Mental Health Stepped Care Services
Operational Guidelines

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## Appendix A

### NQPHN stepped care–eligibility requirements for clinical mental health providers

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

<table>
<thead>
<tr>
<th>Mental health social worker</th>
<th>Accredited mental health social workers with the Australian Association of Social Workers (AASW) and that they therefore:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• maintain current membership of the AASW</td>
</tr>
<tr>
<td></td>
<td>• maintain accreditation as a mental health social worker</td>
</tr>
<tr>
<td></td>
<td>• meet the ongoing requirements of the AASW Continuing Professional Development (CPD) program</td>
</tr>
<tr>
<td></td>
<td>• meet the AASW practice standards for mental health social workers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental health nurse</th>
<th>Current general registration as a nurse (Division 1) or as a registered nurse (Division 1) with a sole qualification notation (mental health nursing) with the Australian Health Practitioners Regulation Agency (AHPRA) and that they therefore meet all the following registration standards:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• criminal history registration standard</td>
</tr>
<tr>
<td></td>
<td>• English language skills registration standard</td>
</tr>
<tr>
<td></td>
<td>• registration standard: Continuing professional development</td>
</tr>
<tr>
<td></td>
<td>• registration standard: Recency of practice</td>
</tr>
<tr>
<td></td>
<td>• registration standard: Professional indemnity insurance arrangements.</td>
</tr>
</tbody>
</table>

Credentialed by the Australian College of Mental Health Nurses Inc., that they therefore have demonstrated evidence of:

- a specialist or post-graduate mental health nursing or psychiatric nursing qualification
- twelve months’ experience since having undertaken a specialist or postgraduate qualification, or a minimum of three years’ experience as a registered nurse in mental health
- recent practice in mental health.

<table>
<thead>
<tr>
<th>Psychologist</th>
<th>General registration as a psychologist with AHPRA and that they therefore meet all the following registration standards:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• continuing professional development registration standard</td>
</tr>
<tr>
<td></td>
<td>• criminal history registration standard</td>
</tr>
<tr>
<td></td>
<td>• English language skills registration standard</td>
</tr>
<tr>
<td></td>
<td>• professional indemnity insurance arrangements registration standard</td>
</tr>
<tr>
<td></td>
<td>• recency of practice registration standard</td>
</tr>
</tbody>
</table>
### Occupational therapist

General registration as an occupational therapist with AHPRA and that they therefore meet all the following registration standards:
- continuing professional development registration standard
- criminal history registration standard
- English language skills registration standard
- professional indemnity insurance arrangements registration standard
- recency of practice registration standard.

### Aboriginal and Torres Strait Islander health workers

General registration as an Aboriginal and Torres Strait Islander health practitioner with AHPRA and that they therefore meet all the following registration standards:
- continuing professional development registration standard
- criminal history registration standard
- English language skills registration standard
- professional indemnity insurance arrangements registration standard
- recency of practice registration standard.

Aboriginal health workers who are not required by their employer to use the title ‘Aboriginal and Torres Strait Islander Health Practitioner’, ‘Aboriginal Health Practitioner’, or ‘Torres Strait Islander Health Practitioner’, are not required to be registered, and can continue to work using their current titles (for example, ‘Aboriginal Health Worker’, ‘Drug and Alcohol Worker’, and ‘Mental Health Worker’).

### Provisional/intern Psychologists and graduate social workers.

Providers of services should be adequately experienced in the field of mental health or (to allow for entry of newly trained persons in the field) under the approved and direct professional supervision of a fully qualified and registered professional expert in that field who meets the criteria set out above.

Supervision must meet the requirements of the relevant professional organisations.

Suicide prevention service, and services to children under 12 cannot be provided by provisional/intern or new graduate staff.

### Remote area workers

Due to the difficulties in recruiting professionals to remote areas, suitably experienced applicants who lack credential criteria will be assessed on a case-by-case basis by a NQPHN subject matter expert panel.

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

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

If providing services to children under 12 the practitioner requires:
- extensive child development knowledge (post graduate level)
- relevant training and experience in working clinically with children, parents, and families.

