you are a part of.

Consortium Name:	☐ Lilly Pilly Counselling ☐ Australian Primary Mental Health Alliance (APMHA) ☐ Sydney Mindhealth ☐ The Gender Centre ☐ headspace Specify Site:
MHP Full Name:	
Profession:	☐ Clinical Psychologist ☐ Registered Psychologist ☐ Mental Health Social Worker ☐ Mental Health Occupational Therapist ☐ Mental Health Nurse ☐ Aboriginal and Torres Strait Islander health workers
AHPRA/Provider Number:	
MHP year of birth: **(New MDS requirement)**	
Gender:	
Practice Name and Address:	
Consortium Approved:	☐ Yes ☐ No
Business Mobile:	
Business Phone:	
Business Fax:	
Business Email:	
Days and hours available for PSS:	
Disability Access:	☐ Yes ☐ No
Ability to practice in language/s - please nominate language	
Identify as Aboriginal and Torres Strait Islander Status	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither
Experience and willing to provide focused psychological intervention to Underservice and/or hard to reach group as per consortium agreement – **Only tick if you have completed the mandatory training as per PSS guidance for those marked and willing to provide evidence***	☐ ***Child** ☐ Young People (12-25 years) ☐ Adult (low income) ☐ Lesbian, Gay, Bisexual, Transgender, Intersex and Queer/Questioning (LGBTIQ) ☐ ***Perinatal Depression (PND)** ☐ ***Aboriginal and/or Torres Strait Islander** ☐ ***Culturally and Linguistically Diverse (CALD)** ☐ ***Suicide Prevention (non-acute)** ☐ Severe Mental Health ☐ Intellectual Disability ☐ Older Adult in a Residential Aged Care Facility (RACF)

MHP Do you consent for your practice details and contact number to be made available on our CESPHN online directory ☐ Yes ☐ No

MHP Name: Date:
MHP Signature:

Consortium Signature: Date:

Please complete and email this form to your Program Officer

Psychological Support Services (PSS) Suicide Prevention Service (SPS) Guidance

EIS Health Limited trading as Central and Eastern Sydney PHN

Last updated March 2020

SUICIDE PREVENTION SERVICE (SPS) GUIDANCE

Scope

This guidance is written in conjunction with the PSS Guidance.
MSA and associated Schedules take presence over this document and this is for general guidance only.

Definitions

In this Document, unless the context otherwise requires:

- **Access** is defined as being unable to either physically get to an available service or afford to pay a fee for an available service
- **Children** means Persons under the age of 18 years as defined in the Child Protection (Working With Children) Act 2012 (NSW) and Child Protection (Working With Children) Regulation 2013 (NSW); however in context the following sub-definition may be used:
    - **Children (0-12)** means children age between 0 -12 years who have not yet graduated from primary school and have not commenced high school
    - **Young People** means youth aged between 12-25 years who have commenced high school.
- **CESPHN** refers to Central Eastern Sydney Primary Health Network.
- **Confidentiality** refers to the treatment of information that an individual has disclosed in a relationship of trust, with the expectation that it will not be given to other people or organisations without prior Consent.
- **Confidential Information** includes, but is not limited to, matters not generally known outside CESPHN, such as information relating to the general business operations with CESPHN including:
    - the Provider's Agreement;
    - trade secrets, know-how and specifications in respect of CESPHN's operations;
    - third party information disclosed to CESPHN in confidence;
    - medical records and health information;
    - any other information which by its nature could reasonably be expected to be regarded as confidential, including financial and funding information of CESPHN.
- **Consent** is defined as express Consent or implied Consent which has four key elements:
    - the Consent must be voluntary;
    - the individual must be adequately informed before giving Consent;
    - the Consent must be current and specific;
    - the individual must have the capacity to understand and communicate their Consent.
- **Clinical Incident** is any unplanned event which causes, or has the potential to cause, harm to a consumer.
- **Medical Practitioner (MP)** is defined in this document as a GP, Psychiatrist, Obstetrician-Gynaecologist and Paediatrician

- **Non-Medical Practitioner (NMP)** is defined as those referring to the programme who are not Medical Practitioners. This includes school counsellors, school principal/deputies, directors of early childhood services, headspace Clinicians, maternal and child health nurses, allied health professionals, lactation consultants, midwifery and neo-natal nurses, Aboriginal health worker, Aboriginal Care coordinator and Outreach worker, House parents of Kirinari Hostel (Sylvania), Aboriginal youth health and well-being coordinators, managers of Aboriginal Community Controlled Health Services (ACCHS), multicultural community health liaison officers, Acute Mental Health Teams, and Psychiatric Emergency Care Centre.

