Australian Government
Department of Health and Ageing

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OPERATIONAL GUIDELINES

FOR THE

ACCESS TO ALLIED PSYCHOLOGICAL SERVICES (ATAPS)

ABORIGINAL AND TORRES STRAIT ISLANDER SUICIDE PREVENTION SERVICES

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Mental Health Services Branch
Mental Health and Drug Treatment Division

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ATAPS ABORIGINAL AND TORRES STRAIT ISLANDER SUICIDE PREVENTION SERVICES

1. Introduction

The Access to Allied Psychological Services (ATAPS) program funds the provision of short term mental health services for people with mental disorders through fund-holding arrangements administered by Divisions of General Practice and established Medicare Locals. The fund-holding arrangements will transition to all Medicare Locals during 2011-12 as they are established and demonstrate capacity to provide mental health services.

A number of streams of funding are available under ATAPS Tier 1 and Tier 2, including the *Taking Action to Tackle Suicide* package, to provide mental health and suicide prevention services to Aboriginal and Torres Strait Islanders. Medicare Locals can access all of these mainstream funding streams in delivering services to Aboriginal and Torres Strait Islanders..

The 2011-12 Budget provided $205.9 million over five years to expand the ATAPS program. This includes $36.5 million, over five years, to enhance and expand ATAPS Aboriginal and Torres Strait Islanders mental health and/or suicide prevention services. This funding will support approximately an additional 18,000 Aboriginal and Torres Strait Islanders under ATAPS.

Where Medicare Locals identify that there is a need for suicide prevention services to specifically target Aboriginal and Torres Strait Islander people within their catchment area they can utilise ATAPS Tier 2 Aboriginal and Torres Strait Islander services funding and/or ATAPS Suicide Prevention Service funding, to enhance the existing ATAPS Suicide Prevention Service or to establish specific culturally appropriate Aboriginal and Torres Strait Islander Suicide Prevention Services.

2. Purpose of this Document

This document is designed for use by Divisions, Medicare Locals and locally sourced organisations that are providing ATAPS Aboriginal and Torres Strait Islander Suicide Prevention Services. This document provides specific information about services and builds on the information available in the *ATAPS Operational Guidelines* and in the *Operational Guidelines for ATAPS Tier 2 Aboriginal and Torres Strait Islanders Mental Health Services*. Organisations should use this information in conjunction with the information in their Funding Agreement and information in the *ATAPS Operational Guidelines* and in the *Operational Guidelines for ATAPS Tier 2 Aboriginal and Torres Strait Islander Mental Health Servcies*.

It is recognised that this document may also be distributed to others, including allied health providers, GPs, and state government health departments and associated services. These audiences should keep in mind that Divisions and Medicare Locals have some flexibility in how these services are implemented

at the local level, and should not rely on this document alone for information on the availability of, and eligibility for, these services in their local area. It is recommended that health care providers contact the Division or Medicare Local that is funded to provide these services for information specifically related to eligibility and service availability in the local area.

3. Objective of ATAPS Aboriginal and Torres Strait Islanders Suicide Prevention Services

Services are to provide priority access to the ATAPS program for Aboriginal and Torres Strait Islanders who have self harmed, attempted suicide or have suicidal ideation and are being managed in the primary health care setting. If appropriate this may also include their families.

The primary objective of ATAPS Aboriginal and Torres Strait Islander Suicide Prevention Services is to provide treatment and support to Aboriginal and Torres Strait Islanders at high risk of suicide or self harm at a critical point in their lives, and training to administrators and providers providing treatment for those individuals. ATAPS Aboriginal and Torres Strait Islander Suicide Prevention Services complement the ATAPS Suicide Prevention Service implemented from 1 July 2011, other ATAPS services, the Mental Health Services in Rural and Remote Areas program and the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative.

Medicare Locals can engage allied health professionals who have specific skills or training to provide clinical care to Aboriginal and Torres Strait Islanders who are at risk of suicide or deliberate self-harm. In 2011-12 funding is also provided to some Divisions which have a significant Aboriginal and Torres Strait Islander population and fall under Tranche 3 Medicare Locals. ATAPS funding also enables Divisions and Medicare Locals to engage with other organisations directly associated with delivering culturally appropriate suicide prevention services to Aboriginal and Torres Strait Islander people, particularly Aboriginal and Torres Strait Islander community controlled primary health care services (ACCHS). Furthermore ATAPS funding is available for local organisations to develop and deliver culturally appropriate training for administrators and allied health professionals providing clinical care to Aboriginal and Torres Strait Islanders who are at risk of suicide or deliberate self-harm.

