Psychological Support Services

CESPHN Psychological Support Services (PSS) Guidance

EIS Health Limited trading as Central and Eastern Sydney PHN
Last updated February 2026
Version 1.05

Contents

Scope

Master Service Agreements and associated Schedules take precedence over this document.

Definitions

In this Document, unless the context otherwise requires:

Access is defined as being an Individual's capacity to get to an available service physically or virtually or afford to pay a fee for an available service.

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

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

CESPHN refers to the Central Eastern Sydney Primary Health Network.

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

Confidential Information includes, but is not limited to, matters not generally known outside CESPHN, such as information relating to the general business operations with CESPHN including:

- The Provider's Agreement.
- Trade secrets, know-how and specifications in respect of CESPHN operations.
- Third party information disclosed to CESPHN in confidence.
- Medical records and health information.
- Any other information which by its nature could reasonably be expected to be regarded as confidential, including financial and funding information about CESPHN.

Consent is defined as express Consent or implied Consent which has four key elements:

- The Consent must be voluntary.
- The Individual must be adequately informed before giving Consent.
- The Consent must be current and specific.
- The Individual must have the capacity to understand and communicate their Consent.

Clinical Incident is any unplanned event which causes, or has the potential to cause, harm to an Individual.

Clinical Lead is defined in this document as a healthcare professional responsible for overseeing clinical practices, coordinating clinical services and guiding clinical decision-making. Clinical Leads may also delegate responsibilities to appropriate personnel.

Medical Practitioner (MP) is defined in this document as a General Practitioner (GP), Psychiatrist, Obstetrician-Gynaecologist, Paediatrician or any other Medical Doctor.

Non-Medical Practitioner (NMP) is defined as those referring to the program who are not Medical Practitioners. This Includes school counsellors/school psychologists, school principals/deputies, University and TAFE mental health clinicians/wellbeing coordinators, Directors of Early Childhood Services, headspace clinical staff, community or neighbourhood centres, maternal and child health clinicians, lactation consultants, midwifery, allied health and neo-natal nurses for perinatal referrals, perinatal mental health clinicians, Aboriginal health workers/care coordinators/outreach workers, House parents of Kirinari Hostel (Sylvania), managers of Aboriginal Community Controlled Health Services (ACCHS), and multicultural community health liaison officers.

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

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

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

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

Work Health and Safety (WH&S) means, as relevant:

- The Work Health and Safety Act 2011 (NSW) and the Work Health and Safety Regulation 2011 (NSW); and
- The Work Health and Safety Act 2011 (Cth) and the Work Health and Safety Regulation 2011 (Cth).

1. Primary Health Networks

Primary health networks (PHNs) key objectives are to increase the efficiency and effectiveness of medical services for individuals, particularly those at risk of poor health outcomes. They also aim to improve coordination of care to ensure people receive the right care in the right place at the right time. PHNs are not for profit, regionally based organisations which aim to strengthen primary care by redirecting frontline health services to improve health outcomes of the community.

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

Our Vision

Our vision is better health and wellbeing of the people who live in Central and Eastern Sydney. We work directly with all key players including general practitioners (GP), allied health practitioners, nurses, secondary care providers, local health districts (LHD) and specialty health networks, local communities, and non-government organisations to ensure improved health outcomes.

Our Activities

Central and Eastern Sydney PHN (CESPHN) prepares a comprehensive needs assessment to identify the key population health and health service needs of people in our region. We use this information to provide programs and services to deliver better health outcomes.

CESPHN commissions services to meet population health needs and reduce barriers to access for communities with the highest needs. These services address specific regional priorities and national health priorities as determined by the Commonwealth. CESPHN's Commissioning Framework guides how health services will be planned, commissioned and procured.

CESPHN also works to improve primary health care such as general practice and allied health. This includes practice management support and continuing professional development.

We also provide a range of programs focused on delivering integrated care with our local health districts and specialty health networks: Aboriginal health, antenatal shared care, aged care, cancer management, child and family health, chronic disease management, domestic and family violence, drug and alcohol, HealthPathways, immunisation, intellectual disability, lifestyle modification, mental health, NDIS, palliative care, and sexual health.

Our Region, Our Community

CESPHN provides services for the 1.5 million individuals living in the 587km² area. This includes the areas from Bondi to the Sutherland Shire in the south, and as far west as Strathfield. The population of Lord Howe Island is also included. The number of people living in the area will reach more than 1.9 million by 2031, with the most significant increase being the number of people aged over 65 years. CESPHN boundaries align with those of South Eastern Sydney LHD and Sydney LHD.
The region incorporates 13 local government areas. Click the link for a complete list of CESPHN catchment area postcodes.