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

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

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

Initially this will include, but not be restricted to:

» Psychological Therapies delivered by mental health professionals (as per previous ATAPS/MHSRRA programs)

» services delivered by mental health nurses, formerly captured through the Mental Health Nurse Incentive Program (MHNIP) session claim process maintained by the Department of Human Services

» mental health interventions delivered by the new ‘low intensity’ workforce

» care coordination targeted at people with severe and complex mental illness

» suicide prevention services delivered to individuals

» services delivered to Aboriginal and Torres Strait Islander peoples.

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

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

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

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

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

(See notes regarding episode on the following page)
Appendix C

Suicide prevention services (SPS)

1. Objectives

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

The service is not intended to increase the number of high-risk people being managed in the primary health care setting or to divert people from the care of the state or territory mental health services, but to better support those people already being managed in the primary health care setting. This service aims to better integrate care between acute and primary mental health care for the management of this group and provide referral pathways for GPs to better support their existing patients. This service is also not designed to reduce the responsibilities of acute mental health services, but to ensure support for people whose care is usually in the primary health setting.

2. Eligibility

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

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

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

3. Ineligible clients

This service is not designed for people who:

» are being managed on an ongoing basis by state government mental health services following discharge from a hospital acute mental health ward or an accident and emergency department
» people who have been discharged from a psychiatric accident and emergency department (these are not available in North Queensland but may be relevant for people who have moved from another state or country).

4. Referrals

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

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

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

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

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

5. Crisis and other referral arrangements

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

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

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

See Section 7: Support services.

6. Intervention timing

The suicide prevention service is designed to provide immediate and short-term support for people during a period of increased suicide risk. The service is not intended to provide long-term intensive support. In most cases people would access services for a period of up to two months.

People referred under this service will have priority access and the mental health provider is to contact the person within 24 hours of referral.

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

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

Clinical service delivery should be primarily face-to-face consultations with a series of follow-up phone calls to promote ongoing therapeutic contact.
The mental health provider may also undertake a care coordination role and facilitate access to other care providers such as a private psychiatrist. Whilst providing care coordination the mental health provider will retain responsibility for the clinical suicide prevention intervention services.

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

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

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

OR

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

7. Support services

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

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

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

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

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

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

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

Psychological Therapies–children under 12 (PTC-U12)

1. Eligibility

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

The eligibility criteria for services include:

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

2. Mental disorders and contextual factors

Mental disorder definitions are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD–10 Chapter V Primary Health Care Version. The mental disorders and contextual factors relevant to children under 12 years of age that can be treated under Psychological Therapies are outlined in Table 1 below.

Table 1: List of childhood disorders

<table>
<thead>
<tr>
<th>No.</th>
<th>Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Attachment disorders</td>
</tr>
<tr>
<td>2</td>
<td>Depressive disorders</td>
</tr>
<tr>
<td>3</td>
<td>Adjustment disorder</td>
</tr>
<tr>
<td>4</td>
<td>Anxiety disorders including:</td>
</tr>
<tr>
<td></td>
<td>(a) Generalised Anxiety Disorder (includes overanxious disorder of childhood)</td>
</tr>
<tr>
<td></td>
<td>(b) Separation Anxiety Disorder</td>
</tr>
<tr>
<td></td>
<td>(c) Social Anxiety Disorder/Social Phobias</td>
</tr>
<tr>
<td></td>
<td>(d) Phobic disorders/Specific Phobias</td>
</tr>
<tr>
<td></td>
<td>(e) Obsessive Compulsive Disorder</td>
</tr>
<tr>
<td></td>
<td>(f) Post Traumatic Stress Disorder</td>
</tr>
<tr>
<td></td>
<td>(g) Panic Disorder*</td>
</tr>
<tr>
<td>5</td>
<td>Elective Mutism (or Selective Mutism)</td>
</tr>
<tr>
<td>6</td>
<td>Sleep Disorders</td>
</tr>
<tr>
<td>7</td>
<td>Somatoform Disorder</td>
</tr>
</tbody>
</table>
Table 1: List of childhood disorders (continued)