It is recognised that some organisations may be unable to provide this service due to unacceptable risk if the state or territory acute mental health service (or equivalent) is unwilling to accept referrals from ATAPS Aboriginal and Torres Strait Islander Suicide Prevention Services when a client is at acute or immediate risk of suicide or self harm. In circumstances where these referral protocols cannot be established with an acute mental health service (or equivalent) for referral in times of crisis, the Division or Medicare Local should contact the Department to discuss the way forward. Divisions and Medicare Locals who approach the Department on this basis will be required to provide information on the efforts made to establish these relationships.

The suicide prevention services must be relevant to Aboriginal and Torres Strait Islander people at risk of suicide or self harm and their families. As such, where appropriate, the guiding principles which should underpin the design, establishment and delivery of ATAPS Aboriginal and Torres Strait Suicide Prevention Services 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 primary health care services (ACCHS) 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 ACCHS to assist each other in the delivery of services;
- Aboriginal and Torres Strait Islander people that are providing services should have the appropriate level of skills and qualifications to deliver services;
- Aboriginal and Torres Strait Islander people are provided with opportunities to develop the appropriate level of skills and qualifications to deliver services; and
- non-Aboriginal and Torres Strait Islander practitioners have undertaken recognised cultural competency training.

4. Service Establishment

Divisions of General Practice already provide ATAPS services to Aboriginal and Torres Strait Islanders. Medicare Locals are expected to provide ATAPS services to Aboriginal and Torres Strait Islanders as part of the transition of the ATAPS program from Divisions to Medicare Locals, in accordance with the *ATAPS Operational Guidelines*. The transition should ensure continuity of services for existing and new clients.

The additional Tier 2 funding available for Aboriginal and Torres Strait Islander suicide prevention services is to enable Medicare Locals to enhance and expand services which more appropriately meet the needs of Aboriginal and Torres Strait Islanders.

This could be achieved through:

- establishment of formal linkages and referral pathways with stakeholders specifically involved with the prevention of suicide in Aboriginal and Torres Strait Islanders;
- engagement (where required) and training/upskilling of allied health providers, including the provision of information on the requirements of the ATAPS program;

- development of support structures, clinical supervision and other clinical governance arrangements across the catchment area; and
- promotion of support structures (including ATAPS After Hours Suicide Support Line for Aboriginal and Torres Strait Islanders at risk of suicide or self harm), where appropriate, and referral to other services when necessary.

Where Aboriginal and Torres Strait Islander services are currently not provided, it may take up to three months to establish Aboriginal and Torres Strait Islander Suicide Prevention Services.

5. Eligibility for ATAPS Aboriginal and Torres Strait Islander Suicide Prevention Service

ATAPS Aboriginal and Torres Strait Islander Suicide Prevention Services are aimed at providing treatment and support to Aboriginal and Torres Strait Islanders in the community who are at risk of suicide or self harm. However services are 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) to support them in the event of a crisis.

These service is primarily designed for three groups of Aboriginal and Torres Strait Islanders:

- Individuals who have attempted or are at risk of suicide (risk factors, suicidal ideation and self harm);
- Family members and friends of people who have died by suicide and who are at risk themselves; and
- Other Aboriginal and Torres Strait Islanders with mental health problems at risk of suicide or self harm.

This should include Aboriginal and Torres Strait Islanders who:

- have been discharged into the care of GPs or ACCHS from hospital, including emergency departments, or from a medical ward following an overnight admission after a suicide attempt or self harm incident;
- have presented to GPs or ACCHS after an incident of self harm;
- have expressed strong suicidal ideation to their GP, ACCHS or community elders; and
- presented with suicidal ideation to a Drug and Alcohol service.

Services should also provide support to those who are considered at significant risk in the aftermath of a suicide.

In considering a person's eligibility for these services, providers should consider the complexity of the individual's circumstances and the number of contributing factors. Consideration should also be given to the short term nature of the ATAPS Aboriginal and Torres Strait Islander

Suicide Prevention Service and whether the individual is more appropriately treated and supported by a specialist mental health service, such as the state or territory acute mental health service.

Services are not designed for people who are being treated on an ongoing basis by state government mental health services following release from a hospital acute mental health ward.

Services are NOT intended to increase the number of high risk people being managed in the primary health care setting. Nor is it intended to divert people from the care of state and territory public mental health services to primary care. The aim is to better integrate care between acute and primary mental health care for the management of this group, and provide referral pathways for GPs and ACCHS to better support their existing patients.

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

There is no limit on the number of times an individual can be referred for these services in a calendar year, however should an individual require multiple referrals; consideration should be given to whether that individual is more appropriately managed by an alternate service.