2. Psychological Support Services (PSS)

- CESPHN is funded by the Commonwealth of Australia, Department of Health and Aged Care (ADoHAC), to commission organisations to provide short-term focused psychological therapy services, targeting the needs of people experiencing mild to moderate mental illness in underserviced groups where there are barriers to accessing Medicare Benefits Schedule (MBS) based psychological intervention.
- PSS has been developed based on ADoHAC PHN primary mental health care guidance.
- Psychological Support Services (PSS; formerly known as ATAPS) provides free structured, evidence-based, short-term face to face or telehealth psychological therapy for people experiencing mild to moderate mental health concerns. This service is available to individuals who live within the CESPHN region, are experiencing financial hardship, and who may not be able to access support through Medicare subsidised psychological services.
- PSS, via the Suicide Prevention Service (SPS) also offers evidence-based psychological interventions for people who have attempted, or are at risk of, suicide or self-harm where access to other services is not available or appropriate.
- Services are delivered by appropriately trained and qualified Mental Health Professionals (MHP) including psychologists (general and clinical), mental health nurses, mental health accredited social workers, mental health accredited occupational therapists and Aboriginal and Torres Strait Islander mental health workers.
- PSS is predominately a 10-session program for eligible referrals. For most individuals using PSS, up to 10 sessions of intervention for an episode of care will be sufficient as they are presenting with mild-moderate level of need.
- Additional sessions are available for Individuals as a one-time extension of up to 8 sessions, subject to clinical criteria and approval from the Provider clinical lead. For more details See 5.3. Additional Sessions.
- CESPHN commissions consortiums in the community that employ MHPs to provide PSS to eligible individuals in the region, across their lifespan.

2.1. PSS Eligibility

Psychological Support Services is for Individuals who:

- Live in the Central and Eastern Sydney region.
- Have a diagnosable mild to moderate mental health concern.
- May benefit from short term treatment.
- Are unable to access other services including Better Access (Medicare subsidised psychological services) due to financial hardship or low income (Guide: Individual income below $67,000 or family income below $140,000).

And fall within one of the following groups:

1. Children (0-12 years who have not yet graduated from primary school) with, or who are at risk of developing a mild to moderate mental, emotional, or behavioural disorder.
2. Young people (12-25 years).
3. Adult (low income).
4. Individuals who identify as Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning (LGBTIQA+).
5. Individuals experiencing perinatal depression and their partners.
6. Individuals who identify as Aboriginal and Torres Strait Islander.
7. Individuals who identify as part of a Multicultural Community.
8. Individuals who have attempted, or who are at risk of suicide, or self-harm.
9. Individuals with mild Intellectual disability who may benefit from short-term psychological intervention when co-occurring mental health concerns are diagnosed.
10. Individuals Impacted by natural disasters or traumatic events.

PSS is NOT for:

- Individuals who are currently being managed and are active clients of a mental health service within a secondary health facility such as Local Health District (LHD) or Local Hospital Network (LHN).
- Individuals currently accessing psychological intervention under Better Access initiative or NDIS. If an individual is funded under NDIS for psychological intervention, they are not eligible for PSS.

- Individuals with severe or complex mental health concerns.
- Primary concerns Acute/crisis, Primary alcohol and drug (see CESPHN website), Sexual assault (Victims Services Counselling), Domestic violence (see CESPHN Website), Couples or family counselling, Primary homelessness support, Dementia (see CESPHN website), Tobacco use disorder or medicolegal matters.
- PSS is not appropriate as the primary support for Individuals who are in current domestic violence situations as other more appropriate services exist. Children living where the perpetrator still reside need to be referred to more appropriate services and child protection support be considered.
- Individuals referred primarily to complete Work and Development Orders (WDO). They will be considered on a case-by-case basis.

PSS will not:

- Duplicate or replace existing services provided by other organisations, including state and tertiary government services, disability support services, NDIS or workers compensation.
- Provide a low intensity service involving self-referral.
- Provide primary psychosocial support, as this is a clinical service. Care coordination sessions are available for all individuals in this program.
- Provide a service which could be provided through the Better Access (MBS) Initiative in the same location for the same population group.

2.2. Individuals Who No Longer Live in the CESPHN Area

- This program is for Individuals who reside in the CESPHN region.
- If an Individual has been accessing PSS because they lived in the CESPHN area and their circumstances have changed and where this is no longer the case, then:
- An Individual can complete their allocated approved PSS sessions. However, care will need to be transferred to either the PHN equivalent service in their area, private services, or an alternative pathway of care.
- If the Individual continues to see the MP in the CESPHN area and needs ongoing treatment, the MP can refer them to a bulk billing practitioner or PSS equivalent in the Individual's region (Find the closest PHN).
- If an Individual moves overseas, they are no longer eligible for PSS as they no longer live in the CESPHN region.