- **Personnel** means managers, subcontractors, consultants, suppliers, employees, agents and other persons engaged by the Provider

- **Privacy** refers to the right of individuals to control how their information is collected, stored and used.

- **Provider/s** means the organisation commissioned by CESPHN to provide PSS

- **Qualified Mental Health Professionals (MHP)** means: Psychologists (general and clinical), mental health nurses, mental health accredited social workers, mental health accredited occupational therapists and Aboriginal and Torres Strait Islander mental health workers.

- **Work Health and Safety (WH&S)** means, as relevant:
  - the Work Health and Safety Act 2011 (NSW) and the Work Health and Safety Regulation 2011 (NSW); and
  - the Work Health and Safety Act 2011 (Cth) and the Work Health and Safety Regulation 2011 (Cth).

1. Psychological Support Services (PSS) Suicide Prevention Service (SPS) Guidance

CESPHN provides priority access to the Psychological Support Services (PSS) Suicide Prevention Service (SPS) initiative for people who are considered at increased risk following a suicide attempt, currently self-harming or who have heightened suicidal ideation and are being managed in the primary health care setting. The primary objective of CESPHN is to provide services to treat and support individuals at increased risk of suicide or self-harm at a critical point in their lives. The PSS SPS complements other PSS services.

CESPHN procures local Providers, to engage allied health professionals who have specific skills or training in providing clinical care to people who are at increased risk of suicide or deliberate self-harm.

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

In considering an individual's eligibility for this service, providers should consider the complexity of the individual's circumstances and the number of contributing factors. Consideration should also be given to the **short-term** nature of the PSS SPS and whether the individual is more appropriately supported by the state or territory acute mental health service.

If in any doubt as to the immediacy of risk of the patient, the mental health professional (MHP) is to contact the acute mental health team. **This project is not intended to have the MHP take on the crisis intervention role, nor replace existing local acute mental health services.**

New South Wales: Access and referral to Acute Mental Health Care Services are via The Mental Health Line Ph: 1800 011 511

2 Eligibility Criteria

This service provides access to PSS SPS for **individuals 18 years and over** who have attempted suicide or who have heightened suicidal ideation and are being supported in the primary health care setting, therefore no longer considered at acute risk.

This service is primarily designed for 4 groups of people:

1) Individuals who, after an attempted suicide and have been discharged into the **care of a MP** from hospital, or released into the care of a MP from an acute care team (ACT) or an Emergency Department/Psychiatric Emergency Care Centre (PECC)
2) Individuals who have presented to acute care team or PECC after an attempted suicide or incident of self-harm, and **discharged to the community**
3) Individuals who have presented or expressed strong suicidal ideation or an incident of self-harm to their MP
4) Individuals who are on general PSS and have appropriately been stepped up.

This Service may also provide support to those who are considered at increased risk in the aftermath of a suicide.

The SPS Program is NOT:

- A crisis service or designed to replace acute care services
- For individuals with an individual suicide risk rating of the following, who need to be referred to acute care or appropriate services:
  - **Assertive Follow-up Services** - Individual has recently attempted suicide, and based on my clinical judgement, requires assertive, community-based, case coordination to keep them safe.
  - **Imminent Risk** - The person is at imminent risk of suicide. Based on my clinical judgement this person requires immediate / urgent assistance.

3 Exceptional Circumstances

3.1 The MHP requires leave (unexpected) during the care period.

- Individual needs to be made aware and agree of this before they commence SPS sessions
- If a MHP has an extended period of unexpected leave during this period, then the MHP must:
  - Advise their Provider clinical lead of their unexpected need for leave and then coordinate care for the individual for the anticipated period of absence
  - Provider clinical lead and current MHP make a clinical decision about whether allocation to a new provider is appropriate given the expected period of absence, and then make necessary arrangements for reallocation.
  - If the individual will not be assigned a new SPS provider, the MHP needs to ensure the individual is linked in with a MP and have the capacity to arrange alternative care in their absence. For example, weekly appointment with the MP, safety plan and link into **All Hours Suicide Support Service** if extra support may be required.
  - The risk will be held with the allocated MHP during this time as the individual is under their care.
  - Consider other programs or ACT.
  - Consider **All Hours Suicide Support Service - 1800 859 585** - This free, specialised phone service is designed to support individuals of PSS MHPs out of hours, whilst the MHP is away, or when there is a long gap between appointments. Support is provided to individuals at risk of suicide 24 hours a day to ensure individuals have access to professional support around the clock.
  - This support is available for a maximum 2-week period.
- More information See below **7. All Hours Suicide Support Service**