More defined eligibility criteria is not provided by the Department. This is to allow Divisions and Medicare Locals some flexibility in the targeting of the services, based on local needs, gaps in service availability and funding limitations. Division and Medicare Locals may choose to develop stricter eligibility criteria for their service, provided this is developed with appropriate clinical input, and remains within the scope and intent of this service as outlined in the funding agreement Schedule and this document.

6. Referral Requirements

People can be referred for services by their GP, an ACCHS, a drug and alcohol service or directly from an emergency department or on discharge from a hospital ward. People may also be referred from the acute mental health team where the individual is not at acute or immediate risk, and is not best supported by that services post assessment. Care coordination must still be provided, and wherever possible this should involve a GP or an ACCHS.

It is noted that various jurisdictions have protocols and policies relating to the way in which people who have attempted or are at risk of suicide or self harm are managed within the state or territory system. Divisions and Medicare Locals must ensure that ATAPS Aboriginal and Torres Strait Islander Suicide Prevention Services are implemented in a manner that complements these existing processes and does not interrupt exiting pathways. For example, in

jurisdictions where it is standard for all people at risk of suicide or self harm who present to an Accident and Emergency Department to be assessed by the acute mental health team before being discharged, it may be more appropriate to develop referral pathways from the acute mental health service rather than directly from the Accident and Emergency Department.

Should a Division or Medicare Local be unsure as to how to implement a service that meets the requirements of these Operational Guidelines and also complements state or territory government processes/services that Division or Medicare Local should contact the Department to clarify and agree on the arrangements.

While many people who attempted suicide have a mental disorder, a person does NOT need to have had a mental disorder diagnosed before referral to access ATAPS Aboriginal and Torres Strait Islander Suicide Prevention Services and it is NOT a requirement to have a GP Mental Health Treatment Plan completed. People referred directly from the hospital setting or acute mental health team should visit their GP or ACCHS, where possible, to ensure all their health care needs are being addressed.

It is recognised that in some communities a GP or ACCHS may not be the primary provider responsible for the overall care of the person. In these instances, the individual should be encouraged to visit an alternate primary health care provider in order to ensure other health care needs are being managed.

7. Number of Sessions

Unlike the standard ATAPS arrangements, there is no limit on the number of sessions available. However it is anticipated that these sessions would be conducted in a defined time period, of around three months.

It should be noted that services provided under ATAPS Aboriginal and Torres Strait Islander Suicide Prevention Service have no impact on a person's entitlement to ATAPS Tier 1 or other Tier 2 services (with the exception of other ATAPS Suicide Prevention Services). The services provided under ATAPS Aboriginal and Torres Strait Islander Suicide Prevention Services also have no impact on an individual's entitlement to Medicare subsidised allied mental health services.

8. Interventions

Services are designed to provide immediate and short term intensive support for people during a period of high suicide risk. Services are not intended to provide long-term intensive support. In most cases people would access services for a period of up to three months.

People referred under this initiative will have priority access to the allied health provider and the allied health provider is to make contact with the person within 24 hours of referral. The first clinical session with the allied

health provider must occur within 72 hours of referral or earlier if necessary. If this is not possible due to limited availability of the allied health professional due to the weekend or public holidays, or for other legitimate reasons, arrangements must be made to contact the person and provide support until the allied health provider engages with the individual. For example the individual could be contacted by the ATAPS After Hours Suicide Support Line available as part of the *ATAPS Suicide Prevention Service* (refer to the Operational Guidelines for the ATAPS Suicide Prevention Service for details). Please note that it is expected that in most cases contact would be made by the allied health provider within the required timeframe.

Divisions and Medicare Locals will engage appropriately qualified and experienced allied health providers to provide culturally appropriate mental health services to clients of the Service. The psychological services to be provided through this Service shall be broadly consistent with those provided across the ATAPS Program, as per January 2012 *ATAPS Operational Guidelines*. The services should be tailored to meet the needs of individuals who are in psychosocial distress and expressing thoughts of self harm or suicide and be part of the treatment for any mental disorder identified as causing the suicidal thinking or behaviour. Consideration must also be given to the most appropriate treatment to address the cause of the self harming or suicidal thinking. This may involve focused psychological strategies and narrative therapy interactions as well as proactive case management and client follow up as a form of support.

Service provision by the allied health provider is expected to be a mixture of face to face consultations and phone calls to sustain ongoing therapeutic contact. Service delivery should be primarily face to face.