2.3. Individuals Who Are Not Australian Citizens living or working in Australia

- Non-Australian citizens including overseas students may access this service after the following options have been considered:
- If an Individual does not have a current Australian Medicare card, then ADoHAC recommends that other options must be investigated before a PSS referral can be made.
- Students on student visas have their own private insurance arrangements in place and should consider accessing services using this means. They can access private services and claim the rebate back from their insurance company. This usually incurs an upfront cost for the service.
- If an Individual does not have access to other services, they may be appropriate for PSS, in which case a PSS referral and GP MHTP is still required.

3. PSS Service Delivery

The model of service will adopt the following key principles:

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

Essential elements of the CESPHN PSS Program includes:

- Providing a level of service commensurate with the clinical needs of the Individual.
- Providing services to complement and not duplicate the role the MBS plays in funding psychological services on referral from Medical Practitioners (MP) and non-MP.
- Delivery of individual therapy using specified, evidence-based psychological treatments.
- Providing referral and/or links to other services within a stepped care approach to ensure services are matched to Individual needs and are reconsidered as these needs change.
- Ensuring smooth transfer between services for individuals as needed, in conjunction with involved parties.

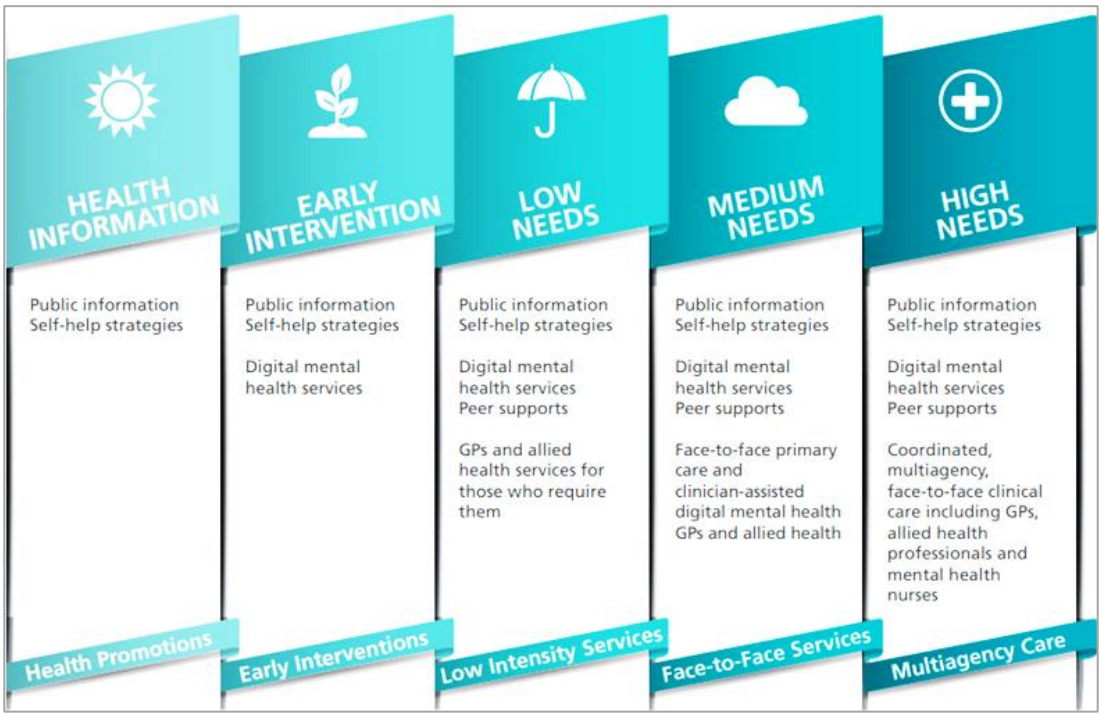
- Recommendations that the MHP assist the Individual in obtaining a MHTP during the course of therapy, including provisional referrals and referrals that require additional sessions as needed.
- Offering flexibility where needed, including the format of delivery of services, which could include Face-to-face individual consultations (primarily), as well as telehealth and virtual-based services as clinically indicated and agreed with the Individual.
- Discussions with parents of young people accessing services (where Consent has been obtained as appropriate).
- Ensuring all MHPs develop a comprehensive assessment and treatment plan, prepared in consultation with the Individual and any family, carers or significant others as requested by the Individual; identifying the Individuals current condition, care planning, suitability and eligibility to the program, risk assessment, goals for their treatment, and recovery and exit planning. The treatment plan should involve regular progress reviews and relapse prevention planning.
- Ensuring that MHPs communicate to the referring GP on:
    - Ensuring the episode starts, outlining the comprehensive assessment and treatment plan.
    - Review of progress against treatment plan if applying for additional sessions.
    - Episode end, to outline treatment outcomes, relapse prevention plans and any further referral recommendations.
- If the Individual cannot be contacted or declines the service after the referral has been accepted.
- Supporting carers, especially where services are provided to Children and Young People.
- MHPs complete training in CIMS and that all required data, including PMHC-MDS data items, is entered into the CIMS within 5 days of the action occurring.
- MHPs upload all correspondence relating to session approval, including GP reports and letters, into the CIMS.
- MHPs maintain adequate and legible records of all services provided as part of PSS Program. Such records by law must be kept for 7 years following completion of treatment or in the case of minors until they reach age 25.
- Ensuring that **no** co-payment, gap fee, cancellation fee or claim to Medicare is charged to the Individual.
- CESPHN will not reimburse for "no shows" or any travel costs. CESPHN defines a ‘no show’ for the purposes of the MDS as an Individual not giving 24 hours’ notice of non-attendance.

