Australian Government

Department of Health and Ageing

OPERATIONAL GUIDELINES

for the

ACCESS TO ALLIED PSYCHOLOGICAL SERVICES INITIATIVE

Updated with effect from January 2012

Mental Health Services Branch
Mental Health and Drug Treatment Division

CONTENTS

1. Introduction

The vision for mental health in Australia outlined in the *National Mental Health Policy* (the Policy), 2008 (page 2) aims for:

..a mental health system that enables recovery, that prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.

The Access to Allied Psychological Services (ATAPS) initiative is an Australian Government program which fulfils part of this vision by providing access to effective, low cost treatment for people with a mental illness who may not otherwise be able to access services.

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

ATAPS is a component of the Better Outcomes in Mental Health Care (BOiMHC) Program which was introduced in July 2001. The objectives of ATAPS are to:

- produce better outcomes for individuals with common mental disorders through offering evidence based short-term psychological interventions within a primary care setting;
- target services to those individuals requiring primary mental health care who are not likely to be able to have their needs met through Medicare subsidised mental health services;
- complement other fee-for-service programs and address service gaps for people in particular geographical areas and population groups;
- offer referral pathways for General Practitioners (GPs) to support their role in primary mental health care;
- offer non-pharmacological approaches to the management of common mental disorders; and
- promote a team approach to the management of mental disorders.

ATAPS is a targeted program designed to increase the capacity of Divisions and Medicare Locals to give priority to hard to reach groups who continue to miss out on Medicare subsidised services under Better Access. These include: people who are less able to pay fees; culturally and linguistically diverse communities; people who are homeless or at risk of homelessness and people in rural and remote locations.

The short term, goal oriented focussed psychological strategies services that ATAPS provides are of most therapeutic value to individuals with common mental disorders of mild to moderate severity.

The program also has dedicated funding to provide innovative services to people who have self harmed or attempted suicide or are at risk of suicide, Indigenous people, children and their families and women with perinatal depression. Funding for suicide prevention, children and Indigenous mental health services has significantly increased since 2010 to increase the capacity of Divisions and Medicare Locals to target these groups.

ATAPS was reviewed between 2008 and 2010 and the ATAPS Review report was released in March 2010. The consultation and associated research undertaken through the review process has indicated that there are four key areas that an enhanced ATAPS initiative could focus upon to better meet the needs of consumers experiencing mental illness. These four key areas are: better addressing service gaps, increasing efficiency, encouraging innovation and improving quality. These are being implemented in a staged approach.

The role of ATAPS has evolved from providing services to a broad population to focussing on service gaps and populations not well serviced by other mental health programs. As such, a more targeted and flexible approach is required in some areas to ensure that vulnerable underserved populations receive appropriate mental health services.

ATAPS has a two-tiered funding model to assist it to better meet the needs of individuals experiencing mental illness. The model consists of:

- **Tier 1** base funding which enables all Divisions and Medicare Locals to target psychological services for hard to reach groups within their population to complement Medicare subsidised mental health service delivery; and
- **Tier 2** special purpose funding which supplements Tier 1 funding and provides an additional, flexible pool of funding for innovative service delivery to specified groups with priority needs which cannot be met through traditional ATAPS service delivery approaches.

These Operational Guidelines are to be read in conjunction with the Funding Agreements and Deeds of Variation between Divisions of General Practice and/or Medicare Locals and the Department of Health and Ageing (the Department).

If there are any questions or issues that need to be discussed, Divisions and Medicare Locals should contact the Department. If clarification is required, the Department will amend and issue subsequent editions of the Operational Guidelines or issue separate Circulars addressing specific issues.

2. ATAPS service delivery model

ATAPS enables GPs to refer individuals with a diagnosed mental illness to allied health professionals. The allied health services to be provided under ATAPS are restricted to focussed psychological strategies, which are time-limited, evidence based psychological treatments (see further explanation and a list of these treatments in the Glossary of Terms at Attachment A). ATAPS short term therapies are particularly suitable for common mental disorders such as anxiety and depression of mild to moderate severity.

2.1 Mental Health Standards

All services provided under ATAPS 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 www.health.gov.au/mhsc.

2.2 ATAPS eligibility

2.2.1 General Eligibility

To be eligible for ATAPS Tier 1 and Tier 2 services (for information on the two-tiered funding structure of ATAPS, refer to section on funding models on page 17), individuals need to have a clinical diagnosis of mental illness. See *Definition of Mental Illness for the Better Outcomes in Mental Health Care Program* in Attachment B. The short term, goal oriented focussed psychological strategies services that ATAPS provides 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 may also be provided with ATAPS services (refer to Section 2.2.1 on page 7).

It is the role of General Practitioners (GPs) to diagnose those individuals who have a mental illness and document this in a *Mental Health Treatment Plan* and to assess whether they would benefit from short term focussed psychological strategies intervention, which could then be provided through ATAPS or the Better Access initiative as part of the Treatment Plan. The treating clinician needs to

decide - based on a range of factors, such as workforce availability and the patient's ability to contribute to the cost - whether to refer a patient to Better Access or to ATAPS. However, it should be noted that individuals should only be referred to one of these Programs in any calendar year.

Relationship with Better Access
ATAPS has always been a complementary program to Better Access and is not designed to offset or top up services delivered under Better Access. The changes to Better Access announced in the 2011-12 Budget do not alter this relationship.

People who have already completed ten sessions or more of individual services under Better Access in a calendar year should not be referred to ATAPS to access additional services during the remainder of that calendar year. However, from 1 January the following year these people can access a further ten individual or ten group services under Better Access in the subsequent calendar year.

Alternatively, if their circumstances have changed, and it would be more appropriate to be referred to ATAPS these people can access ATAPS services in the subsequent calendar year. Changed circumstances include: changes in location where the person is no longer able to access Better Access services due to workforce constraints; or their financial circumstances change and they are no longer able to meet the co-payments associated with Better Access services. In deciding if ATAPS is more appropriate GPs should consider the focus and target of the ATAPS program.

Priority Groups
All ATAPS services are to be targeted to give priority to population groups which have particular difficulty in accessing mental health treatment in the primary care sector. The Department encourages Divisions and Medicare Locals to consider models suitable for such groups, including:

- People who are not able to access Medicare funded mental health services;
- People who are less able to pay fees;
- Carers with a diagnosis of mental illness;
- Culturally and linguistically diverse (CALD) communities;
- Aboriginal and Torres Strait Islander people;
- People who are experiencing, or are at risk of, homelessness;
- Children with or at risk of developing a mental disorder;
- People in remote locations;
- People who have self harmed or attempted suicide or are at risk of suicide;
- Women with perinatal depression;

Further information can be found at Attachment C.

For people with severe mental illness, children, women with perinatal depression, people at risk of suicide or self harm and people who are affected by extreme climatic conditions the following considerations should be taken into account:

2.2.2 Severe Mental Illness
To access ATAPS services the condition of a person with a severe mental illness must be one that will benefit from short term psychological treatment (as part of the overall treatment plan). Such people will also be able to be provided with services. People whose condition is not only severe but also persistent (likely to be long term) may not benefit from short term focussed psychological strategies services. These people generally require longer term treatments rather than those that ATAPS can provide. ATAPS may not be able to meet the needs of such people over time.

2.2.3 Children
Children may be referred to ATAPS by a GP, paediatrician or psychiatrist. Children diagnosed with a mental disorder or assessed as being at risk of developing a mental disorder where this causes ‘significant dysfunction in everyday life’ are eligible for ATAPS services.

2.2.4 Women with Perinatal Depression

Women with perinatal depression may be provisionally referred by a maternal and child health nurse for the National Perinatal Depression initiative. The referring physician **must** prepare a *Mental Health Treatment Plan* (MB**S** items 2700, 2701, 2715 or 2717**)** for the individual being referred. However, the decision to charge to one of these MBS items, or another MBS item which does not require a diagnosis of a mental disorder to be lodged with Medicare, lies with the referring physician. For more information on referrals and provisional referrals, refer to the section 2.3 in these Operational Guidelines on referral processes.

2.2.5 People at Risk of Suicide or Self Harm

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

2.2.6 People who are affected by extreme climatic events

Extreme Climatic Events include major events such as floods, cyclones and bushfires which may cause ongoing psychological symptoms resulting from trauma or loss that require provision of medium term psychological treatment, as advised by the Department.

2.2.7 Intake Processes, Assessment and Triage

As ATAPS has expanded to deliver innovative services for special groups, it has become important that those who are referred will be appropriately served by ATAPS and that they are referred to the right service within ATAPS. Therefore, Divisions and Medicare Locals are to have mechanisms in place to ensure people are referred to appropriate services, resources are effectively targeted, duplication is avoided and expected levels of unmet demand are managed. Divisions and Medicare Locals are expected to use systems that best suit local conditions, which could include, but are not restricted to: a panel arrangement; a salaried staff member with appropriate qualifications and clinical expertise; a specialist contractor with appropriate qualifications and expertise appointed by the Division/Medicare Local; or a quality assurance model to review referral processes and decisions on eligibility and access to services.

The Department considers triage and assessment of an individual as an element of service provision prioritising clients on the basis of highest need or appropriateness and referring them to ATAPS services which best meet their needs. Assessment and triage may be able to be completed based on the referral documentation provided by the referring practitioner, or on occasion may require a face to face or telephone based session with the individual. Where there is a need for a face to face session, the one triage/assessment session is not to be considered a treatment session, and this does not count towards the individual's allowed ATAPS treatment sessions in a calendar year. It is not considered necessary for there to be a review of all clients referred to ATAPS, but it is necessary that there is a system of review for referrals.

Where assessment services are to be provided, they are to be performed by allied health professionals (including psychologists, and appropriately trained nurses, occupational therapists, social workers and Aboriginal and Torres Strait Islander health workers) who meet the standards outlined in the *Purchasing Guidance for the Access to Allied Health Services Projects* in Attachment D.

The Department recognises that there may be a number of different intake processes depending on the service delivery model used by the Division/Medicare Local such as vouchers and direct referral to allied health providers. In all cases, the Division/Medicare Local needs to have in place arrangements to ensure that clients are referred to appropriate ATAPS services and demand is managed within available resources and that referrals are accepted throughout the financial year. The Clinical Governance Framework developed for Medicare Locals will provide guidance on this matter.

A system of monitoring the triage/assessment process will be useful for Divisions/Medicare Locals in identifying where a GP may be consistently making inappropriate referrals to ATAPS. Where this occurs, the Department encourages Divisions/Medicare Locals to work with the GP and educate them on ATAPS.

2.2.8 Managing Demand

Clinical eligibility is a separate issue to the targeting of access to service delivery by Divisions or Medicare Locals to particular population groups and geographic areas through ATAPS. Clearly with a capped program allocation, it would not be possible for ATAPS to meet the needs of all people with a diagnosed mental illness, nor should there be a need to do so, given the availability of the Better Access initiative. Consistent with the policy decisions and announcements of Government, ATAPS is a complementary program to Better Access that can be effective at targeting particularly hard to reach and disadvantaged groups.

It is also important that there is consistency in the availability of services under ATAPS throughout the year. Divisions/Medicare Locals are required to carefully monitor the resources available (funding) to ensure service provision can be provided throughout the year. It should also be noted that it is equally important to ensure available ATAPS services are fully subscribed, through educating and promoting to GPs appropriate referral pathways to ATAPS.

A triage officer may be one possible appropriate point for management of demand and referral on for people who are not eligible or suitable for ATAPS or who could not be accepted onto the program at that point in time. Once a client has been referred and accepted for services under ATAPS, they should be provided with the number of services they clinically require, consistent with the ATAPS operational guidelines, and consistent with short term psychological interventions.

A strategy on how to manage the demand for services should be incorporated in a Division's or Medicare Local's Annual Plan and Budget. Strategies to manage demand should include:

- ensuring an amount of funding is allocated for each month of the financial year,
- prioritising access to ATAPS services,
- educating and promoting to GPs appropriate referral of patients to ATAPS; and
- ensuring alternative referral pathways are established for those for whom ATAPS services cannot be provided.

2.2.9 Unique Individual ATAPS Identifier

Each individual who is accepted for ATAPS services is to be allocated a unique individual identifier. That identifier should be used for each referral and session of care for the individual and will assist in monitoring the number of services an individual has been provided and whether they are returning for treatment for the same or new conditions.

Medicare numbers are not appropriate to be used for ATAPS identifiers.

2.2.10 Compliance with Personally Controlled Electronic Health Record

As part of the 2010/11 federal budget, the Government announced a $466.7 million investment over two years for a national Personally Controlled Electronic Health Record (PCEHR) system for all Australians who choose to register online, from 2012-13.

From July 2012, all Australians who choose to can register for a PCEHR. As the PCEHR system matures, Australians who use a PCEHR will be able to see their important health information in one consolidated view. They will be able to share this information with trusted healthcare practitioners, who in turn will be able to access their patient's PCEHR to support the delivery of high quality healthcare regardless of where and when it is needed.

Divisions and Medicare Locals are to demonstrate commitment to align and integrate their ATAPS service with broader national health reforms, including adoption of the PCEHR in the their operations

from 1 July 2012. This would include agreeing to opt in as service providers to participate in the PCEHR by, for example, contributing health events to records where a client has given consent.

For more information about the PCEHR please see:
http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/pcehr-document

2.3 Number of services and referral requirements

The number of services people can receive in any calendar year and referral requirements for Tier 1 and Tier 2 ATAPS services are outlined below. Special conditions exist around ATAPS requirements for children under 12 and people who are at risk of or have attempted suicide or self harm. See page 7 for more information.