N.B. Care is only interrupted if unexpected circumstances.

- In circumstances where the individual requires unexpected leave during the period of care under SPS, for example, a medical hospital admission, travel, competing responsibilities such as university exams, then the MHP and Provider Clinical lead will need to determine whether SPS sessions continue during this period, or whether the episode of care is closed. The MHP can reassess risk once the individual is able to attend sessions again and can request SPS sessions should they be required.

3.1.1. Extensions of the SPS program

- Extensions of the SPS program can be requested if the individual's presentation remains elevated after the initial 2-month period, and the individual cannot be better serviced by more secondary health care services.

- All requests for the extension are to be emailed to mentalhealth@cesphn.com.au and cc your Provider clinical lead. Please title the email "**URGENT SPS referral**" and await approval by CESPHN Mental Health Intake Clinical Lead.

- If individual requires ongoing care then extension of SPS should be used to transfer care to an appropriate service, develop relapse prevention plan and safety plan.

- Consider All Hours Suicide Support Service - 1800 859 585 - This free, specialised phone service is designed to support individuals of PSS MHPs out of hours, whilst the MHP is away, or when there is a long gap between appointments. Support is provided to individuals at risk of suicide 24 hours a day to ensure individuals have access to professional support around the clock. This support is available for a maximum 2-week period.
  NOTE All options need to be clearly communicated to CESPHN intake and documented clearly of reasons for example, MHP on annual leave or individual is in hospital.

3.2 Individuals under 18 years of age

- Children under 15 years **are not eligible** for SPS PSS. Children at risk can be referred to their local hospital Emergency Department or referred to the **Mental Health Line Ph 1800 011 511** to access the local Child and Adolescent Mental Health Services. Please also refer to PSS Guidance 4.9. Mandatory Reporting, if applicable.

- Child referrals are not permittable to be stepped up to within the SPS service.

- Young people under the age of 18 who are referred to CESPHN Centralised Intake for SPS PSS will be referred to headspace Centres for support under PSS SPS. headspace centres provide a collaborative and multidisciplinary service for young people and have close relationships with the local Child and Adolescent Mental Health Services

- MHPs currently working with young people under the age of 18 may need to request a step up in care should the individual's risk change during the course of treatment. Please **see Section 4 Step-up Care to SPS PSS** of this guidance for specific instructions on how-to step-up care for these young people.

3.3 Who Can Refer?

SPS is limited to individuals referred by:

- Medical Practitioners (MP - General Practitioners and Psychiatrist)
- Acute Care Team (ACT)
- Psychiatric Emergency Care Centre (PECC)
- Current MHPs in stepping up from general PSS
- headspace clinicians with clinical lead approval

3.4 How to Refer?

- MPs can refer to SPS by completing a PSS referral including a MHTP. **See Online Form**
- ACT, PECC and headspace can refer by completing a NMP PSS referral form and attach a comprehensive mental health assessment or discharge summary. **See Online Form**.
  Please note Individuals referred directly from the hospital setting or Acute Care Team (ACT) should consult their MP within 2 weeks of discharge to ensure all their health care needs are being addressed, and to obtain a MHTP for ongoing psychological support. MHP may need to assist individuals to access a MP and MHTP.
- MHPs who have identified individuals to be eligible for SPS can apply to step up care. This is done by notifying clinical leads and CESPHN who will assist in referring the individual to a MHP with relevant SPS clinical training.
  Please note evidence of communication to the MP is needed for step up and step-down care and must be uploaded to rediCASE.