Allied health providers will also undertake an education/clinical support role (for example, provide support to GP practice staff/nurses, ACCHS and other organisations involved in early response client care, in a capacity building role). Direct service delivery to clients should be the primary role of the Service.

Care coordination should always be led by an individual's GP or ACCHS, the allied health provider may assist care coordination and facilitate access to other care providers such as the individual's GP or other allied health provider. Whilst providing care coordination the allied health provider will retain clinical responsibility for the suicide prevention intervention service. Medical practitioners who participate in case conferences may be eligible to bill that service against a Medicare item. Divisions and Medicare Locals should ensure medical practitioners are aware of the relevant Medicare items to encourage participation in case conferences as appropriate.

If in any doubt as to the immediacy of risk of the client, the allied health provider is to call the acute mental health team (or other specialist mental health provider). The allied health provider is not expected to take on the crisis intervention role, but 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 developed by Divisions and Medicare Locals.

9. Transition

The allied health provider will decide, in consultation with the person and their GP and/or ACCHS, when it is appropriate for the intensive treatment service to cease and assist in facilitating access to any further required services. This may include (but is not limited to) transition to ATAPS Tier 1 or other Tier 2 services or Medicare based mental health services.

10. Training and Support

Allied health providers engaged to provide services must at a minimum, meet the requirements to be an ATAPS provider, as per the January 2012 *ATAPS Operational Guidelines*. In addition, providers must have specific training in providing services to people at risk of suicide which is culturally appropriate. This training is designed to ensure that all providers have at least a minimum level of understanding of how to work appropriately with this high risk group. If individual providers do not feel that this training is sufficient, they should seek out additional training and educational opportunities before providing services.

It is mandatory for all allied health providers working in services to complete local cultural competency training, organised by Divisions and Medicare Locals, and the Aboriginal and Torres Strait Islander Suicide Prevention training and assessment that may be developed to support services. If any training is made available, all providers will be required to complete the new training requirements as soon as possible.

Divisions and Medicare Locals will be advised of any training once it becomes available.

Divisions and Medicare Locals will be responsible for maintaining a register of allied health providers delivering treatment services and ensuring that all allied health providers have completed the required training and have undertaken the required continuing professional development training.

Provisionally registered allied health providers are NOT eligible to provide services.

<u>Liaison/Development of Linkages and Crisis Referral Arrangements</u>

Divisions and Medicare Locals will also have a formal liaison role with other services, including local GP practices, ACCHS, drug and alcohol services and emergency services in the local hospitals, to ensure optimal and timely referral of individuals to allied health providers.

In order to provide services through ATAPS Aboriginal and Torres Strait Islander Suicide Prevention Service, Divisions and Medicare Locals 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 commencement of service provision.

Divisions and Medicare Locals will work with state and territory 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. This should include Standby and other non-government organisations involved in early response client care.

It is recognised that the availability of acute mental health services varies both across and within jurisdictions. Rural and remote areas in particular may have limited acute mental health services available. Should the Division or Medicare Local be unsure of how to set up appropriate crisis support arrangements within the catchment area for the service, those organisations should contact the Department.

Evidence and/or information on these arrangements must be provided to the Department in progress reporting.

Support Services

Divisions and Medicare Locals must ensure appropriate support arrangements are in place for allied health providers working under this Service, for example clinical supervision. These supports should complement any support arrangements available at a national level.

Additionally, under the ATAPS Suicide Prevention Service the ATAPS After-Hours Suicide Support Line is available, further detail on this is provided in the *ATAPS Suicide Prevention Service Operational Guidelines*. The ATAPS After-Hours Suicide Support Line is sensitive too and may be utilised for Aboriginal and Torres Strait Islander clients at risk of suicide or self harm that need additional support.

However, the Support Line isn't specifically designed for Aboriginal and Torres Strait Islander clients. This is still to be developed further, and until this has been done any use of the Support Line for Aboriginal and Torres Strait Islander clients should be done with caution and taking this into consideration.

11. Budget Allocation

Divisions and Medicare Locals which decide to establish Aboriginal and Torres Strait Islander Suicide Prevention Services may use up to 25% of total funding in the first year for establishment costs. This additional administration capacity allows for the development of linkages and protocols with state and territory mental health services, emergency departments, GPs, ACCHS', Drug and Alcohol Services and Standby.

Following this establishment allowance, Divisions and Medicare Locals will be required to allocate and spend funds consistent with the *ATAPS Operational Guidelines*. For detailed information on what is considered Administration Costs and what is considered to be Service Delivery Costs refer to the *ATAPS Operational Guidelines*.

12. Further Information

Further information in relation to the requirements under the ATAPS CMHS component can be obtained by contacting:

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