Individual Sessions	
1-6	Tier 1 and Tier 2 • Referral from a GP. • A referring GP must ensure the client's *Mental Health Treatment Plan* is completed. • Psychiatrists and paediatricians may make referrals. • In some circumstances other clinicians may make a provisional referral (refer to referral processes on page 12). • In the case of provisional referral or referral by a maternal and child health nurse the *Mental Health Treatment Plan* should be completed within two weeks of the commencement of treatment, or four weeks in a rural and remote area, or as soon as practical where access to GPs is not readily available. Please advise the Department if this is occurring regularly. • Where there are difficulties in meeting the *Mental Health Treatment Plan* requirement for some groups of clients the Department will consider exemptions. • See *Mental Health Treatment Plan: Exceptions.*
7-12	• On completion of the initial course of 6 sessions, the allied health professional is to provide a written report to the referring medical practitioner. The written report is to include information on assessments carried out, treatment provided, the individual's outcomes and recommendations on future management of the individual's mental disorder. Following receipt of the report, the referring practitioner will consider the need for further treatment and if clinically required refer the individual for an additional 7-12 sessions. This request may be arranged through telephone or email and does not require a face to face consultation. However, where referral for additional sessions is obtained by telephone, the allied health professional is to document the GP's agreement to the continuation of treatment. • Further allied mental health services may not be provided without referral or agreement by the GP for additional sessions. • **Unless the individual under treatment is being provided with a new referral for a new course of treatment for a different condition, this is considered to be a continuation of the original course of treatment and is not to be recorded as a new course of treatment or as a new individual.**

13-18	• In exceptional circumstances, the individual may require an additional six sessions above those already provided (**up to a maximum total of 18 individual sessions per client per calendar year**)[1]. • On completion of 12 sessions of treatment, the allied health professional must provide a written report to the referring medical practitioner. The written report is to include information on assessments carried out, treatment provided, the individual's outcomes and recommendations on future management of the individual's mental disorder. Following receipt of the report, the referring practitioner will consider the need for further treatment and issue a referral for an additional 6 sessions. • The individual must undertake a GP consultation in order to be referred for the additional six sessions and the exceptional circumstances must be documented in the referral. • Further allied mental health services may not be provided without a referral for additional services. • **Unless the individual under treatment is being provided with a new referral for a new course of treatment for a different condition, this is considered to be a continuation of the original course of treatment and is not to be recorded as a new course of treatment or as a new individual.**

Group Sessions	
1 - 12	• Up to 12 group therapy services within a calendar year involving 6-10 people. • Referral from a GP, psychiatrist or paediatrician (and for Perinatal Depression services, obstetricians and maternal and child health nurses can refer patients). • In some circumstances other clinicians may make a provisional referral (refer to referral processes). • The referring practitioner should ensure the client's *Mental Health Treatment Plan* or *Referred Psychiatrist Assessment And Management Plan* is completed. • In the case of provisional referral or referral by a maternal and child health nurse the *Mental Health Treatment Plan* should be completed within two weeks of the commencement of treatment, or four weeks in a rural and remote area or as soon as practical where access to GPs is not readily available. Refer to the *Mental Health Treatment Plan: Exceptions*. • Group sessions do not count towards the 12 individual allied mental health services in a calendar year. • Two facilitators are required to lead group sessions with each facilitator meeting the ATAPS eligibility criteria to provide services.

Where the severity or chronicity of an individual's condition indicates that more extensive treatment will be required than allowed or appropriate under ATAPS Tier 1 or Tier 2 arrangements, the individual should be referred for treatment under another appropriate mental health service instead of ATAPS.

[1] Exceptional circumstances are defined as a significant change in the client's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. It is up to the discretion of the referring practitioner, who should be guided by their professional ethics and/or Code of Conduct, to determine that the client meets these requirements. In these cases a new referral should be provided and exceptional circumstances noted on that referral.

2.3.1 Tier 1 Referral Process

It is envisaged that individuals utilising ATAPS Tier 1 services are formally referred by a GP or paediatrician or psychiatrist. Where referral by a GP is not possible provisional referrals may be made by allied health professionals who are eligible to provide services under ATAPS. An allied health professional may not refer someone to themselves or to someone operating in the same practice.

Referrals may be made face-to-face, by telephone, electronically or by a written referral. It is suggested that Divisions or Medicare Locals use a referral proforma based on the format suggested by the Royal Australian College of General Practitioners (RACGP). For the parameters for a referral letter see Attachment E.

A GP who is referring a client to ATAPS must undertake an assessment and prepare a *Mental Health Treatment Plan*. Where a provisional referral is made, the allied health professional providing psychological treatment must work with the Division or Medicare Local to have a GP develop a *Mental Health Treatment Plan*, preferably within two weeks of the first session, or four weeks in a rural and remote area, or as soon as practical where access to GPs is not readily available. Please advise the Department if this is occurring regularly. See *Mental Health Treatment Plan: Exceptions*.

2.3.2 Tier 2 Referral Process

The referral process for Tier 2 is similar to the process for Tier 1. In addition, a school may refer children to ATAPS and obstetricians and maternal and child health nurses may refer women to ATAPS under the National Perinatal Depression Initiative. However, the individual must have a *Mental Health Treatment Plan* prepared in consultation with a GP as soon as possible, preferably within two weeks of the first session or four weeks in a rural and remote area, or as soon as practical where access to GPs is not readily available. Please advise the Department if this is occurring regularly.

Divisions should refer to the ATAPS Suicide Prevention Services Operational Guidelines (Attachment F) for information on the referral processes for this group of clients. Child mental health services operational guidelines will be provided separately.

2.3.3 Referral Pathways

All referrals must be made either to the ATAPS Coordinator or copied or notified to the ATAPS Coordinator for the Division or Medicare Local. This will allow Divisions and Medicare Locals to monitor referrals to ensure they are appropriate, to triage and will assist in managing demand.

Where individuals who have been referred to ATAPS do not meet ATAPS eligibility requirements, they should be referred to another service appropriate for their needs. Referrals may involve an informal arrangement or may be a more formal process involving multiagency pathways.

2.3.4 Mental Health Treatment Plan: Exceptions

The Department recognises that it is not always possible or appropriate to meet the requirements of an assessment and a *Mental Health Treatment Plan*. Where a person has been referred because they are at risk of, or have attempted, suicide or self harm, a *Mental Health Treatment Plan* is not required. A *Mental Health Treatment Plan* is required, for children. Where a diagnosis of a mental illness does not exist, the referring practitioner should document that the child is assessed as being at risk of developing a mental disorder in the *Mental Health Treatment Plan.*

There may also be difficulties in meeting the *Mental Health Treatment Plan* requirement where there is difficulty accessing GPs, with providing treatment to homeless people, or in some Aboriginal and Torres Strait Islander communities. Divisions and Medicare Locals encountering difficulties in meeting the requirement of a *Mental Health Treatment Plan* should endeavour to have a *Mental*

Health Treatment Plan prepared as soon as possible, and if this is occurring regularly should approach the Department.

2.3.5 Measurement of Outcomes and Satisfaction

In order to measure improvement for individuals as an outcome of their treatment, outcome measures are to be employed by ATAPS service providers and reported on in the Minimum Data Set for all clients where clinically possible and appropriate. These should comprise of outcome measures listed in the Minimum Data Set outlined in the *Evaluation of the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care Initiative: Minimum Dataset* at Attachment G.

Client satisfaction surveys are also to be employed. The survey should be provided to all clients on intake, with a stamped addressed envelope to allow anonymous response if required. Electronic or internet options for client satisfaction surveys may also be made available. A sample client satisfaction survey is to be provided to the Department with the Annual Plan and Budget. In addition, Divisions and Medicare Locals will be required to provide a summary of responses to client satisfaction surveys in their regular reports.

While allied health professionals may use any outcome measure that they are experienced in using, the Department encourages the use of the following most commonly used outcome measures to enable comparison of client outcomes:

- Beck Anxiety Inventory (BAI);
- Behaviour and Symptom Identification Scale 32 (BASIS-32);
- Beck Depression Inventory (BDI);
- Depression Anxiety Stress Scales (DASS);
- Global Assessment of Functioning (GAF);
- General Well-Being Index (GWBI);
- Hospital Anxiety and Depression Scale (HADS);
- Health of the Nation Outcome Scales (HoNOS);
- Edinburgh Postnatal Depression Scale (EPDS);
- Modified Scale for Suicidal Ideation (MSSI); and
- Kessler 10 (K-10).

2.3.6 Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access)

Individuals who access treatment through Better Access are not eligible to receive individual or group services under ATAPS within the same calendar year (refer to Section 2.2).

2.3.7 Aged Care Facilities

ATAPS services are available for eligible clients living in the community.

It is recognised that residents of aged care facilities experience mental illness and it is important that services be available to support them. People living in an aged care facility where the facility is funded by the Australian Government, or an aged care facility where the resident is an Australian Government funded resident, are not eligible for ATAPS services. For residents of aged care facilities, GPs are able to contribute to care plans using the Enhanced Primary Care (EPC) Chronic Disease Management (CDM) Medicare item 731.

Under the CDM Medicare items, the resident's GP can contribute to the care plan prepared by the facility and the resident is eligible for referral to allied health and dental care services, including referral for services by psychologists, mental health workers and occupational therapists. If a resident of an aged care facility is a private in-patient being discharged from hospital the resident may be eligible for a 'discharge' GP *Mental Health Treatment Plan*, if clinically appropriate.

However, a person who is a privately funded resident of an aged care facility (that is, the facility is not receiving a subsidy for their care from the Australian Government under the *Aged Care Act 1997*) is eligible for ATAPS services, provided that a *Mental Health Treatment Plan* has been prepared.[2]

2.4 Who can Deliver Services?

Allied health professionals (including psychologists, and appropriately trained nurses, occupational therapists, social workers and Aboriginal and Torres Strait Islander health workers who meet the standards outlined in the *Purchasing Guidance for the Access to Allied Health Services Projects* in Attachment D) are eligible to provide services for Tier 1 and Tier 2 ATAPS.

Divisions and Medicare Locals planning to use Aboriginal and Torres Strait Islander health workers to provide services to Aboriginal and Torres Strait Islander people should liaise with Aboriginal and Torres Strait Islander primary mental health care services to ensure that the proposed workers are appropriately skilled. Divisions and Medicare Locals should also ensure that, where relevant, the Aboriginal and Torres Strait Islander primary mental health care service has agreed to the participation of these workers.

It should be noted that the Australian Health Practitioner Regulation Agency (AHPRA) is planning to incorporate Aboriginal and Torres Strait Islander Health Practitioners (ATSI Health Practitioner) as one of its registered practitioners, with requirements to be phased in from 1 July 2012. Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care (Practice) qualification is being considered as a potential appropriate level qualification for registration as an Aboriginal and Torres Strait Islander health practitioner. Subject to the outcome of the AHPRA deliberations regarding Aboriginal and Torres Strait Islander Health Practitioners, the Department may review the Aboriginal health worker qualifications required to deliver ATAPS services to be consistent with the AHPRA requirements.

Special mandatory training requirements must be met for the ATAPS Suicide Prevention Service. See Attachment F. Special training requirements will apply for the provision of child mental health services and these will be provided as part of the child mental health operational guidelines.

2.4.1 Allied Health professionals: qualifications and standards

To ensure a high quality standard of service delivery, allied health professionals who are to deliver ATAPS Tier 1 and Tier 2 services must:

- be credentialled in the field of mental health, or (to allow for entry of newly trained persons into the field of mental health) under the approved and direct professional supervision of a fully qualified and accredited professional expert in that field who meets the ATAPS criteria; and
- meet the required qualifications and standards to provide the specified therapies including continuing professional development requirements.

Provisionally registered allied health professionals are not eligible to provide suicide prevention services, services for children and services for people with a severe mental illness[3].

The definition/requirements of direct professional supervision will vary for each allied health profession, and Divisions/Medicare Locals should contact the relevant peak body or registration body for specific details.

[2] To establish if a client is a Commonwealth-funded resident of an aged care facility, the GP or practice staff should ask the client and, if unsure, ask the aged care facility whether the client is a privately funded resident. The advice of the client and/or aged care facility should be accepted and a note made in the client record indicating by whom and when the advice was provided.

[3] For a person with a severe mental illness to access ATAPS services, their condition must be one that will respond to short term psychological treatment (as part of their overall treatment plan).

Attachment D *Part B* provides detail of the qualifications and standards required for allied health professionals to provide ATAPS.

Divisions and Medicare Locals must have appropriate quality assurance processes in selecting and monitoring clinicians, including the use of credentialling and mandatory continuing professional development (CPD) in line with the standards of the relevant profession. These requirements apply immediately to allied health professionals being engaged from 1 January 2012. Where allied health professionals have been engaged as providers prior to 1 January 2012, a six month period to 30 June 2012 is allowed for them to meet the continuing professional development requirements. These requirements are in line with those introduced for the Better Access initiative.

What the new CPD requirements will involve
Recognising that allied mental health professionals provide a range of psychological services, and that not all the services they provide are related to focussed psychological strategies, as a minimum the new mental health CPD requirements will include 10 hours of focussed psychological strategies CPD activities per year. The cycle would run annually from 1 July to 30 June.

Focussed psychological strategies CPD requirements count from the time the provider is engaged to provide services under ATAPS. Part-time providers are required to have 10 hours of focussed psychological strategies related CPD, the same as full-time providers.

For providers who are engaged as ATAPS service providers during the course of the CPD year, their obligation to undertake CPD will be on a pro rata basis. The number of units will be calculated from the 1st of the month immediately succeeding the month they were engaged by the Division/Medicare Local. The obligation is 1/12 of the yearly requirement for each month.

Type of activities covered under the CPD requirements
The CPD only covers training for delivering evidence based therapies as outlined in Attachment D.

In addition to CPD activities to enable delivery of the focussed psychological strategies treatments listed in Attachment D, it is important that practitioners have the required skills to undertake a full assessment of a patient in order to form a diagnosis and commence treatment planning. Therefore, CPD in these clinical skills will also count towards the minimum CPD requirements. Relevant training in psychopathology of these disorders also counts towards CPD requirements.

CPD activities must be relevant to delivering ATAPS focussed psychological strategies services and must be able to be justified. Acceptable CPD activities where the content is related to focussed psychological strategies can include formal postgraduate education, workshops, seminars, lectures, journal reading and assessment/analysis, writing papers, receipt of supervision and peer consultation, and online training programs.

There is flexibility in the CPD activities that can be undertaken to meet individual professional needs and their practice/client base and client needs. For example, activities may also include assessment and treatment of specific disorders and client types such as youth, or different modalities and delivery such as working with groups.

Divisions and Medicare Locals are to provide the Department with de-identified details of the number of allied health professionals, their qualifications and credentials and that evidence of continuing professional development has been obtained as per requirements of the relevant professions.