4 Step-up Care to SPS PSS

If a PSS MHP identifies the need for the individual to step-up to the SPS service or stepped down from SPS, the following process is to be followed:

- Notify their Provider clinical lead and obtain approval to step up or step down
- The MHP will contact the referring MP or send a letter to the MP advising of both step up and step-down changes. Communication with the MP or a copy of the letter must be uploaded into rediCASE prior to approval of SPS referral.
- MHP will need to contact CESPHN Intake to request for step-up /down to SPS prior to commencing sessions as this needs to be correctly recorded into the CIMS. This will not be triaged through CESPHN. The request will not be actioned unless appropriate correspondence is uploaded into CIMS (e.g. MHP letter to MP regarding change).
- If no MP has been engaged at this point (due to a NMP referral) then the Provider clinical lead will need to consult with CESPHN intake and request approval for SPS sessions. MHP to support the individual to engage with a MP as soon as possible and within 2 weeks.
- Please note that when an individual is being stepped down after SPS sessions, there is no need for a new MHTP for this action. The MHP needs to track the number of sessions that have already been delivered under general PSS and resume from this point. Therefore, if a new referral or review is needed to continue with general sessions please ensure this paperwork is up to date and uploaded. If there is no PSS referral at all, please ensure there is one before commencing the general PSS sessions.
- The risk will be held with the allocated MHP during this time as the individual is under their care
- When an individual is stepped up or down, a new client ID is started as this is identified as a new episode of care. To avoid over administration of outcome measures between episodes of care, the client is asked to complete a K10 score when being stepped up and then again when stepped down. These scores can then be entered as pre/post measures for the two episodes of care. For example, if a client is stepped up to SPS at session 4 and then stepped down after 5 sessions under SPS, then a K10 needs to be completed at session 4 and then again at SPS session 5. This K10 score is used as the post-measure for sessions 1-4 of general PSS and as

the pre-measure for sessions 1-5 of SPS. The second K10 score is used as the post-measure for the SPS episode of care, and the pre-measure for the next episode of general PSS).

4.1. Limitations

- The SPS Service is designed to provide immediate and short-term support (up to 2 months) for individuals during a period of increased suicide risk. The service is not designed to provide long term support or treatment.
- SPS session are allocated in lots of 12 sessions but can be delivered in 2 options. Please note you must not exceed 12 sessions regardless of the option chosen:
    - 12 individual focused psychological intervention sessions and no care coordination sessions
    - 10 individual focused psychological intervention sessions and 2 care coordination sessions, please refer to **Section 3.1.1. Extensions of the SPS service**.
- Given the short-term nature of SPS, individuals with the following presentations are **not** generally suitable for the program. Individuals:
    - with complex circumstances or with numerous contributing factors requiring case management;
    - who are presenting with primary substance misuse;
    - with persistent and recurring thoughts or behaviours of self-harm for months or years, as a feature of a mental disorder and who are at risk of acting on these thoughts;
    - who present with conditions requiring long term intervention (some personality disorders, severe PTSD and other experiences of trauma);
    - presenting with acute psychotic phenomena.
- If in doubt regarding the suitability of stepping up an individual for referral to the PSS SPS please discuss your potential referral with your clinical lead.

5 Mental Health Professional Qualifications and Experience

- MHPs are expected to hold Australian Health Practitioner Regulation Agency (AHPRA) registration or Mental Health Social Work Association Registration. Only PSS-approved clinicians are able to deliver PSS SPS services/treatments.
- Provisionally registered allied health professionals and students are **not** eligible to provide suicide prevention services.

Providers are required to:

- be credentialed in the field of Mental Health;
- be adequately experienced in the field of mental health, and trained in delivering psychological therapies; currently or recently engaged in clinical practice in that field and minimum 2 years of post-graduate experience working in the field;

- be appropriately trained and experienced to deliver suicide prevention services. Recognised training includes:

Individuals at risk of suicide	▪ Recognised **initial** training includes Suicide prevention: A practitioner's guide online training provided by the Australian Psychological Society (APS) ▪ Recognised **ongoing** training includes Advanced Training in Suicide Prevention training provided by the Black Dog Institute

- a National criminal record check;

  a Working with Children Check when providing support to children and young people under the age of 18 years.