<table>
<thead>
<tr>
<th></th>
<th>Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Neurasthenia (Chronic Fatigue Syndrome)</td>
</tr>
<tr>
<td>9</td>
<td>Eating Disorders</td>
</tr>
<tr>
<td>10</td>
<td>Feeding Disorders</td>
</tr>
<tr>
<td></td>
<td>In cases where children (e.g. with behavioural/toileting/feeding difficulties) can competently be treated by GPs, paediatricians, maternal and child health nurses, and/or mental health nurses etc.) it is recommended that the child should not be referred to Psychological Services as a first option. However, an exception may arise when families live in remote areas and do not have access to a range of primary care services.</td>
</tr>
<tr>
<td>11</td>
<td>Encopresis</td>
</tr>
<tr>
<td>12</td>
<td>Enuresis</td>
</tr>
<tr>
<td>13</td>
<td>Bereavement Disorders</td>
</tr>
<tr>
<td>14</td>
<td>Childhood behavioural disorders, limited to:</td>
</tr>
<tr>
<td></td>
<td>(a) Conduct Disorder</td>
</tr>
<tr>
<td></td>
<td>(b) Attention—Deficit/Hyperactivity Disorder (ADHD)</td>
</tr>
<tr>
<td></td>
<td>(c) Oppositional Defiant Disorder</td>
</tr>
<tr>
<td></td>
<td>(d) Disruptive Behaviour Disorder not otherwise specified (NOS)</td>
</tr>
<tr>
<td>15</td>
<td>Tic disorders (e.g. Tourette’s syndrome)</td>
</tr>
<tr>
<td>16</td>
<td>Substance use disorders (e.g. glue sniffing, alcohol and drugs)</td>
</tr>
<tr>
<td>17</td>
<td>Sexual disorders—including but not limited to Gender Identity Disorder of Childhood</td>
</tr>
<tr>
<td>18</td>
<td>Dissociative (conversion) Disorder*</td>
</tr>
<tr>
<td>19</td>
<td>Emotional disorders with onset specific to childhood (F93)</td>
</tr>
<tr>
<td>20</td>
<td>Mental disorder, NOS</td>
</tr>
<tr>
<td>21</td>
<td>Contextual factors—including but not limited to:</td>
</tr>
<tr>
<td></td>
<td>(a) Problems related to upbringing (Z62)</td>
</tr>
<tr>
<td></td>
<td>(b) Problems related to negative life events in childhood (Z61)</td>
</tr>
<tr>
<td></td>
<td>(c) Other problems related to primary support group, including family circumstances (Z63)</td>
</tr>
</tbody>
</table>

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

3. Access to PTC-U12 by parents and family

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

References in this document to persons having responsibility for a child accessing Psychological Therapies include parents, guardians, or persons having custodial responsibilities for the child.
4. Eligibility of children at risk of suicide or self-harm

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

Children who are at acute or immediate risk of suicide or self-harm or who have a severe and persistent mental illness should be referred to the emergency department or relevant state government acute mental health service or a child psychiatrist. Psychological Therapies is not designed for individuals who are already being managed by state government mental health services and is not intended to divert people from the care of state public mental health services. It aims to provide referral pathways for GPs or other approved professionals to better support their patients in the primary care setting.

5. Referral requirements

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

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

6. Provisional referral

In some instances, a referral from a GP, paediatrician, or psychiatrist may not be possible. Provisional referrals to the PTC-U12 service may enable service delivery to commence while arrangements are made to see a GP and have a Child Treatment Plan (otherwise known as a ‘GP Mental Health Treatment Plan’) developed.

A provisional referral can be made by the following professions and clinicians:

» Allied health professionals who are eligible to provide services under PTC-U12 (appropriately trained occupational therapists, social workers, psychologists, mental health nurses, and Aboriginal and Torres Strait Islander health workers). An allied health professional may not refer someone to themselves or to someone operating in the same practice.

» School psychologists/counsellors or Deputy Principals/Principals. Referrals from schools and early childhood services need to be made via senior staff members (e.g. Directors or Principals/Deputy Principals), where the school or early childhood service does not have a qualified psychologist or counsellor (in consultation with the parents).

» Directors of early childhood services.

» Medical officers in non-government organisations (NGOs).

Other provisional referral arrangements apply for the different target groups, which may be appropriate for some children.
7. Child Treatment Plan (CTP)

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

Where referrals are made by professions other than a GP, patients must have a CTP prepared in consultation with a GP as soon as possible, preferably within two weeks of the first session or four weeks in a rural and remote area or as soon as practical where there is no ready access to GPs.