2.4.2 Models for Engagement of Providers

Divisions and Medicare Locals may use several models for the engagement of providers:

- allied health professionals may be directly employed by the Division or Medicare Local;

- allied health professionals can deliver services to clients referred directly by GPs. The Division or Medicare Local and the allied health professional should agree on the process prior to services being provided. For example, services could be provided on a sessional basis, or a referral and claim system; or
- allied health professionals may be subcontracted through another agency. If this option is selected, then a supporting letter from the agency is required stating that the service being provided is additional to that normally provided, that the allied health professionals will only use focussed psychological strategies treatments as outlined in Attachment D and the services will be provided in accordance with the ATAPS operational guidelines.

The need to provide professional support to allied health professionals is likely to depend on whether the allied health professional is directly employed by the Division or Medicare Local or is a private provider and hence responsible for managing their own professional support arrangements. All providers are required to conform to the ATAPS Guidelines. The Clinical Governance Framework developed for Medicare Locals will provide guidance on this matter.

Divisions and Medical Locals should (where such options exist) use a range of allied health providers to ensure that patients can receive services appropriate to their requirements. Divisions and Medicare Locals can find details of local credentialled allied health providers through the professional associations' websites specified in Attachment D.

2.4.3 Subcontracting

Divisions and Medicare Locals may wish to subcontract with other agencies within their jurisdictions for the delivery of allied health services, particularly where the Division and/or Medicare Local is seeking to innovatively meet the needs of priority target groups. For example, a Division or Medicare Local may wish to provide some funding to a non-government organisation (NGO) to provide services to a population of homeless people, or to an Aboriginal Medical Service (AMS) to provide services to a community of Aboriginal and Torres Strait Islander people. The Department will consider such proposals on a case by case basis and will assist Divisions and Medicare Locals with the requirement under the Funding Agreement.

The Department will expect that all providers under subcontracting arrangements will conform to the ATAPS Operational Guidelines and relevant Funding Agreements.

Divisions and Medicare Locals should be aware that they remain responsible to the Australian Government for the services provided under subcontracting arrangements.

The Department must approve any subcontracting of services. Refer to the current Funding Agreement for more detailed information.

2.5 Complaints Mechanism

Every Division or Medicare Local is required to put in place a complaints mechanism for people who are provided with services under ATAPS in accordance with section 1.16 of the National Standards for Mental Health Services. This mechanism must be documented in a plain English brochure and, as appropriate, in other languages. All people who are provided with services under ATAPS are to be provided with a copy of the complaints mechanism brochure. The Division/Medicare Local must provide a copy of this brochure to the Department with its Annual Plan and Budget.

A mechanism for complaints by service providers is also required. This must also be provided to the Department with the Annual Plan and Budget.

2.6 Co-payments

Every Division or Medicare Local is required to approve and monitor co-payments that may be put in place ensuring that a key objective of ATAPS, which is to provide low cost focussed psychological strategies services to individuals, is met. Where a co-payment is charged they should be minimal, must be less than $30 and based on an individual's capacity to pay.

2.7 Crisis Support Mechanism

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

A copy of the crisis support mechanism is to be provided to the Department with the Annual Plan and Budget.

2.8 Videoconferencing and Telephone-based Cognitive Behaviour Therapy (T-CBT)

Divisions and Medicare Locals are encouraged to utilise videoconferencing and T-CBT where face to face intervention is difficult or not preferred by a referred individual. Divisions and Medicare Locals must note:

- videoconferencing and T-CBT are to be conducted in accordance with existing ATAPS Operational Guidelines;
- allied health professionals must have undertaken specific training in Cognitive Behaviour Therapy (CBT) and be competent in the delivery of these therapeutic techniques when treating people with mental disorders via video conferencing or telephone (refer to Attachment H for further detail);
- no additional funds will be provided to Divisions and Medicare Locals using videoconferencing or T-CBT as a mode of service delivery;
- videoconferencing is only to be used by Divisions and Medicare Locals where IT infrastructure is already in place; and
- consent must be obtained from clients by signing a form.

Allied health professionals are required to identify when videoconferencing and/or T-CBT is used as a mode of service delivery through the standard ATAPS six month reports and/or the minimum dataset.

2.9 Utilisation of web-based therapy

The Mental Health - *Telephone Counselling, Self Help and Web-Based Support Programs* measure particularly benefits people in rural and remote areas who face barriers in accessing face-to-face services. Activities under this measure to date have included funding for general psychosocial telephone helplines, online counselling, online self help and peer support resources and self directed online treatment modules.

There is sound evidence supporting online therapies for people with anxiety and depression, both nationally and internationally.

These services, in the majority of cases, do not require a referral and clients can access them in their own time and in the privacy of their own home. The programs have built in screening and/or triage

capability and provide clear information for practitioners and clients alike as to who will benefit most from the programs and those for whom the program is not suitable.

The available online treatment programs are mainly self guided and can be accessed by people while they wait for face to face appointment(s), as a follow up to face to face, or instead of, depending on the individual's needs and circumstances. There is also capacity for mental health practitioners to be actively involved with clients as they complete online therapies, should this be desirable or considered necessary, however it is not mandatory.

Each service must provide comprehensive information and guidelines about the programs/services available for practitioners and clients. Further information can be found in Attachment I.

3. Funding and Contractual Requirements

3.1 Divisions of General Practice and Medicare Locals

Medicare Locals as they are established will progressively take on the fundholding role for ATAPS that is currently being undertaken by Divisions. Divisions and Medicare Locals have certain obligations under their Funding Agreements with the Department. These include:

1. The Department must be notified in writing at the earliest opportunity when Divisions and Medicare Locals have a change of legal status, particularly when they:
   - amalgamate or incorporate;
   - are amalgamated or incorporated and then separate; or
   - have any other change of legal entity.

   The Department may need to prepare new Funding Agreements, or appropriate Variations to existing Funding Agreements, as the Department can only enter into contractual arrangements with legal entities.

2. Where Divisions or Medicare Locals are working jointly, they must notify the Department in writing which one is the primary or fund-holding Division/Medicare Local.

3.2 Medicare Locals

Medicare Locals are being established as locally based organisations responsible for ensuring local primary care services work as a coordinated system to meet the health needs of their local community. Medicare Locals will work closely with the full range of primary health care service providers in their region – whether funded by the Commonwealth or by states – and with Local Hospital Networks to provide better coordinated and integrated services to their local community. Medicare Locals will be required to work in partnership with Aboriginal and Torres Strait Islander organisations to deliver culturally appropriate mental health services.

Medicare Locals will be expected to engage with the full range of primary health care providers in their community, such as general practitioners, allied health professionals and other professional groups such as pharmacists and physicians.

It is envisaged that as Medicare Locals come on line and demonstrate capacity to provide ATAPS services, the funding and management of service provision for ATAPS will smoothly transfer to Medicare Locals with minimal or no disruption to clients and services.

3.3 The ATAPS Funding Model

The model for the funding of ATAPS was developed as an outcome of a review of ATAPS which was finalised in March 2010. The objectives of the approach are to:

- Promote innovative models of care for particularly vulnerable groups;
- Improve efficiency through an incentive for achieving activity targets; and
- Target future ATAPS funding to ensure it better complements Medicare funded mental health services.

To achieve these objectives a two tiered approach has been implemented with changes phased in to allow time for Divisions or Medicare Locals to adapt and to prevent disruption to service provision.

To ensure a more equitable distribution of ATAPS funding across the country, a new funding distribution formula was introduced in 2011-12 which is based on population size weighted for socioeconomic disadvantage, rurality and relative access to Medicare subsidised mental health services.

Tier 1 ***Core Funding*** **-** In 2011-12, all Divisions have received ATAPS core funding at least at the levels of 2010-11, excluding special purpose funding. Tier 1 funding will be subject to the phased introduction of efficiency targets. Efficiency targets should be challenging, but achievable and fair. The Department also recognises that there are Divisions that are already operating very efficiently and that the potential to further increase efficiency may be minimal for them.

The Department will be moving towards activity based funding, with a national average target, and flexibility to allow for local factors. This is consistent with the direction of health reform in the primary care sector and will assist in the move to Medicare Locals. Further information on the targets will be provided during the 2011-12 financial year.

Tier 2 ***Special Purpose Funding*** **–** As detailed in the 2011-12 funding agreement, Tier 2 funding enables targeting of hard to reach groups such as women with perinatal depression, individuals who have recently attempted suicide or self-harm or are at risk of suicide, people who are experiencing or are at risk of homelessness, individuals impacted by the extreme climatic events such as the 2009 Victorian bushfires, 2011 Queensland floods and cyclones who have a diagnosis of mental illness, people in remote locations, Aboriginal and Torres Strait Islander people, children with mental disorders and behavioural problems and people with a severe mental illness.

In 2011-12 people who have attempted or are at risk of suicide or self harm are a mandatory target group. It is also mandatory to provide services to women with perinatal depression. However, where perinatal depression services are provided locally by state based or funded services and there is no demand for additional perinatal depression services, the funding intended to provide perinatal depression services can be redirected to another identified priority group needs area.

Where there is insufficient demand locally for perinatal depression services to be provided under Tier 2 funding, women may be treated under Tier 1 where appropriate.

3.4 Voucher Systems

Voucher systems have been used by a number of Divisions and their use may continue under certain conditions. The usual practice is for the vouchers to be provided to GPs. GPs then provide the vouchers to their patients to present to the agreed ATAPS allied health professional. The allied health professional redeems the value of the voucher from the Division or Medicare Local as payment for the provision of ATAPS services. This relies on a contractual relationship between the Division/Medicare Locals and agreed ATAPS allied health providers. Other voucher systems also exist.

Where voucher systems are used, a Division or Medicare Local is expected to closely monitor the use of the vouchers and to provide the Department with an annual audit of the vouchers. In particular, vouchers need to be managed in accordance with an approved demand management strategy (refer to

page 8) to ensure consistency in the availability of ATAPS services throughout the year, and a system must be in place to assess each referral to ascertain its appropriateness (refer to pages 7 and 8).

Divisions utilising voucher systems have reported to the Department difficulties caused by the voucher systems, including managing demand for ATAPS services and an additional burden in their administration. Divisions and Medicare Locals may wish to carefully consider whether to use the voucher systems.

3.5 Contractual Requirements and Financial Accountability

Funding provided for ATAPS is to support allied mental health professionals to provide quality primary mental health care with the aim of improving mental health outcomes for consumers.

An allied health professional who is receiving a salary from a Division or Medicare Local to provide ATAPS services may not bill the MBS for services provided under ATAPS.

Allied health professionals may provide services under more than one program (e.g. services under ATAPS for one or more days a week, services under Better Access for one or more days, or private practice for one or more days) provided that the services are correctly attributed to each program. Divisions and Medicare Locals must clearly delineate between ATAPS funds (and their use) and funds received from any other source.

ATAPS funding may only be used to deliver ATAPS services. ATAPS funds may not be used to pay for services under programs such as Better Access, or to "top up" services under other programs. ATAPS funding may not be used for an occasion of clinical service if:

- the service provider also receives funding for the same clinical service from another source (other than patient co-payment); or
- if the service provider was receiving a salary for clinical service work from a source other than ATAPS, and the service was provided during their salaried hours of work.

ATAPS funding must be clearly reported to the Department in the financial statements and reports submitted by Divisions and Medicare Locals.

Financial Management Practice
Divisions and Medicare Locals are to record financial transactions and prepare financial statements using Australian Accounting Standards.

Committed funds means ATAPS funds that at a particular date, can be identified as amounts that the Division or Medicare Local is contractually obliged to pay in respect of the activities for which those funds were provided. **'Committed'** at a particular date means Funds that the Participant is contractually obliged to pay to a third party in respect of any part of the activities making up the Project or the Final Report and that can be identified in a written contractual arrangement with that third party. Examples include outstanding amounts on a contract with an allied health professional, or invoices received for service delivery which have not yet been paid.

Where services are not yet allocated to an individual, or where a Division or Medicare Local is using a voucher system, vouchers that are not attached to an individual (i.e. which have been allocated to a GP, but not yet dispensed) are considered as uncommitted funds, unspent or unexpended funds. Where an individual has commenced a course of treatment or where vouchers have been attached to an individual, the funds are considered as committed. In general, it is recommended that these funds are committed for no more than a three month period.

Unspent funds (also referred to as profits, debt, surplus, underspend or uncommitted funds), may accrue if approved budget items were not met, under-expended or if the project generated more

revenue than anticipated. **'Unspent'** at a particular date means Funds that have not been spent or committed by the Participant. Divisions and Medicare Locals should identify at the point of each progress report whether they have unspent funds.

The Department may, at any time, withhold payments or ask a Division or Medicare Local to relinquish funds if a project is running at a significant underspend as described in clause 3 of the funding agreement. In certain circumstances, the Department will process payments if it is satisfied that the Division or Medicare Local will effectively use those moneys. If a potential underspend is identified, Divisions or Medicare Locals should contact the Department as early as possible.

Divisions or Medicare Locals which have unspent funds at the end of a financial year and would like the funding rolled over into the next financial year will be required to submit a short business case to the Department for approval outlining how this funding will be utilised. Please contact the Department to obtain the current pro forma.

Throughout the financial year, payments are subject to Divisions or Medicare Locals reporting about their progress, as well as the ongoing conditions of the Funding Agreement. Extensions may be made to reports, but these need to be negotiated with the Department in advance of the due date.

Administration Costs
Administration costs may include:

- project officer hours for ongoing management of the project and its contractual reporting arrangements;
- travel costs for the project officer;
- costs supporting an allied health provider who is an employee of a Division or Medicare Local to attend training (but not the costs of purchasing the training);
- postage, photocopying, printing;
- office facilities;
- advertising costs of program;
- insurance;
- staff recruitment; and
- project officer's mobile phone charges.

Costs related to referral, intake, assessment or making appointments for individuals to access ATAPS services are not considered to be administration costs.

Service Delivery Costs
Service delivery costs are for the delivery of clinical services to referred mental health clients. These may include:

- costs related to referral of or making appointments for individuals to allied health professionals, including an appointment reminder system;
- costs related to assessment and triage;
- resources for allied health professionals;
- payments to allied health professionals;
- reasonable travel costs for allied health professionals to locations of service provision (and overnight accommodation costs where necessary);
- costs related to renting a location for allied health service provision (eg a room in a GP surgery or a community health centre);
- supervision of intern/provisional providers;
- ongoing professional development for ATAPS providers where they are engaged directly by Divisions or Medicare Locals;
- clinical supervision of allied health providers directly employed by Divisions or Medicare Locals;

- use of interpreter services;
- promotion and prevention activities; and
- development of linkages and referral pathways.