6 What Services Can Be Provided?

6.1. Terms of Sessions

The focus of SPS sessions is to manage any risk and provide individuals with the necessary skills to manage major stressors and potential risk situations in order to reduce future risk. This may involve the use of specific crisis management strategies or elements of evidence based Focused Psychological Strategies (FPS) as indicated by the Department of Health. These can include interventions such as

- Cognitive behaviour therapy (CBT)
- Interpersonal psychotherapy (IPT)
- Narrative therapy
- Family therapy and family-based interventions
- Mindfulness-based cognitive therapy (MBCT)
- Acceptance and commitment therapy (ACT)
- Solution-focused brief therapy (SFBT)
- Dialectical behaviour therapy (DBT)
- Psychoeducation

For further information, please see: Australian Psychological Society - Evidence-based Psychological Interventions in the Treatment of Mental Disorders: A Literature Review: http://recqc.ca/wp-content/uploads/2017/03/Evidence-BasedPsychological-Interventions.pdf

6.2. Session Format

- Each session (face to face, telephone or Skype) shall be provided on the basis of at least 50 minutes per individual, evidence based, FPS.

- In the situation where a session extends beyond 60 minutes due to the complexity that the individual presents with during your consultation, then the MHP can bill for the extra time with the individual if the total time spent with the individual is 100 minutes or more. That is, if an extra 50 minutes is provided, then the MHP can bill for an entire second session. These sessions need to be entered into the CIMS as two separate sessions.

- The maximum billable face to face, telephone or Skype sessions delivered under SPS on the same day is 120 minutes.

- MHP's are not to pre-book 120 minutes sessions for SPS individuals. The provision above is for situations where a session inadvertently goes longer than anticipated due to the complexity of the presentation of the individual.
- Face to face sessions are preferable

- SPS session are allocated in lots of 12 sessions but can be delivered in 2 options. Please note you must not exceed 12 sessions regardless of the option chosen:
    - 12 individual focused psychological intervention sessions and no care coordination sessions
    - 10 individual focused psychological intervention sessions and 2 care coordination sessions

- All SPS sessions are only valid for a 2-month period from MHP accepting the referral.

- Telephone and Skype sessions are recommended if face to face is not available in the initial assessment. If telephone or Skype is to continue past initial appointment, approval from the clinical lead is required.

- Telephone or Skype session are required to include:

    - risk assessment;

    - safety planning to identify current needs;

    - Link to appropriate or support services as needed e.g. more regular visits to MP between sessions, All Hours Suicide Support Service, Suicide Call Back Service , or Local Acute Care Team.

6.2. Care Coordination

- Care coordination SPS sessions are available to MHPs to:

    - work within the system and holistically across the dimensions of the individual's experiences including phone calls to family members, All Hours Suicide Support Service, MP's and other providers involved in the individual's care;

    - work with other community and social services to support an individual's mental health, including education, housing, other local community services, justice and family violence services;

    - coordination between services to ensure appropriate referrals are made including Acute Care Services, and MPs;

- **Two care coordination sessions** <u>without</u> the young person present can be provided within the 2-month allocation period for SPS once an initial session with the young person has been delivered.

- **Care coordination may take less than the allocated minimum 50-minute session requirements. If this is the case, care coordination sessions are to be entered into the CIMS once the total time incurred has reached a minimum of 50-minutes.**