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

7.1 Format of the PTC-U12 CTP

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

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

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

8. Number of sessions

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

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

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

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

It is a requirement of PTC-U12 for the child to attend for regular review and monitoring by the clinician during treatment (e.g. estimated as every third session).
Table 2: Sessions

Sessions 1–6  Sessions one to three may contribute to the initial assessment to identify if the PTC-U12 is appropriate for the individual or inform the most appropriate treatment.

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

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

Sessions 12–18  In exceptional circumstances, the individual may require an additional six sessions above those already provided (up to a maximum total of 18 individual sessions per client per calendar year).

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

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

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

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

Group sessions

1–Sessions 1–12  Up to 12 group therapy services within a calendar year involving 6–10 people, providing appropriate referrals have been made and CTPs are prepared.

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

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

A comprehensive assessment always includes:

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

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

Parents, guardians, family members, or other persons having responsibility for the child can also access the PTC-U12 to assist them to better support the child that has or is at a significant risk of developing a disorder and who has an CTP.
In circumstances where it is not clinically appropriate for the child to be present, parents, guardians, family members, or other persons having responsibility for the child can access sessions without the child present. Parents, guardians, family members and other persons with responsibility for the child may attend treatment sessions subject to the following:

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

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

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

10. Interventions

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

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

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

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

- attachment intervention—family-based intervention (where expertise is available)
- behavioural interventions
- CBT (including individual child and family/parent-based)
- Family-based interventions (behaviour or CBT based intervention only)
- Parent-Child Interaction Therapy (PCIT)—for attachment and behavioural disorders (where expertise is available).

The following interventions were not included under the previous ATAPS program and are therefore not included for CTP-U12:

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

10.1 Intervention period

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

Aboriginal and Torres Strait Islander peoples

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

1. Aims of the service

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

As such, where appropriate, the guiding principles which should underpin the design, establishment, and delivery of Psychological Therapies—Aboriginal and Torres Strait Islander include the following:

» high-quality services delivered in a culturally appropriate manner equitable to those received by all Australians

» services are based on Aboriginal and Torres Strait Islander definitions of health incorporating spirituality, culture, family, connection to the land, and wellbeing and grounded in community engagement

» funded organisations form practical partnerships with Aboriginal and Torres Strait Islander community controlled organisations (ACCOs) and these are documented in funding applications and annual plans and budgets

» two-way support mechanisms are put in place to allow both non-Aboriginal and Torres Strait Islander funded organisations and ACCOs to assist each other in the delivery of services

» Aboriginal and Torres Strait Islander people that are providing services should have the appropriate level of skills and qualifications to deliver services and are provided with opportunities to develop the appropriate level of skills and qualifications to deliver services

» non-Aboriginal and Torres Strait Islander practitioners have undertaken recognised cultural competency training.

Service providers for Psychological Therapies for Aboriginal and Torres Strait Islander populations must ensure that:

» appropriate referral pathways and linkages with government and non-government stakeholders at the community level (including those associated with the clinical mental health system such as ACCOs) are established and maintained

» efficient and effective services are provided, that are managed within the overall capacity of the organisation to meet demand for services

» a high-quality service is provided, that is clinically appropriate for Aboriginal and Torres Strait Islander people and delivered by qualified and appropriately trained and skilled allied health professionals.
2. Eligibility for Psychological Therapies—Aboriginal and Torres Strait Islander peoples

The services are designed for Aboriginal and Torres Strait Islander people who have, or are at risk of developing, a mild to moderate mental disorder, and who could benefit from short term focused psychological strategies services. The short-term, goal oriented focused psychological strategies services that Psychological Therapies provides are of most therapeutic value to individuals with common disorders, such as anxiety and depression, of mild to moderate severity.

The services are not intended to provide long-term intensive treatment and support, and organisations should ensure clients and other stakeholders are aware of the intention of the services. Individuals with more severe illness whose conditions may benefit from short-term focussed psychological strategies services may also require Psychological Therapies—Aboriginal and Torres Strait Islander.

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

3. Interventions

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

4. Qualifications and standards

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