3.5.1 Budget Allocation
The Department expects Divisions and Medicare Locals to keep within the allocated budget split of 85% of total funds provided for service provision and 15% for administration costs, unless the Division or Medicare Local has received approval from the Department for a different split. Administration costs are intended to cover overheads and contract management tasks only. In general, initial higher administration costs will only be supported in conjunction with innovative projects. Divisions and Medicare Locals are to ensure that administration is cost-effective. The Department acknowledges that innovative programs and targeting of hard to reach groups may involve higher administration costs, and will take this into account, particularly in relation to Tier 2 funding.

3.5.2 Training Costs
Divisions and Medicare Locals must not utilise funding received under ATAPS to fund GP training costs.

The ATAPS program has always been linked to education and training initiatives designed to support GPs in the diagnosis and referral of patients to Better Access or ATAPS. Previously the Better Outcomes in Mental Health program supported educational activities. Since its introduction in November 2006, the Better Access program has offered education and training infrastructure and training for GPs. This supports GPs to refer those patients to ATAPS who would clinically benefit from the intervention, and referral is based on their clinical judgement, and is at their discretion, as long as the patient has a diagnosis of mental illness.

Where an allied health provider is employed directly by a Division or Medicare Local, a portion of the administrative component of ATAPS funding may be used to support them to attend training, but may not be used to purchase training. ATAPS funding is not to be used to provide training for allied health providers who are sub contracted or are paid on a fee for service basis.

4. ATAPS Evaluation

Divisions and Medicare Locals are required to participate in the ATAPS evaluation through the Minimum Dataset (MDS – see below) and ad hoc surveys and interviews.

The University of Melbourne's Centre for Health Policy, Programs and Economics (UoM) conducts the ongoing evaluation of ATAPS. To conduct the evaluation, UoM has synthesised data from (a) the minimum dataset; (b) interviews and surveys with project officers and providers, and (c) ATAPs local evaluation reports.

4.1 Minimum Dataset
The MDS comprises person-based fields and session-based fields, and has provided invaluable information on the level of uptake of the projects (by GPs, allied health professionals and consumers), the profile of consumers who are accessing services through the projects, and the extent and nature of services that consumers are receiving through the projects.

In addition, a series of outcome measure fields have been added to the minimum dataset, which allows the evaluation to explore the effectiveness and efficiency of the projects in improving the mental health of consumers.

The MDS also accommodates additional activities being implemented through ATAPS, including the ATAPS component of the National Perinatal Depression initiative, and the responses to extreme

climatic events such as the 2009 Victorian bushfires as well as new measures as they are being implemented such as the new children's and suicide prevention measures.

Divisions and Medicare Locals are required to collect data in line with the requirements of the MDS which feeds into the national evaluation of the Program. Divisions and Medicare Locals are issued with a username and password. GPs and allied health professionals can use the username and password provided to the Division or Medicare Local and enter the data themselves. The person entering the data does not have to be the GP; the allied health professional may also enter data.

It is important that data be entered promptly into the MDS, as this will impact on each Division's or Medicare Local's targets set for service delivery and evaluation of progress towards performance targets which will be introduced in 2012-13. The Department reviews data on a regular basis.

Divisions and Medicare Locals should refer to the document on the Minimum Dataset *"Evaluation of the Access to Allied Health Services initiative: Minimum Dataset"* (Attachment G).

5. Access to Psychiatrist Support (GP Psych Support) Service

The Access to Psychiatrist Support (GP Psych Support) Service provides GPs with access to patient management advice from psychiatrists within 24 hours. To access this service GPs can:

Telephone: 1800 200 588. GPs will be asked some brief questions concerning the enquiry and a psychiatrist will return the call within 24 hours (48 hours in the case of children – refer to www.psychsupport.com.au).

Fax: 1800 012 422. Using the **faxback form**, provide details regarding the issue for discussion. A psychiatrist will then fax or phone the GP to discuss case details.

Email: www.psychsupport.com.au is a secure and password protected website. GPs can log in and submit questions online. For username and password, call 1800 200 588.

Glossary of Terms

Allied Health

For the purpose of this Program, the definition of allied health includes the professions of psychology, mental health nursing, occupational therapy, social work and Aboriginal and Torres Strait Islander health workers.

Web based therapy

Successful models for web based therapy have been developed in the UK which provide cognitive behavioural therapy to clients at their GP surgery. In the UK program the GP recommends the treatment and the trained practice nurse supervises the computer based therapy sessions and provides feedback to the GP. An Australian computer based program would be supported for use under this Program.

Divisions and Medicare Locals should seek approval from the Department to introduce computer based therapy sessions prior to introducing this service model.

Crisis management

The only crisis intervention for which allied health services can be purchased is crisis intervention which can be addressed by the approved focussed psychological strategies. Allied health services cannot be purchased for crisis intervention that falls into the category of Emergency Management (see below). Therefore, Divisions and Medicare Locals need to have in place a strategy for managing and referring people to Emergency Management.

Emergency management

Is the need for immediate care where there is a significant risk of harm to the health and/or safety of self and/or others.

Focussed psychological strategies

Focussed psychological strategies to an individual and/or focussed psychological strategies to a group.

The definition of 'focussed psychological strategies' for the *Better Outcomes in Mental Health Care Program* refers to the provision of time-limited, evidence-based psychological treatments which are restricted to the following therapies:

- **Psycho-education**

(including motivational interviewing)

- **Cognitive-behavioural therapeutic strategies including:**

- **Behavioural interventions**
  - Behaviour modification
  - Exposure techniques
  - Activity scheduling

- **Cognitive interventions**
  - Cognitive therapy

- **Relaxation strategies**
  - Progressive muscle relaxation
  - Controlled breathing

- **Skills training**
  - Problem solving skills and training
  - Anger management
  - Social skills training
  - Communication training
  - Stress management
  - Parent management training

- **Interpersonal Therapeutic Strategies** (especially for depression)

- **Narrative Therapeutic Strategy**
  - Emphasises the changes that can be brought about in people's lives through particular tellings and retellings of the stories of their life, understanding these stories and re-authoring them in collaboration between the clinician and the client. This is a particularly useful and beneficial strategy for Aboriginal and Torres Strait Islander populations.

Mental disorder

A mental disorder may be defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder – this definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD - 10 Chapter V Primary Health Care Version.

Mental illness has been defined as: 'a mental disorder' (see above)

DEFINITION OF MENTAL ILLNESS FOR THE *BETTER OUTCOMES IN MENTAL HEALTH CARE PROGRAM*

A mental disorder may be defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder – this definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD - 10 Chapter V Primary Health Care Version.

These disorders include:

- Alcohol use disorders
- Chronic psychotic disorders
- Bipolar disorder
- Phobic disorders
- Generalised anxiety
- Adjustment disorder
- Unexplained somatic complaints
- Eating disorders
- Sexual disorders
- Conduct disorder
- Bereavement disorders
- Drug use disorders
- Acute psychotic disorders
- Depression
- Panic disorder
- Mixed anxiety and depression
- Dissociative (conversion) disorder
- Neurasthenia
- Sleep problems
- Hyperkinetic (attention deficit) disorder
- Enuresis
- Mental disorder, not otherwise specified

In case of children, additional disorders will be outlined in the child mental health operational guidelines.

Dementia, delirium, tobacco use disorder and mental disability disorders are excluded. Persons with these conditions are **not eligible** to receive sessions under ATAPS. However, if a person has dementia, delirium, tobacco use disorder or mental disability and **also has** a mental disorder, that person **is eligible** to receive sessions under ATAPS.

ATAPS Tier 1 is restricted to supporting the management of common mental disorders of mild to moderate severity. The ATAPS support and treatment of people at risk of suicide and self harm is an exception to this restriction. People with severe mental disorders which would not benefit from short term psychological strategies services, such as acute psychotic disorders, severe eating disorders, or severe bipolar disorder, are to be referred to the appropriate mental health services.

TIER 2 FUNDING

Tier 2 funding may be used flexibly to provide psychological services to the following priority groups under service arrangements specified in the table. It is noted that many of these groups could be among those traditionally targeted through ATAPS. Tier 2 funding raises the capacity to address the needs of these groups, and provides an increased level of flexibility in provision of psychological services.

Tier 2 Priority Group	**Type of Service (including any flexibilities)**
Women with perinatal depression (MANDATORY with exceptions – refer to page 18)	Focussed psychological services, group sessions, liaison with child/maternal nurses regarding referral pathways, family therapy, telephone and web based services.
Individuals who have attempted suicide or self harm or who are identified as being at high risk of suicide (MANDATORY)	Focussed psychological services, care coordination, proactive follow up, liaison with local emergency departments, links with acute mental health team to support clients in crisis and education and clinical support. Service provision may exceed normal number of ATAPS services for a period of up to two months. Referral to an ATAPS provider can originate from a GP, emergency department or hospital ward, or from a mental health crisis service. More information on the ATAPS Suicide Prevention Service can be found at Attachment F.
People who are experiencing, or are at high risk of, homelessness	Outreach services (including 'mobile clinics'), provisional referrals to ATAPS before GP assessment, focussed psychological services, liaison with local NGOs supporting homeless individuals.
People in remote locations	Outreach services, focussed psychological services, telephone and web based services. Geographical remoteness classifications are used by the Department to assign a level of remoteness to an area which reflects that area's access to general services. The assessment of remoteness is used by programs to determine eligibility and funding, and for reporting. The Department uses the Australian Standard Geographic Classification – Remoteness Areas (ASGCRA) to assess remoteness. For the purposes of ATAPS eligibile remote locations fall under RA4 and RA5. To ascertain an area's classification, visit www.doctorconnect.gov.au. Separate operational guidelines will be provided for general and suicide prevention Aboriginal and Torres Strait Islander mental health services.
Aboriginal and Torres Strait Islander People	Innovative and culturally appropriate service provision. There is flexibility for Divisions and Medicare Locals to negotiate with the Department to deliver ATAPS services to Aboriginal and Torres Strait Island people under Tier 2 in non rural and remote areas, where there is a need for non-standard referral pathways, for example, via collaboration with Aboriginal Medical Services.
Children with mental disorders and behavioral	For the purposes of ATAPS, children are defined as being 11 years of age or under (or up to and including 15 years of age in exceptional circumstances where clinically needed and appropriate).

problems (MANDATORY)	Pre-adolescent children with mental health problems require special psychological treatment options. The most common treatment option available is cognitive behavioral therapy (CBT) which, in its standard form, requires a level of cognitive development which is generally not achieved until adolescence. For pre-adolescent children, CBT needs to be specially modified and other psychological therapies are required for common childhood mental health problems such as Attention Deficit Hyperactivity Disorder, conduct disorder, oppositional defiant disorder, anxiety and depression. In general these therapies can also be provided through normal (Tier 1) ATAPS arrangements. However, appropriate psychological treatment options for pre-adolescent children sometimes involves therapies which involve the whole family, or which in other ways do not fit the parameters of focussed psychological strategies funded under ATAPS or Medicare. This may include family based therapies such as behavioral therapy, and parent training in behavior management, which entail working closely with parents and families. ATAPS providers are able to provide these supports under Tier 2. It is acknowledged that as these treatment options are not generally part of the standard training of allied mental health service providers, additional training and/or clinical support may be required to enable these providers to appropriately treat these children to achieve better mental health outcomes. ATAPS does not fund allied health service providers to undertake such training. *Involvement of parents, guardians or other family members in treatment* Divisions and Medicare Locals should also consider the involvement of parents, guardians or other family members when treating a child where this involvement is appropriate. Parents, guardians or other family members may attend treatment sessions where the individual is a child (and where the child is the person with a Mental Health Treatment Plan) as long as: • the allied health professional is comfortable with more than one person being in the room; • this is not detrimental to treatment of the client; and • the primary focus of the session is treatment of the child. It is expected that the child will be present for these sessions, except in those circumstances where it is not clinically appropriate. The Department requires 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 in a calendar year. 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 client services in a calendar year. If parents of a child client require more sessions they should be considered as separate clients and referred to Tier 1 ATAPS. Separate child mental health operational guidelines will be provided. A purchasing guidance will be provided to Medicare Locals to assist them to establish this service.

In providing the above services to the above special needs groups it is recognised that Divisions and Medicare Locals may need to use ATAPS funding for outreach and liaison, including establishing referral pathways for hard to reach groups. This might include for instance forming linkages with midwives and hospital maternity wards or entering into a sub-contract arrangement with an Indigenous organisation to offer services.

Other groups which may be treated under ATAPS
The following groups may be provided with focussed psychological strategies services under ATAPS.

Group	Type of Service (including any flexibilities)
People with a severe mental illness	A person with a severe mental illness whose condition may benefit from focussed psychological strategies may be provided with ATAPS services. Any intervention provided under ATAPS must form part of an overall intervention utilising linkages and referral pathways. For example, the person's medication needs, social supports and housing needs may form part of an intervention. ATAPS providers should facilitate their referral to another provider or service (eg a mental health nurse, an NGO or a private psychiatrist) to meet the person's needs that are in addition to focussed psychological strategies services. Where a person has a long term (persistent mental illness) ATAPS may not be able to meet their needs over time. ATAPS providers are to ensure that, where they can not meet the needs of such people, the people are referred on to appropriate services and that a transition process for their treatment is developed.
People impacted by severe climatic events who have a diagnosis of mental illness[§]	Service provision may exceed normal number of ATAPS services for individuals who have been diagnosed as experiencing severe and persisting symptoms resulting from trauma or loss. For duty of care reasons, specialist review should take place following prolonged treatment. Diagnosis by a GP of a mental illness is required. Where a person has a provisional referral, the allied health professional providing treatment must work with the Division or Medicare Local to have a GP develop a *Mental Health Treatment Plan*, preferably within two weeks of the first session, or four weeks in a remote area or as soon as practical where access to GPs is not readily available. Where a person who has been referred to ATAPS is not eligible for ATAPS services or ATAPS is not clinically appropriate for them, they should be referred to another service appropriate for their needs.

Web-based support for Cognitive Behavioural Therapy

Tier 2 funding can also be used to purchase or provide telephone and web based psychological services and support for people with mental illness who are unable or unwilling to access face to face services, particularly in rural areas. However, the total number of services provided to an individual including web based support are not to exceed the total number of allowed ATAPS services.