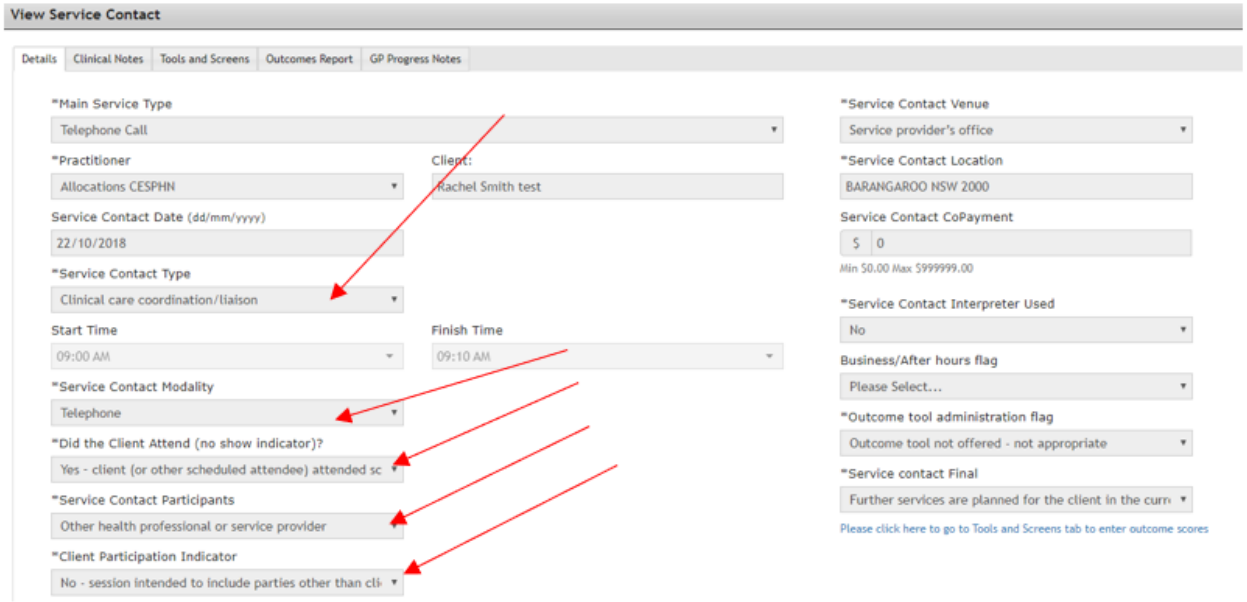
- **When entering the care coordination session into the CIMS, the details of when the care coordination actually occurred needs to be recorded in the Notes section detailing:**

    - Date the care coordination occurred

- Duration
- Description of the type of care coordination

- This accumulation of care coordination process is used only when care coordination is < 50 minutes and over a number of occasions. For example, a 20minute phone call to Acute care services on one day, a 20 minute phone call to parents on another day, and a 15 minute phone call to the school counsellor on another day would only be entered ONCE into rediCASE as a 55-minute session with the specific details listed in the Notes section.
- You will only be paid for care coordination once a minimum of 50 min is reached. Please do not try and bill increments smaller than 50 min.
- This is only valid for SPS sessions only.
- Please enter Care Coordination sessions as shown below:

Entering Care coordination session select the appropriate drop down fields as set out below:



6.4. Time Frames

- First session with the individual is to be conducted as mandated by the DoH, **within 7 days of the referral date,** as submitted to the CIMS MDS. (This timeframe starts from the date it has been entered into the CIMS (rediCASE) not the original date of the referral).
- Individual referred to SPS will be triaged and allocated within 24 hours
- MHP must accept or decline referral within 24 business hours of allocation. MHP are to accept the referral based on their capacity, that is, before contacting the individual and any call attempt to contact the individual must be documented. If unable to contact the individual, please refer to the PSS Guidance **6.3 MHP Unable to Contact an Individual**
- If an initial face to face sessions **cannot** be conducted within the 7-day period, the MHP will need to arrange an assessment via telephone or Skype. This contact with the individual must include: an assessment including risk and complete a safety plan as needed. This will then be entered as a telephone-based service contact in rediCASE.

- Should further telephone or Skype sessions be required the MHP will need to get approval from the clinical lead, and note this in rediCASE
- All contact attempts must be recorded in the CIMs, including any care coordination prior to MHP accepting the referral.

- SPS sessions are to be provided within 2 months of the referral date (Please refer to **3. Exceptional Circumstances** for further information)

- Please be considerate to the individual's safety needs if the referral is being declined after midday on a Friday. Please ensure you call your Clinical Lead to notify them of your decline so that they can re allocate to another provider or arrange supportive services over the weekend.

6.5. MHP Unable to Contact an Individual

- When a MHP has accepted a referral, they have assumed the duty of care for that individual. Therefore, it is expected that the MHP will make repeated attempts to contact the individual. It is reasonable that after 3 attempts to contact the individual the MHP can assume individual is unable to be contacted;

- The MHP must communicate to the referrer and their MP after the 3rd attempt, updating them of non-engagement with an individual. This communication must be via telephone or secure messaging, to ensure that the referrer has received this information before the referral can be closed. The MHP must document this communication in CIMS in the Note section before **closing the episode** (not declining) the referral. Please note once a referral has been closed, it cannot be re-opened, and a new ID number will need to be created if the circumstances change. Re-opening a file causes a major problem with data extraction.