[§] Applicable only to those Divisions of General Practice or Medicare Locals participating in the Australian Government Mental Health Response to the 2009 Victorian Bushfires or the 2011 response to the floods and cyclone Yasi, or other mental health response authorised by the Australian Government.

PURCHASING GUIDANCE FOR THE ACCESS TO ALLIED PSYCHOLOGICAL SERVICES PROJECTS

Introduction

Allied health services to be purchased under the *Better Outcomes in Mental Health Care Program* are to be restricted to the provision of focussed psychological strategies.

A. Services to be purchased

Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies.

Following are specific focussed psychological strategies shown to be evidence-based for a number of psychological disorders, as listed in the Medical Benefits Schedule Note M7.1 as at 27 April 2011 (http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Downloads-201101):

1. Psycho-education
(including motivational interviewing)

2. Cognitive-behavioural therapeutic strategies including:

- **Behavioural interventions**
  - Behaviour modification
  - Exposure techniques
  - Activity scheduling
- **Cognitive interventions**
  - Cognitive therapy

3 Relaxation strategies
- Progressive muscle relaxation
- Controlled breathing

4 Skills training
- Problem solving skills and training
- Anger management
- Social skills training
- Communication training
- Stress management
- Parent management training

5. Interpersonal Therapeutic Strategies (especially for depression)

6. Narrative Therapeutic Strategy
- Emphasises the changes that can be brought about in people's lives through particular tellings and retellings of the stories of their life, understanding these stories and re-authoring them in collaboration between the clinician and the client. This is a particularly useful and beneficial strategy for Aboriginal and Torres Strait Islander populations.

It is clear from the recommended list of evidence-based, focussed psychological interventions that all allied health professionals to be credentialled under the Program must have undertaken rigorous

training and be competent in the delivery of these therapeutic techniques when treating people with mental disorders.

More information on evidence-based therapies appropriate for various conditions can be found in *Evidence-based Psychological Interventions in the Treatment of Mental Disorders: A Literature Review, 3rd Ed*, which is available through the various allied health professional organisations.

B. Skills required to deliver services

To competently provide services under the Program, the allied health professionals must have appropriate:

(i) Knowledge (including the theory underpinning evidence-based interventions, and research into their effectiveness);

(ii) Skills (in delivering best practice, evidence-based, effective interventions); and

(iii) Experience in assessing and treating clients with the range of mental health problems to be targeted.

These criteria could be met through the provider's educational qualifications, plus clinical supervision by relevantly qualified and experienced professionals, continuing professional development and documented experience.

It is important that all services under the Program are high quality, evidence-based, best practice and shown to be effective for the treatment of the mental health problems included under the Program. For Social Workers this can be confirmed by the requirement of accredited Mental Health Social Worker current certification.

A framework for assessing the competencies of allied health professionals able to deliver the Program services is provided.

Level of Service	**Knowledge and Skills**		**Experience**
Focussed Psychological Interventions	Psychopathology – diagnostic criteria and assessment	6 months (13 x 2hr sessions) training in assessment and diagnostic skills	6 months experience in assessment and diagnosis of clients with a wide range of mental health problems (under supervision)
	Counselling theory and practice	6 months (13 x 2 hr sessions) training in counselling	6 months practice in counselling under supervision 12 months practice in implementation of basic evidence-based interventions under supervision
	Evidence based, effective, interventions for specific mental health problems – theoretical basis of treatment and skills involved	12 months 26 x 2hr sessions) training in specific evidence-based interventions for mental health problems	

C. Allied health professionals who can be used

i. Allied health professionals to be employed to deliver mental health services under the *Better Outcomes in Mental Health Care Program* are: appropriately trained occupational therapists, social workers, mental health nurses, psychologists, and Aboriginal and Torres Strait Islander health workers.

ii. Consultations with the various professions and subsequent more detailed investigations have shown the basic qualifications of each of the professions: equip the respective professionals as follows with respect to the knowledge and skills for competent delivery of focussed-psychological strategies.

Profession	**Counselling**	**Assessment & Diagnosis**	**CBT**
Occupational Therapy	In many OT courses	In many OT degrees	At a basic level in some OT degrees
Social Work	In all social work courses	Assessment in all, diagnosis only in specialist postgraduate courses	In some social work degrees
Mental Health Nursing	In most Postgraduate Diplomas and Masters degrees	In most Postgraduate Diplomas and Masters degrees	At a basic level in most Postgraduate Diplomas and Masters degrees
Psychology	In many Postgraduate Diplomas, and in virtually all Masters and Professional Doctorate degrees in psychology	In virtually all clinical, counselling, forensic, neuropsychology and some other Masters and Professional Doctorate degrees in psychology	In virtually all clinical, health, forensic, educational and developmental, and in some other Masters and professional Doctorate degrees in psychology

iii. To ensure a high quality standard of service delivery, allied health professionals who are to deliver services under the Program should be:

(a) appropriately qualified according to the requirements of their profession;

(b) registered by an appropriate state or national authority to practise (where state or national registration exists), and/or (where the profession does not have registration);

(c) 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;

(d) adequately experienced in the field of mental health, meaning for occupational therapists at least two years' experience working in mental health, or (to allow for entry of newly-trained persons into the field of mental health) under the approved and direct clinical professional supervision of a fully qualified and registered professional expert in that field;

(e) currently or recently engaged in clinical practice in that field or (if otherwise employed, eg. in a university research centre focussed on mental health routinely exercising clinical

knowledge and skills) in a comparable professional area relevant for expert treatment of mental disorders;

(f) continuing involvement in relevant professional development;

(g) available to provide services within an agreed geographic region; and

(h) satisfy all standards outlined in their profession's relevant practice standards or competency standards documents[**].

The individual professionals need to state their relevant qualifications, experience, and professional development undertaken, to be considered for eligibility to deliver services under ATAPS. Social workers (other than new graduates and those with less than 2 years mental health supervised practice) are required to provide current certification as Accredited Mental Health Social Workers.

On 1 July 2010 a single national registration scheme commenced for psychologists in Australia. All practicing psychologists must be registered with the Psychology Board of Australia (PBA). The PBA operates under the *Health Practitioner Regulation National Law Act 2009*, known as the National Law in participating jurisdictions. These functions include overseeing:

- the registration of psychologists;
- the development of profession standards;
- the approval of accreditation standards and accredited courses of study;
- the handling of notifications, complaints, investigations and disciplinary hearings for the profession; and
- the assessment of overseas trained practitioners who wish to practise in Australia.

Information on registration for psychologists can be found at the web site of the Australian Psychological Society at www.psychology.org.au/national-registration/.

On 1 July 2012 a single national registration scheme will commence for occupational therapists in Australia. All practicing occupational therapists must be registered with the Occupational Therapy Board of Australia (the Board). The Board operates under the *Health Practitioner Regulation National Law Act 2009*, known as the National Law in participating jurisdictions. These functions include overseeing:

- the registration of Occupational Therapists;
- the development of profession standards;
- the approval of accreditation standards and accredited courses of study;
- the handling of notifications, complaints, investigations and disciplinary hearings for the profession; and
- the assessment of overseas trained practitioners who wish to practice in Australia.

Information on registration for Occupational Therapists can be found at the web site of the Australian Psychological Society at http://www.ahpra.gov.au/occupational-therapy.aspx

The service delivery component of ATAPS funding may be used for the supervision of intern/provisional providers. This issue is addressed in more detail in Attachment J.

Contact details for the allied health organisations are:

[**] The relevant document for occupational therapists is *Australian Competency Standards for Occupational Therapists in Mental Health (1999)*, published by OT Australia.

Australian Association of Occupational Therapists
Mr Ron Hunt
Chief Executive Officer
Ph: (03) 9415 2900 Fax: (03) 9416 1421
Email: info@ausot.com.au
Website: http://www.ausot.com.au/

Australian Association of Social Workers
Ms Kandie Allen-Kelly
CEO's representative
Ph: (02) 6232 3900 Fax: (02) 6230 4399
Email: CEO@AASW.asn.au
Website: http:///www.aasw.asn.au

Australian College of Mental Health Nurses
Kim Ryan
Executive Officer
Ph: 1300 667 079
Email: enquiries@acmhn.org
Website: http://www.acmhn.org

Mr Peter Santangelo
President
Ph: 1300 667 079
Email: enquiries@acmhn.org
Website: http://www.acmhn.org

Australian Psychological Society Ltd
Professor Lyn Littlefield
Executive Director
Ph.: 1800 333 497 Fax: (03) 9663 6177
Email: contactus@psychology.org.au
Website: http://www.psychology.org.au

D. Proforma for judging skills
Divisions and Medicare Locals could use the following proforma to assess the skill level of allied health professionals.

APPLICATION FOR ALLIED HEALTH PROFESSIONAL TO PROVIDE SERVICES UNDER THE *BETTER OUTCOMES IN MENTAL HEALTH CARE PROGRAM*

REQUIREMENTS	CRITERIA	EVIDENCE OF MEETING CRITERIA
QUALIFICATIONS:		**State qualifications**
Counselling	6 month course (26 hours)	Name course
Assessment and diagnosis	6 month course (26 hours)	Name course
Cognitive-behaviour therapy	12 month course (52 hours)	Name course

Registration		Registration number and body
Member of Professional Association		Association, grade of membership and membership number
Experience working in mental health	2 years minimum Supervised experience	Where Qualification of supervisor
Current position/Type of Clinical Practice	In mental health field	Where Position Range of clients
Status of Professional Development	On-going and relevant PD and/or supervision	List PD undertaken in last 2 years, and/or type of supervision

For social workers (other than new graduates and those with less than 2 years mental health supervised practice) current certification as Accredited Mental Health Social Workers ensures that all these criteria are met.

ATTACHMENT E

PARAMETERS FOR REFERRAL AND REPORTING

Based on the format suggested by the Royal Australian College of General Practitioners (RACGP)

The minimum requirements for a referral to an allied health professional to deliver ATAPS services are:

- Name of patient
- Personal details of patient
- Does the person live alone/with family/carer or friend
- Presenting problem/provisional diagnosis/diagnosis
- Any medication prescribed
- Any known allergies
- What the GP is requesting from the allied health professional ie. focussed psychological strategies up to 6 sessions
- Information on the assessment conducted
- The outcome tool utilised and the results
- The proposed *Mental Health Treatment Plan*
- A timeframe for a review of the patient
- A timeframe for a review of the *Mental Health Treatment Plan*[††]
- Any other relevant health professionals that are being consulted by the patient
- Contact details (so the allied health professional can contact the GP if required)

Divisions and Medicare Locals should also develop a proforma for the allied health professional to report back to the GP. This would include:

- A restatement of the assessment/diagnosis
- Any diagnostic or outcome tools used and any change in an individual's condition
- A summary of progress through the 6 sessions
- Any ongoing issues
- Any obstacles to treatment i.e. consumer not turning up for treatment
- Suggestions for further management
- Contact details for the GP (or psychiatrist) to contact the allied health professional if required.

[††] A Mental Health Treatment Plan must be reviewed if a client is being referred for additional sessions under 'exceptional circumstances'.

OPERATIONAL GUIDELINES FOR THE ATAPS SUICIDE PREVENTION SERVICE

1. Introduction

This Service provides priority access to the Access to Allied Psychological Services (ATAPS) initiative for people who have self harmed, attempted suicide or who have suicidal ideation and are being managed in the primary health care setting.

The primary objective of the Service is to provide treatment and support to individuals at increased risk of suicide or self harm at a critical point in their lives. The ATAPS Suicide Prevention Service complements other ATAPS services and the Better Access to Mental Health Care initiative.

This Service provides funding to Divisions of General Practice (Divisions) and Medicare Locals 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.

This service is a mandatory component of the ATAPS Program, however 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 the ATAPS Suicide Prevention Service 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 may be required to provide information on the efforts made to establish these relationships.

2. Purpose

This document is primarily designed for use by Divisions and Medicare Locals who are providing the ATAPS Suicide Prevention Service. This document provides information specific to the Suicide Prevention Service and builds on the information available in other sections of the overarching ATAPS Operational Guidelines. Divisions and Medicare Locals should use this information in conjunction with the information in their Funding Agreement and information in the overarching ATAPS Operational Guidelines.

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 and eligibility of 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 availability in the local area.

3. Transition from other Suicide Prevention Projects

Divisions who received funding as part of the *Additional Support for Patients at Risk of Suicide or Self Harm* demonstration projects, or who provided suicide prevention services under Tier 2 prior to 1 July 2011 are required to transition these services to ensure consistency with the requirements of these Operational Guidelines for the ATAPS Suicide Prevention Service. Impacted Divisions will have until 31 December 2011 to complete this transition. Should a Division wish to be granted an

exemption to this, prior written approval must be granted by the Department. Any request of this nature should include details of the reasons for this request.

4. Eligibility for the ATAPS Suicide Prevention Service

The ATAPS 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 ATAPS Suicide Prevention Service is primarily designed for three 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 Accident and Emergency Department;
- people who have presented to GP after an incident of self harm; and
- people who have expressed strong suicidal ideation to their GP.

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

In considering a person's eligibility for these services, providers should consider the complexity of the individual's circumstances and the number of contributing factors. Consideration should also be given to the short term nature of the ATAPS Suicide Prevention Service and whether the individual is more appropriately supported by the state or territory acute mental health service.

This Service is not designed for people who are being managed on an ongoing basis by state government mental health services following release from a hospital acute mental health ward or an Accident and Emergency department. The Service is also NOT designed for people who have been released from a Psychiatric Accident and Emergency Department.

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 support those who are not appropriately support through this setting.

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

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.

5. Referral Requirements

People can be referred for services by their GP or directly from an Accident and Emergency Department or on discharge from a hospital ward. People may also be referred from the state or territory acute mental health support team, where that service has identified the individual is not at acute or immediate risk, and is not best supported by that service post assessment.

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 the ATAPS Suicide Prevention Service is 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 released, 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 discuss.

While many people who attempt suicide have a mental disorder, a person does NOT need to have had a mental disorder diagnosed before referral to ATAPS Suicide Prevention Service, and is NOT required to have a GP Mental Health Treatment Plan completed.

People referred directly from the hospital setting or acute mental health support team should visit their GP within two weeks of the first service to ensure all their health care needs are being addressed. This should specifically include the treatment of any mental disorder of which suicidal thinking or behaviour is a symptom. The allied health provider will encourage and support this contact.

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 for example, the individual should be encouraged to visit this alternate primary health care provider in order to ensure other health care needs are being managed and continuity of care is maintained.

Where the client is in the Accident and Emergency Department following a self harm incident or suicide attempt, the Accident and Emergency Department may contact the ATAPS After-Hours Suicide Support Line and request this service contact the client. More information on the ATAPS After-Hours Suicide Support Line is provided in section 12.2.

6. Intervention Period

The ATAPS 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 project will have priority access to the allied health provider and the allied health provider is to contact the person within 24 hours of referral. The first session with the allied health provider must occur within 72 hours of referral or earlier if clinically indicated. 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 ATAPS After–Hours Suicide Support Line to make contact with the person and provide support until the allied health provider

can contact the individual and/or deliver a service. More detail on the ATAPS After-Hours Suicide Support Line is provided in section 12.2. Please note that it is expected that in most cases contact would be made by the allied health provider within the required timeframe.

Unlike the standard ATAPS arrangements, there is no limit on the number of sessions the client can access. However it is anticipated that these sessions would be conducted in a condensed time period, of around 1-2 months and will be based on individual client need.

It should be noted that services provided under the ATAPS 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 initiatives). The services provided under the ATAPS Suicide Prevention Service also have no impact on an individual's entitlement to Medicare subsidised allied mental health services.

7. Interventions

Divisions and Medicare Locals will engage allied health professionals to provide services to clients of the ATAPS Suicide Prevention Service. The allied psychological services to be provided through this Service shall be broadly consistent with those provided across the ATAPS Program (refer to the ATAPS Operational Guidelines). The services should be tailored to meet the needs of individuals who are in psychosocial distress associated with suicide or self harm and be part of the treatment for any mental disorder identified as causing the suicidal thinking or behaviour.

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

Allied health providers may also undertake an education/clinical support role (for example, provide support to GP practice staff/nurses in a capacity building role). This role should be a small component of the Suicide Prevention Service, with direct service delivery to clients at risk of suicide or self harm being the primary role of the service. However, this role may be somewhat more significant in the early stages of establishing the service to assist in encouraging GP uptake and engagement in the service.

The allied health provider may also undertake a care coordination role and facilitate access to other care providers such as a private psychiatrist. Whilst providing care coordination the allied health provider will retain responsibility for the clinical suicide prevention intervention services. Medical practitioners who participate in case conferences may be eligible to bill that service against a Medicare item. Divisions and Medicare Locals should ensure medical practitioners are aware of the relevant Medicare items to encourage participation in case conferences as appropriate. Should providers not be appropriately skilled in care coordination, consideration should be given to education and training activities that could be undertaken to build knowledge and experience as well as appropriate supervision.

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

8. Transition

The allied health provider will decide, in consultation with the person and their GP, when it is appropriate for the intensive suicide prevention treatment service to cease and assist in facilitating access to any further required services. This may include (but is not limited to) transition to ATAPS

Tier 1 or other Tier 2 services, Medicare based mental health services or specialised mental health services.

9. Training Requirements

Allied health providers engaged to provide services under the ATAPS Suicide Prevention Service must at a minimum, meet the requirements to be an ATAPS provider (refer to the ATAPS Operational Guidelines). In addition, providers must have specific training in providing services to people at risk of suicide. This training is designed to ensure that all providers working under the ATAPS Suicide Prevention Service have at least a minimum level of understanding of how to work appropriately with this higher risk group. If individual providers do not feel that this training is sufficient, these providers should seek out additional training and educational opportunities before providing services under the Suicide Prevention Service.

It is mandatory for all allied health providers working under the Suicide Prevention Service to complete the training and assessment developed by the Australian Psychological Society to support the Additional Support for Patients at Risk of Suicide or Self Harm demonstration project. Further information on this training can be obtained by contacting Allen White at the Australian Psychological Society on (03) 8662 3378 or emailing a.white@psychology.org.au.

Based on feedback provided by stakeholders, this training is currently being updated, and is expected to be available in early 2012. Once the updated training is available, any providers who have not already completed the training developed for the demonstration project will be required to undertake the updated training and assessment before providing services under the ATAPS Suicide Prevention Service.

Divisions and Medicare Locals will be formally advised when the updated training becomes available and how to access it.

As part of this update, a system for the recognition of prior learning is also being considered. Until such time as a recognition of prior learning system is in place, all allied health providers delivering the ATAPS Suicide Prevention Service will be required to complete the mandatory training.

Divisions and Medicare Locals participating in the Service 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.

Provisionally registered allied health providers are NOT eligible to provide services under the ATAPS Suicide Prevention Service.

10. Crisis Referral Arrangements

In order to provide services through the ATAPS 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 provision of services.

Those Divisions that were providing suicide prevention services under Tier 2 arrangements or the suicide demonstration projects prior to 1 July 2011 may continue service provision, but must develop arrangements with the acute mental health team (or equivalent) for support in the event of a crisis as soon as possible, and by 31 December 2011 in order to continue to provide ATAPS Suicide Prevention Services after this date.

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.

11. Liaison/Development of Linkages

The Division/Medicare Local 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 Division/Medicare Local will work with state or 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.

12. Support Services

Divisions and Medicare Locals must ensure appropriate support arrangements are in place for allied health providers working under the Suicide Prevention Service, for example clinical supervision. These supports should complement the support arrangements available at a national level through the Clinical Support Service and the ATAPS After–Hours Suicide Support Line (see below for further information on these services). Divisions and Medicare Locals must promote the supports available to allied health providers, including the ATAPS After Hours Support Service and the Clinical Support Service.

12.1 Clinical Support Service

The Australian Psychological Society is funded to provide the Clinical Support Service for allied health professionals working under the Suicide Prevention Service. This service provides debriefing and support, clinical advice and assistance with training materials. This service is staffed by an experienced allied health professional.

The Clinical Support Service can be contacted on 1800 894 868 and is available between 9am and 4pm Monday to Friday. Alternatively, you can send an email to clinicalsupport@psychology.org.au

Divisions and Medicare Locals are required to promote the availability of this service to allied health providers who are delivering the ATAPS Suicide Prevention Service.

Please note that this is not a crisis service and immediacy of response can not be guaranteed. This service is also not considered a clinical supervision arrangement and carries no clinical responsibility for cases where advice is provided. Divisions and Medicare Locals are responsible for putting in place local clinical supervision arrangements.

12.2 ATAPS After-Hours Suicide Support Line - 1800 859 585

Crisis Support Services are funded to provide the ATAPS After-Hours Suicide Support Line. This telephone service supports clients of the ATAPS Suicide Prevention Service and operates between 5pm and 9am Monday to Friday and 24 hours on weekends and public holidays.

The service provides counselling and support to clients with the primary focus being the management and reduction of the risk of suicide and self harm.

The ATAPS After-Hours Suicide Support Line can be accessed in two ways:

a. Allied health providers, referring practitioners or Divisional Officers may contact the ATAPS After-Hours Suicide Support Line directly and request that a call be made to a client. This can be used when an allied health provider is unable to see the client immediately, for example

when a client is referred to the ATAPS Suicide Prevention Service outside of business hours. It can also be used where an allied health provider feels an existing client needs additional support outside of standard business hours.

To request a call to a client, providers should EITHER telephone 1800 859 585 or email ataps-afterhours@crisissupport.org.au.

b. A client of the ATAPS Suicide Prevention Service may directly contact the ATAPS After-Hours Suicide Support Line when they feel they need additional support.

Information on contact with clients is recorded by ATAPS After-Hours Suicide Support Line staff in a database that can then be accessed by the relevant allied health provider or referring practitioner on the next business day (with permission of the client).

Divisions and Medicare Locals MUST promote the ATAPS After-Hours Suicide Support Line to clients of the ATAPS After Hours Support Service through either referring practitioners, triage officers, or allied health providers or a mix of these. It is not acceptable for the Division/Medicare Local to only promote state government funded after hours support.

Divisions and Medicare Locals can obtain further information and resources to assist in promotion of the ATAPS After-Hours Suicide Support Line from Crisis Support Services by contacting the Program Leader, Suicide Services on (03) 8371 2800.

Further information on the service can also be obtained by emailing ataps-afterhours@crisissupport.org.au.

Please note that this service is separate to the Suicide Call Back Service.

13. Service Establishment

Where an organisation is establishing a new service, establishment of the ATAPS Suicide Prevention Service may be undertaken in two phases.

Phase One will include:

- development of arrangements with the state or territory acute mental health team for support in the event of a crisis;
- development of linkages and referral pathways with hospitals (including emergency departments), GPs and state and territory mental health services;
- engagement (where required) and training of allied health providers, including the provision of information on the requirements of the ATAPS Suicide Prevention Service;
- development of support structures; and
- promotion of support structures (including ATAPS After-Hours Suicide Support Line and Clinical Support Service) as appropriate.

Phase One may take three to six months to complete before Phase Two commences.

Phase Two will include:

- commencement of service delivery;
- maintenance of arrangements with the state or territory acute mental health team;
- maintenance of linkages and referral pathways with other care providers as appropriate; and
- promotion of support structures as appropriate.

14. Budget Allocation

Divisions and Medicare Locals may use up to 25% of total funding provided in 2011-12 for the Suicide Prevention Service for the establishment of the Service. This additional administration capacity reflects the additional administrative work associated with establishing a new service.

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.

Evaluation of the *Access to Allied Psychological Services* component of the *Better Outcomes in Mental Health Care* initiative: Minimum Dataset

Purpose of the minimum dataset

The minimum dataset was developed to gather common, basic information from all *Access to Allied Psychological Services* projects, and therefore acts as an important evaluation tool. The minimum dataset is designed to capture de-identified, consumer-level information. The minimum dataset is invaluable in collecting information that provides a picture of the level of uptake of the projects (by GPs and other referrers, allied health professionals and consumers), a description of the socio-demographic and clinical characteristics of consumers, and an overview of the services they are receiving. Sociodemographic and clinical information are collected by the GP or referrer, and treatment information is collected by the allied health professional at each session. Importantly, the minimum dataset also captures consumer-level outcome data.

The database is a web-based system allowing multiple users and regular reporting at a national level. The database is password-protected, so that only authorised personnel are able to access it to enter data and personnel from a given Division or Medicare Local are only able to access their own information.

The minimum dataset was launched in 2003 and since that time the number of Division and Medicare Locals entering data has been steadily increasing, and all projects are now represented in the database. Divisions and Medicare Locals are required to collect and enter the minimum dataset items as part of their ATAPS contracts with the Department of Health and Ageing. The data entered are periodically reported in aggregated form by Melbourne University's Centre for Health Policy, Programs and Economics as part of their national evaluation work. This provides the opportunity to showcase the achievements of this major national initiative, and highlights the importance of representation by each Division and Medicare Local in the dataset.

Specific items in the minimum dataset

The items included in the minimum dataset have been selected because they are considered important in the context of the national evaluation. They have been selected to provide a profile of the socio-demographic, clinical and treatment characteristics of ATAPS patients. In developing these items, particular consideration has been given to their comparability with other relevant local, state/territory and national data collections (e.g., the Census, local government statistics, the National Health Survey, the National Mental Health Survey, the BEACH Study).

The two tables below outline the items included in the minimum dataset, and the specific response categories associated with each item. Within the minimum dataset, a patient is created first, then a referral is created for the patient, then session information is entered for the referral. Information regarding outcome measures is entered within the referral section of the patient information.

The program allows for up to 12 sessions (6 + 6) per patient within a 12 month period from the initial referral date, and up to a maximum total of 18 individual sessions in exceptional circumstances. When patients complete their first 6 sessions they are required to attend their GP for a review, before a further 6 sessions are allowed (if required). This review is NOT considered a new referral unless the patient has developed a new mental health problem or is being referred to a different AHP. Therefore, if a patient uses 12 or less sessions within 12 months from the original referral the same referral is maintained for reporting purposes in the MDS against the patient key throughout these sessions. In all circumstances, a referral is only valid for 12 months. Also, if more than the 12 sessions are required beyond the first 12 months of any given referral, a new referral must be issued.

A new referral is issued under these circumstances:

- a new patient is referred for the first time for a presenting mental health condition
- an existing patient who has previously been referred to an AHP but has used up all 12 sessions within a 12 month period and is requiring further sessions
- an existing patient has presented with a new mental health condition and is being referred for treatment

It is important to maintain the same patient key for a single patient within the minimum dataset, regardless of the number of referrals, in order to identify how many sessions in total each patient has had across the lifespan of the program.

Table 1: Data items to be collected by the GP or referrer on a patient referral form – Sociodemographic and clinical characteristics of patients

ITEM	RESPONSE CATEGORIES	NOTES
1. Patient Key	• _____	Each patient should be allocated a 'patient key' which is a unique code to de-identify a patient, allowing him/her to be followed across his/her sessions with the allied health professional, without the evaluators ever needing to know his/her name. Ideally, these codes should be generated and inserted on the form by the Division or Medicare Local. The GP or referrer should not generate the code.
2. Year of birth	• yyyy	When combined with 'Date of referral', 'Year of birth' allows age to be calculated. This provides more information than if respondents were asked to tick an age band (e.g., 20-29), and allows for subsequent data aggregation for comparison with Census data.
3. Gender	• Male • Female	Allows for comparisons with Census data.
4. Does the person speak a language other than English at home? *[Tick one only. If more than one language, tick the one that is spoken most often]*	• No, English only • Yes, Italian • Yes, Greek, • Yes, Cantonese • Yes, Mandarin • Yes, Arabic • Yes, Vietnamese • Yes, other – please specify • Unknown	This question is useful in providing a description of those who are accessing allied health care. It is asked in the same format as on the Census, to allow for comparison.