6.6 Data Requirements

- The data entered in CIMs is uploaded into the Department of Health Minimum Data Set, therefore it needs to be a true and accurate representation of session delivery. The CIMs is also used to help Provider Organisations comply with their clinical governance.

- The first session with the individual is to be conducted as mandated by the DoH, **within 7 days of the referral date,** as submitted to the CIMS MDS. (This timeframe starts from the date the referral has been entered into the CIMS (rediCASE) not the original date of the referral).

- Please refer to the PSS Guidance **4.10. Minimum Data Set (MDS)** in the PSS guidance for the general PSS data entry requirements

- Additional data entry specifications for SPS include:

    - On the "Commence Episode" page in the CIMs, the MHPs need to select **"Psychological Therapy" as the Principle Focus of Treatment plan and the Suicide Referral Flag must be "Yes".**

    - All contact attempts are to be entered into the Notes section of CIMS

    - SPS sessions that are longer that 60 minutes, need to be entered as **two separate** entries into CIMS. The first entry is for 60 minutes, and then second entry is for the remaining time period delivered by the MHP. Where possible the MHP must get prior approval for a two-hour session by their clinical lead. If the MHP only enters one occasion of service for the two hours they will only be paid for a 1 session

- Please refer to PSS Guidance **13. Outcomes and Satisfaction** for the general PSS outcome requirements.

7 All Hours Suicide Support Service

All Hours Suicide Support Service (AHS; formerly ATAPS) is funded by the DoH. This information is adapted from information received from All Hours Suicide Support Service.

- This free, specialised phone service is designed to support the individuals of allied health providers out of hours, whilst they are away, or when there is a long gap between appointments. It provides support to individuals at risk of suicide 24 hours a day to ensure these individuals have access to professional support around the clock.
- All individuals who are referred to this service must be assessed as **low to medium risk** and **15 years or over**.
- Individuals from a CALD background can access interpreter services through teleconference if an interpreter is needed.
- Individuals need to have an **ongoing treating practitioner** (Allied Health Practitioner) or should be in the process of being linked in with one.
- The Allied Health Practitioner (for example Psychologists, Social Worker, Mental Health Clinician etc.) must be registered with CESPHN and should have successfully completed the **SPS Training**.
- **Please note**, this service is not responsible for case management of the individual. Thus, outbound calls are check in calls for the individual and occur for up to **two weeks** at a time and **once** a day. Should additional calls be required, this will need to be reviewed by All Hours Suicide Support Service management before confirming.

How to make an individual referral to AHS

- If you are not registered with us as an Allied Health Practitioner, kindly fill out the **Practitioner Detail Form** https://ontheline.org.au/wp-content/uploads/2019/02/AHS-Practitioner-Details-Form-OP-FM-29.5.pdf and send it to ahs@ontheline.org.au

All individual referrals will now only be accepted via email.

- Download and complete the **Client Referral Form** https://ontheline.org.au/wp-content/uploads/2019/02/AHS-Client-Referral-Form-OP-FM-31.5.pdf and email it to ahs@ontheline.org.au
- Please advise the individual of the scheduled first call and that the call will be from a private number. Please direct the individual to contact 1800 859 585 should they require additional support between appointments.

Incomplete forms may cause a delay in AHS' ability to support individuals at the required time

Accessing individual notes

- If Consent is provided individual information will be securely emailed to you as a PDF attachment following an individual contact with AHS, or attempted contact with the individual by one of the AHS counsellors. This is done immediately after each contact.

- The password protected PDF will be a snapshot of the information the counsellor collects on the call, including case notes. While meeting Privacy requirements, this will also be a more efficient way of providing you with the information you need.

What is the password for the new PDF of individual case notes?

- All PDF attachments containing individual call information and case notes will be password protected. The password for opening each PDF is **AHS** plus the **month** and **year** of the call record. The call received date will be in the email subject line. So, the password format is: **AHSMMYYYY**. For example, for an email notification received on 04 December 2018, the password would be **AHS122018**.

- If you require any further information, contact AHS Team on 1800 859 585 or ahs@ontheline.org.au


Client referral form.pdf


Practitioner Details Form.pdf

Review and Version Tracking

Version	Review	Date Approved	Approved by	Next Review Due
1.0	1/04/2019	12/12/2019	Belinda Ivanovski	20 January 2020
2.0	11/2/2020	03/3/2020	Belinda Ivanovski	1 July 2020