ITEM	RESPONSE CATEGORIES	NOTES
5. How well does the person speak English?	• Very well • Well • Not well • Not at all • Unknown	This question is useful in providing a description of those who are accessing allied health care. It is asked in the same format as on the Census, to allow for comparison. Two response categories (i.e., not well and not at all) imply that the person will need further services in a language other than English.
6. Is the person of Aboriginal origin? *[For persons of both Aboriginal and Torres Strait Islander origin, tick both 'yes' categories]*	• Yes • No • Unknown	This question is useful in providing a description of those who are accessing allied health care. It is asked in the same format as on the Census, to allow for comparison.
7. Is the person of Torres Strait Islander origin? *[For persons of both Aboriginal and Torres Strait Islander origin, tick both 'yes' categories]*	• Yes • No • Unknown	This question is useful in providing a description of those who are accessing allied health care. It is asked in the same format as on the Census, to allow for comparison.
8. Referral Type	• 2010-11 Floods and Cyclone Yasi • Aboriginal and TSI • Bushfire • Children • General ATAPS • Homelessness • Perinatal Depression • Rural and remote • Suicide Prevention	This field was introduced in December 2010 to distinguish between the Tiers of programs. Some 'referral types' have specific data options available to them within the MDS. Please select this option carefully as some of the other MDS items are dependent on your selection here.
9. Referrer Code	• _____	This is a unique code that is used to de-identify the individual referrer (previously known as 'provider').
10. Referral date	• dd/mm/yy	As noted, this can be combined with 'Year of birth' to allow age to be calculated. It also provides information on any delays in access to subsequent care.

ITEM	RESPONSE CATEGORIES	NOTES

11. Referrer Type	• General ATAPS
	  o GP
	• Bushfire
	  o GP
	  o Case Manager
	• 2010-2011 Floods and Cyclone Yasi
	  o GP
	  o Self
	  o Centrelink social workers
	  o State mental health services
	• Aboriginal and Torres Strait Island
	  o GP
	  o NGO
	• Children
	  o GP
	  o School
	• Homelessness
	  o GP
	  o NGO
	• Perinatal Depression
	  o GP
	  o Midwife
	  o Obstetrician
	  o Maternal Health Nurse
	• Rural and remote
	  o GP
	• Suicide Prevention
	  o GP
	  o Psychiatrist
		The referrer type for General ATAPS is GP. However, some of the Tier 2 services have other allowable referrers. These will be presented to you as a drop down menu option.

ITEM	RESPONSE CATEGORIES	NOTES
	o Community Mental Health o Emergency Department	
12. Postcode of the patient's residence	• _____	Residential postcode, combined with the postcode of the Referrer's practice, can provide information about the distance that people travel to receive care. Information on socio-economic indicators and on rurality can also be gleaned from residential postcode. Local evaluations may add more detailed questions to describe area of residence in rural areas where a single postcode may cover a substantial area.
13. Postcode of the referrer's practice	• _____	As noted above, postcode of the referrer's practice, combined with residential postcode, can provide information about the distance that people travel to receive care.
14. Does the person live on his/her own?	• Yes • No • Unknown	This question relates to the important issue of the role of others in transacting care. Supplementary questions in the local evaluation may provide further information in this regard.
15. Is the person on a low income?	• Yes • No • Unknown	This question is useful in providing a description of those who are accessing allied health care. It requires the Referrer to make a judgement that takes into account comparative levels of income and evidence such as health care card or pension status.
16. What is the highest level of education the person has completed?	• Primary or below • Between Primary and Year 10 • Secondary – Year 10 or equivalent • Secondary – Year 11 or equivalent	This question is useful in providing a description of those who are accessing allied health care. It is asked in a format that can be mapped to the Census, for comparison

ITEM	RESPONSE CATEGORIES	NOTES
	• Secondary – Year 12 or equivalent • Tertiary	purposes.
17. Has the person ever received specialist mental health care before (public/private, medical/allied health)?	• Yes • No • Unknown	This questions relates to any episode of illness – not just the one for which the person is currently being treated.
18. Has the person been allocated additional sessions following the review session?	• A tick box labelled "Additional Sessions" is provided for each referral. Ticking the box indicates the person has been allocated additional sessions (usually 6), following the review session.	
19. If a referral has concluded, in what way has it concluded?	• Patient could not be contacted • Patient referred elsewhere • Patient refused treatment • Treatment complete • Treatment incomplete but referral closed	Once this field is completed, the referral is deemed to have concluded and therefore no further information can be entered for this patient, for this referral.
20. ICD-10 primary care diagnostic categories *[Multiple responses permitted]*	• F1 Alcohol and drug use disorders • F2 Psychotic disorders • F3 Depression • F4 Anxiety disorders • F5 Unexplained somatic disorders • No formal diagnosis (available only for Floods and Cylone Yasi, and the Suicide Prevention Services) • Unknown • Other diagnosis: (please specify) •	These categories represent the ICD-10 Chapter V Primary Care Version Brief Version (with amended categories) and are the minimum required. Projects may chose to include the Concise Version (with amended categories) as described in the Guidelines for Submissions to Conduct Pilots eg F10 Alcohol use disorders F11 Drug use disorders etc.
21. For which focussed psychological strategy is the person being referred *[Multiple responses permitted]*	• Diagnostic assessment • Psycho-education • Interpersonal therapy	This question recognises that an important role of mental health specialists is further diagnostic assessment as well as provision of

ITEM	RESPONSE CATEGORIES	NOTES
	• Narrative therapy • Other (please specify) _____	specialised treatments.
22. For which Cognitive-behavioural therapy (CBT) is the person being referred *[Multiple responses permitted]*	• Behavioural interventions • Cognitive interventions • Relaxation strategies • Skills training • Other CBT interventions (please specify) _____	
23. Is the person receiving psychotropic medication? *[Multiple responses permitted]*	• Benzodiazepines and anxiolytics • Antidepressants (such as SSRIs, SNRIs, TCAs) • Phenothiazines and major tranquillisers (such as risperidone, olanzapine, chlorpromazine, haloperidol, clozapine) • Mood stabilisers (such as lithium carbonate, sodium valproate or carbamazepine)	This question relates to the issue of the quality use of medicines, and will permit an examination of whether focussed psychological strategies are being provided instead of, or as an adjunct to, medication.

Table 2: Data items to be collected by the allied health professional at each session, on an ongoing management form – Treatment characteristics

ITEM	RESPONSE CATEGORIES	NOTES
1. Patient Key	• _____	Each patient should be allocated a 'patient key' which is a unique code to de-identify a patient, allowing him/her to be followed across his/her sessions with the allied health professional, without the evaluators ever needing to know his/her name. Ideally, these codes should be generated and inserted on the form by the Division or the Medicare Local. The Referrer should not generate the code.
2. Session Date	• dd/mm/yyyy	
3. AHP	• _____	This is a unique code that is assigned to the Allied Health Professional delivering the session. A coding system for all AHPs should be managed by the division in order to maintain uniformity.
4. Was a co-payment collected? If so, what was the amount?	• Yes → Amount $_____ • No	The co-payment is the amount paid by the patient per session. In many cases it will be zero and zero should be entered where appropriate.
5. Session type	For general ATAPS and all Tier 2 except childrens' services: • Individual • Group For Children's services • Child • Parent(s) • Child & parent(s) • Child, in a group • Parent(s), in a group	

ITEM	RESPONSE CATEGORIES	NOTES
	• Child and parent(s), in a group	
6. Duration of session	• 0-30 mins • 31-45 mins • 46-60 mins • >60 mins	
7. Patient did not attend	• A tick box labelled "No Show" is provided for each session. Ticking the box indicates the patient did not attend that session.	
8. Session Modality – How was the session delivered?	• Face to face • Telephone • Video conference • Web-based	
9. Type of focussed psychological strategy provided *[Multiple responses permitted]*	• Diagnostic assessment • Psycho-education • Interpersonal therapy • Narrative therapy • Other (please specify) _____ Also for children's services: • Family therapy • Parent training in behaviour management • Play therapy	
10. For which Cognitive-behavioural therapy (CBT) is the person being referred *[Multiple responses permitted]*	• Behavioural interventions • Cognitive interventions • Relaxation strategies • Skills training • Other CBT interventions (please specify) _____	
11. Scores on patient outcomes measures	• Total scores from a given outcome	The most commonly used patient outcome

ITEM	RESPONSE CATEGORIES	NOTES
	measure are entered directly, or calculated automatically from individual item scores. • Total scores are entered at assessment and review for a given consumer, enabling the change in scores over time to be determined.	measures include the Kessler 10 (K10), Depression Anxiety Stress Scales (DASS), the Edinburgh Postnatal Depression Scale (EPNDS, for the perinatal services), the Modified Scale for Suicidal Ideation (MSSI, for the Suicide Prevention services), the Strengths and Difficulties Questionnaire (SDQ, for children's services), and the Kessler 5 (K5) for indigenous people. For the DASS it is possible to enter subscale items (stress, anxiety, depression). On the referral page, the associated measures are listed in the "Measures" box on the right side. To view the details of each individual measure, click on the measure name, or the "edit" link next to it to go directly to the editing view. There are up to three options for entering data when editing (or creating) a measure - individual, subscales and total. (Subscales may or may not be available to enter, depending on whether the measure you are editing supports it.) Select the type you wish to enter by clicking the radio button; then enter the data into the field(s) that appear below. **You only need to enter one type - individual scores OR total OR subscales.** If outcome measures are not completed please do not complete these fields.

Recent changes related to the Tier 2 Services

Additional fields were added to the minimum dataset to accommodate the additional activities of the Tier 2 services. These changes are summarised in the table below.

ATAPS component	Changes Implemented
Tier 1 ATAPS	1) Default 'referral type' 2) Year of birth warning 3) Addition of SDQ – 3 versions - for • 4-10 yo – Parent- rated • 11-17yo – Parent-rated • 11-17yo – Self-rated o Each version has 6 subscales plus overall score
Suicide prevention	1) Added as 'referral type' 2) 'Referrer type' options have been added: 'GP', 'Community Mental Health', 'Psychiatrist', 'Emergency Department' 3) MSSI as outcome measure tool N.B. administered by AHP not the GP 4) Diagnosis is not mandatory, so if applicable according to referral, enter "no formal diagnosis".
Perinatal depression	1) Added as 'referral type' 2) 'Referrer type' options: 'GP', 'Midwife', 'Obstetrician', 'Maternal health nurse' 3) EPND scale is already an outcome measure but all Divisions will need to 'enable' this measure 4) For diagnosis, select 'Depression' or "Anxiety'
Bushfire affected	1) Added as 'referral type' 2) 'Referrer type' has been added to distinguish between 'GP' and 'Case manager' as sources of referral
Homelessness	1) Added as 'referral type' 2) 'Referrer type' options: 'GP', 'NGO
Aboriginal or Torres Strait Island	1) Added as 'referral type' 2) 'Referrer type' options: 'NGO' 3) K5 added as outcome measure.
Rural & remote	1) Added as 'referral type'
Children	1) Added as 'referral type' 2) 2) Session types: Child, Parent(s), Child & parent(s), Child, in a group, Parent, in a group, Child and parent(s), in a group 3) Strategies: 'Family therapy', 'Parent training in behaviour management', 'Play therapy'
2010-11 Floods and Cyclone Yasi	1) Added as 'referral type' 2) 'Referrer type' options: 'GP', 'Self', Centrelink Social Workers', 'State Mental Health Services' 3) Diagnosis is not mandatory, so if applicable according to referral, enter "no formal diagnosis".

Before an outcome measure can be used, each Division or Medicare Local will need to enable the relevant outcome measure in the minimum dataset. This can be done by selecting them in the "**select measures**" link on the minimum dataset home page.

Divisions and Medicare Locals will be notified of the details of any other changes to the minimum dataset.

How Divisions and Medicare Locals can access the minimum dataset

A dedicated Help Desk is available to support the ATAPS projects in relation to the minimum dataset system. All enquiries should be directed to: support@boimhc.org

Your Division or Medicare Local should have a username and password (received via email). If you do not have a username and password, please contact support@boimhc.org. The username and password provided to the Division or Medicare Local can be used by more than one staff member to view the minimum dataset at the same time, however only one person in a given Division or Medicare Local can make changes to the data at a time, and you should take care not to enter data about the same patient at the same time. GPs and allied health professionals can use the username and password provided to the Division and enter the data themselves.

The minimum dataset is accessed on the web at the following address: http://boimhc.org/. A brief description of the minimum dataset system is located there including a link to the logon page. The application includes online help for each of the pages. This website provides useful information, tools and documentation to provide support to Divisions and Medicare Locals involved in the ATAPS projects. It includes links to: Frequently Asked Questions (FAQs) for the minimum dataset; the collection of ATAPS Evaluation Reports; and to other useful reports, articles and ATAPS Evaluation Presentations.

Questions regarding the minimum dataset can be directed to the following central email address that allows queries to be viewed by all members of the evaluation team: support@boimhc.org

Divisions and Medicare Locals vary in their method of providing data to the national database. While the majority are entering data directly, some are utilising other databases in formats such as Excel and Access (or Chilli and MHAGIC). In order to avoid double entry of data wherever possible, there is some functionality for Data Upload if your Division has an alternative means of collecting and storing the minimum dataset items. Information on this procedure can be found in the online Help. You may also contact support@boimhc.org for assistance.

Data should be entered into the minimum dataset as soon as it becomes available so that at any given time data can be downloaded nationally to provide an overall picture of service provision via ATAPS. Data should be entered as frequently as is possible and should not lag by more than a month. This is also the case where data is being collected via an alternative database; data should be uploaded to the minimum dataset at least monthly.

Divisions and Medicare Locals should ensure that the data entered into the minimum dataset are as complete and accurate as possible. The aim is to minimise missing data as much as possible. When data is missing (i.e. it has not been provided or is unknown) please leave

these fields blank rather than entering a zero, for example when outcome measures have not been completed, so that it is clear to the evaluators that this data is missing. Conversely, where it is known that the correct response is zero, for example, where it is known that no session co-payment is collected, please enter zero rather than leaving the field blank, otherwise this will be interpreted as missing data).

How Divisions and Medicare Locals can use the minimum dataset

Divisions and Medicare Locals are not required to conduct any analyses of the minimum dataset data for the purposes of the national evaluation, but may wish to do so as part of their local evaluations.

Divisions and Medicare Locals are able to access their minimum dataset data at any time even after entering information. Be sure that you keep a record of Patient Keys (unique identifiers) so that you can look up specific patient information already entered into the minimum dataset. This is done from the link to **File Transfers** on the home page. Select the desired time period (e.g., financial year, quarter) and click "Download". Each Division and Medicare Local can only view data that has been entered by that Division or Medicare Local, not data entered by other Divisions. The Download function produces a CSV file, which is easily imported into an application such as Excel or SPSS allowing you to manipulate the data for your internal use. It is also possible to create Individual Division Reports using the minimum dataset (detailed below).

Reporting

The minimum dataset enables users to automatically generate a series of individual Division reports which give the minimum dataset greater clinical and management utility for Divisions and Medicare Locals. In addition, the minimum dataset allows Divisions and Medicare Locals to download their own data and import it into an alternative program such as Excel or Access to analyse and generate reports, though some do not have the capacity to do this.

The addition of the reporting capability enables Divisions and Medicare Locals to generate a series of tables for the minimum dataset fields, including both patient and session data. These tables provide patient or session counts for each of the response options, as well as percentages. Total scores are given both with and excluding missing data or "no response". These reports present data on consumers referred in a given period (e.g., number, breakdown by demographic and clinical characteristics) and sessions provided in a given period (e.g., number, breakdown by session characteristics). Individual Divisions are able to compare themselves with the national picture, or with de-identified, aggregated 'peer' Divisions (e.g., a rural Division could be compared with all other rural divisions).

The reporting capability is accessed via the minimum dataset home page. Click on the links from the home page: either **Data Summary** or **Report Selection (Frequency Distribution)**. On "Report Selection", select a report item, (e.g., language spoken at home), and a time period, click view to display the table.

Functionality

Uploads

Divisions and Medicare Locals have always been able to upload data to the minimum dataset, minimising double entry of data if another administrative system is used. More recently, it

has been possible to test whether data can be uploaded. However, until now, Divisions and Medicare Locals have not been able to test sessions without uploading patients. It is now possible to do both at once so that they can happen within the same transaction.

It is important to note that the updating of the patient data table, to include both information by patient and by referral, affect the way data is uploaded to the minimum dataset. If your Division currently uploads data to the minimum dataset, please see the online Help section or contact support@boimhc.org for information on the required changes to preparation of your data files for upload.

Referrer and Allied Health Professionals Lists

The Referrers and AHP lists allow Divisions and Medicare Locals to manage their own codes (they can be renamed and deleted from here). It is also possible to identify which patients are assigned to a particular Referrer or AHP. Whenever a Referrer or AHP code is updated or removed, all associated patients must be reallocated to an alternative code. A new capability has been added so that when a Referrer or AHP code is updated, the user is prompted for confirmation that all relevant referrals / sessions should be assigned to the updated GP or AHP code and when selected, this then occurs automatically. These can be accessed via the minimum dataset home page via the 'Manage Referrers' and 'Manage AHPros' links. Further information on how to use these new capabilities can be found in the online Help section of the minimum dataset, accessed from the Main Page.

The minimum dataset will soon be changed to enable more data collection and functionality around referrers and AHPs. Recent data gathered through the AHP survey will be incorporated into the minimum dataset. The evaluators will inform Divisions and Medicare Locals about these changes as soon as they occur.

Ethical issues: Confidentiality and informed consent

Patient confidentiality is paramount. All data should be de-identified (i.e., names and other identifying information removed) before it is provided to the minimum dataset. Patient names should be removed from all forms before they leave the GP or the allied health professional, and patients should only be identified by a unique number. The unique number is necessary to ensure that the patient can be 'followed' across their six (to 12 or 18 in exceptional circumstances) sessions with the allied health professional. The unique patient number should be generated by the Division or Medicare Local, and should not be the responsibility of the referring GP. Whilst maintaining confidentiality of consumers from the evaluators is paramount, Divisions and Medicare Locals need to collect sufficient information about each patient to ensure that if the patient receives a new referral during another year (within the same Division or Medicare Local) that the referral and session information can be entered using the same unique patient number.

Similarly, it is preferable that GP and allied health professional names not be entered into the minimum dataset for reasons of confidentiality. An appropriate alternative is to assign a code to represent each of the GP/ allied health professionals who are referring clients as part of the project. You can use any coding system of your choice (i.e. letters, numbers, initials, etc.); the idea is just for you to be able to distinguish one provider from another when looking up data after it has been entered.

Information sheets describing each project should be made available to patients at the outset. Patients should be informed that they are participating in a pilot project that is being evaluated, and that data on their socio-demographic, clinical and treatment characteristics will be made available to the evaluators in a form that does not allow them to be identified by name. They should also be informed of the other steps outlined above that will ensure that their confidentiality is protected. It is not considered necessary to seek informed consent from participating patients, but the information sheet should make it clear that if they object to their information being provided to the evaluators that they can choose for it to be withheld.

Approval for the overall national evaluation has been obtained by the national evaluators from the relevant Ethics Committee.

The Transition from 'Divisions' to 'Medicare Locals'

The evaluators are working to facilitate a smooth transition as 'Divisions' move to functioning as 'Medicare Locals'. The evaluators are in close consultation with the Department of Health and Ageing to ensure minimum disruption to Divisions and Medicare Locals in regards to ATAPS data collection. However, this move may create some data entry issues. The evaluators will keep Divisions and Medicare Locals informed of any changes or issues as soon as possible. If Divisions and Medicare Locals have any questions or encounter any difficulties please contact the evaluators via email at support@boimhc.org .

T-CBT TRAINING

Where ATAPS allied health workers are providing services via the telephone, they must undertake mandatory training in the delivery of these modes of service delivery. This training is being delivered by the Australian Psychological Society (APS) and all training has been developed for delivery via webinar and teleconference technologies. The training consists of two modules:

- Module One - Three (3) hour training on the adaptation of cognitive behavioral therapy for telephone-based service delivery and the evaluation requirements of ATAPS; and
- Module Two - One (1) hour follow-up training designed to support and reinforce the initial training module planned for approximately 8 weeks post initial training. This training is designed to be undertaken once ATAPS workers have begun to deliver services.

AVAILABLE RESOURCES

The APS can provide a copy of *Clinical Support Service* for the ATAPS workers to receive clinical support and advice about any aspect of the delivery of services.

In addition, the APS can provide workers with a set of resources to assist them in delivering sessions.

Information sheets for GPs and consumers have been prepared and can be obtained by contacting the Department. These sheets are designed to provide an overview of T-CBT to those GPs and consumers interested in utilising it. Once completed, this should be attached to the *Mental Health Treatment Plan* for the ATAPS workers, with a copy kept on file.

WHAT TO DO IF YOU HAVE QUESTIONS

For clinical questions, please contact the APS directly by contacting Dr Lynne Casey, Senior Project Coordinator, Australian Psychological Society, Phone: 03 8662 3300.

AVAILABLE ONLINE TREATMENTS AND SUPPORT

The **Clinical Research Unit for Anxiety and Depression** (CRUfAD) provides online treatment program, CRUfADclinic freely available through rural Allied Health Professionals and GPs in a staged national roll out. The program will allow mental health professionals, and GPs, to provide evidence-based online treatment programs as a valuable adjunct to other systems of treatment.

CRUfADclinic offers 5 online courses that GPs and other clinicians can prescribe for their patients who are seeking treatment for anxiety and depression.

CRUfADclinic courses are designed to be largely self-guided so that patients, once prescribed or referred by their clinician, can progress at their own pace and gain insight and knowledge into their condition. All material is based on the latest research on each condition and has been written by professionals with years of experience in the field.

To get started on CRUfADclinic, clients will need to have:

- Access to the internet
- A valid email address
- Read the FAQs on www.crufadclinic.org
- Downloaded and read the “How to Guide” for patients
- Downloaded the technical requirements

For more information, contact CRUfAD Clinic at https://www.crufadclinic.org/ .

The **National e-Therapy Unit** at the Swinburne University of Technology, has developed a full suite of e-therapy programs for anxiety disorders in both automated and therapist-assisted forms. Anxiety Online is a comprehensive online mental health service offering information, assessment, online diagnosis and treatment programs ("eTherapy") for the anxiety disorders.

The automated programs are most suitable for those with a mild to moderate anxiety disorder. There is also a low cost therapist-assisted program which is suitable for most people who have a moderate to severe anxiety disorder, assistance is in the form of weekly email communication. This form of treatment has been proven more effective than purely self-help programs

Anxiety Online comprises 3 main areas:

1. High quality information and resources are provided to enable clients to gain a comprehensive understanding of anxiety generally, and of anxiety disorders specifically.

2. Our online psychological assessment program (e-PASS) enables clients to complete a comprehensive psychological assessment online and obtain an online diagnosis. This assessment will provide feedback as to the type and severity of your anxiety, and appropriate recommendations for addressing any anxiety problems you may be experiencing.

3. Comprehensive and effective treatment programs are available for treating anxiety

disorders (Generalised Anxiety Disorder, Obsessive Compulsive Disorder, Panic Disorder, Post Traumatic Stress Disorder and Social Anxiety Disorder).

Anxiety Online was launched on 23 October 2009 and can be accessed at www.anxietyonline.org.au

The **Centre for Mental Health Research** at the Australian National University, has developed and provides online self help treatment through the use of CBT in a suite of online modules, such as MoodGYM, BlueBoard, BluePages and e-couch - these programs are targeted at youth and adults.

MoodGYM is an innovative, interactive web program designed to prevent depression. It consists of five modules, an interactive game, anxiety and depression assessments, downloadable relaxation audio, a workbook and feedback assessment. Using flashed diagrams and online exercises, MoodGYM teaches the principles of cognitive behaviour therapy – a proven treatment for depression. It also demonstrates the relationship between thoughts and emotions, and works through dealing with stress and relationship break-ups, as well as teaching relaxation and meditation techniques
MoodGYM was developed as a training program to help prevent depression in young people. All information provided by MoodGYM users is kept confidential and the Centre for Mental Health Research is under a legal obligation to protect the integrity of personal information

BlueBoard is an online community for people suffering from depression or anxiety, their friends and carers, and for those who are concerned that they may have depression or anxiety and want some support. This bulletin board is designed to enable people to reach out and both offer and receive help.
BluePages provides information on treatments for depression based on the latest scientific evidence. BluePages also offers screening tests for depression and anxiety, a depression search engine, and links to other helpful resources.

e-couch is a self-help interactive program with modules for depression generalised anxiety and worry, relationship breakdown, social anxiety and grief and loss.
It teaches strategies drawn from cognitive, behaviour and interpersonal therapies as well as relaxation and physical activity.

More information can found at www.ehub.anu.edu.au

A service currently offered by the **Black Dog Institute**, running as a research project, uses the myCompass program - a newly-developed internet and mobile phone based program - to learn how different situations affect people and how to stay positive despite life's ups and downs.

The myCompass program is designed to help clients understand their stress, worry and/or low mood and to manage it better. As part of this 19 week research project, clients will be asked to use a version of the myCompass program for 7 weeks in their own time. This will give access to useful information and activities that will help you learn new skills to feel better and stay better.

Clients will receive feedback about their stress, worry or low mood at the end of the 19 week research study.

Within the research project, clients will be asked to complete questionnaires about how they are feeling on three occasions:

- before they start using the program
- after seven weeks, when they have finished using myCompass; and
- twelve weeks later.

Clients can take part if they:

- Are aged 18-75 and live in Australia
- Are feeling stressed, worried or low
- Have an internet-enabled mobile phone
- Have access to a computer with an internet connection
- Have a valid email address
- Agree to use the myCompass program for 7 weeks and complete three research questionnaires over 19 weeks.

ENGAGEMENT OF PROVISIONAL/INTERN PSYCHOLOGISTS AND NEW GRADUATE SOCIAL WORKERS

The Department supports the use of provisional/intern psychologists and graduate social workers under supervision in the delivery of Access to Allied Psychological Services (ATAPS) Tier 1 and Tier 2, and recognises the important role provisional/intern psychologists and graduate social workers play in providing services where it is sometimes difficult to attract workforce.

To ensure a high quality standard of service delivery, allied health professionals who are to deliver ATAPS services should be:

> *adequately experienced in the field of mental health, or (to allow for entry of newly trained persons into the field of mental health) under the approved and direct professional supervision of a fully qualified and registered professional expert in that field who meets the ATAPS criteria.*

Divisions and Medicare Locals should refer to the Psychology Board of Australia to ensure that both the provisional/intern psychologists engaged to deliver ATAPS and the supervising psychologists meet the necessary requirements. Further information can be found at http://www.psychologyboard.gov.au/Codes-and-Guidelines.aspx. For social workers the equivalent information can be achieved by contacting the Australian Association of Social Workers (AASW) on www.aasw.asn.au for Education and Accreditation Standards and Code of Ethics. Graduates employed in ATAPS must be members of the AASW.

Divisions and Medicare Locals should also ensure that they are meeting the requirement of their current Funding Agreements, specifically in relation to Item J Insurance, where it is noted that Divisions and Medicare Locals are responsible for seeking independent professional advice on the appropriate levels of insurance which allied health professional are required to have prior to delivering focussed psychological strategies under ATAPS. The full clause from current ATAPS funding agreements is quoted below for your reference:

Please note, Divisions and Medicare Locals must also ensure that provisional/intern Psychologists engaged to deliver ATAPS have the appropriate levels of insurance which allied health professionals are required to have prior to delivering focussed psychological strategies under ATAPS. Graduate social workers can demonstrate this through membership of the AASW which has insurance cover for its members.

The Department continues to support the engagement of intern/provisionally registered psychologists, and social workers with accreditation in mental health and less than two years experience, in accordance with the guidelines for the delivery of ATAPS. Supervisors for intern/provisionally registered psychologists and social workers may be funded from the ATAPS service delivery component.

Exceptions to the engagement of intern/provisionally registered psychologists is where a Division or Medicare Local is where children or people who have attempted or are at risk of suicide are being provided with treatment – the use of student interns is not permitted.

FURTHER INFORMATION AND RESOURCES

For information regarding policy, management and payments of the Access to Allied Psychological Services projects, Divisions and Medicare Locals should contact the Department's Central Office in Canberra. Contact details are as follows:

Director
Primary Care Programs Section
Mental Health Services Branch
Mental Health and Drug Treatment Division
Department of Health and Ageing
MDP 602
GP Box 9848
CANBERRA ACT 2601
Telephone: (02) 6289 8996
Fax: (02) 6289 7680

or

Director
Primary Care Service Development Section
Mental Health Services Branch
Mental Health and Drug Treatment Division
Department of Health and Ageing
MDP 602
GP Box 9848
CANBERRA ACT 2601
Telephone: (02) 6289 8545
Fax: (02) 6289 7680