3.1. The National Safety and Quality Digital Mental health (NSQDMH) Standards.

- The NSQDMH Standards were developed to improve the quality of digital mental health service provision, protect service users and their support people from harm and improve the quality of health service provision.
- As mental health services, such as PSS, transition to digital delivery, it is important to be aware of the relevant standards and utilise the available resources to support workforce members in providing health services to individuals with existing or emerging mental health issues.
- Overview of the NSQDMH Standards
- National Safety and Quality Mental Health Standards for Community Managed Organisations.
- NSQHS Standards User Guide for health services providing care for people with mental health issues

3.2. Stepped Care Approach

- Stepped care is an evidence-based approach comprising of interventions, from the least to the most intensive based on the level of mental health care needs.
- This approach will support people to access services based on their needs, at the right time.
- CESPHN provides a stepped care approach to meet the needs of Individuals being referred to the services of PSS, including Suicide Prevention Service (SPS), at no cost to Individuals.
- An experienced clinician will review and assess referrals and allocate each referral to an appropriate service in accordance with each person's individual choice and the level of their mental health needs applying a stepped care approach.
- The PSS and SPS programs sit in line with low to medium needs. Individuals who require more or less support should be referred appropriately.



Stepped Care Principles

- Under the Stepped Care Principles, services are focused on an Individual's choice as well as being matched to the Individual's needs and recovery goals. Needs are reflected on a continuum and interventions are matched to the severity and complexity of needs and preferences. Individuals do not have to start at the least intensive level of intervention to progress to the next level. They can enter the system and have their individual requirements and needs met.
- Services should be connected, easy to access, flexible and responsive to changing needs. In addition, services commissioned by CESPHN are expected to be informed by evidence and accountable with a key focus on the underserviced groups, including children, young people, people who identify as Aboriginal and/or Torres Strait Islander and people from Multicultural Communities in the CESPHN region.

Rationale for Stepped Care

- In the ADoHAC guidance (PHN Mental Health and Suicide Prevention Implementation Guidance), the reasons for stepped care being considered a priority activity for PHNs was outlined and has been summarised below:
- Preventing underservicing and over servicing of need. Stepped care aims to match a person presenting to the health system with the least intensive level of care that most suits their current treatment need, with the ability to monitor treatment experiences and outcomes to enable a step up or down in treatment intensity as necessary.

- Shifting focuses on self-care and early intervention and away from costly face to face high intensity interventions.
- Improving community access to mental health services so that a person who experiences mental illness does not have to wait until their situation worsens by implementing early intervention approaches.
- Encouraging more efficient and effective use of primary mental health services, including Medicare subsidised psychological services and the use of clinician moderated self-help digital services.
- The ADoHAC has initiated the national use of the Initial Assessment and Referral (IAR) Decision Support Tool to ensure that Individuals receiving care anywhere in Australia are consistently being recommended an appropriate level of care for their presenting issues. CESPHN has incorporated the eight IAR domains into the PSS referral form, to help referrers ensure that PSS is the most appropriate service for the Individual's needs.

3.3. Initial Assessment and Referral Decision Support Tool (IAR-DST)

- The IAR-DST, an initiative of the Australian Department of Health, integrates Australian and international evidence with expert advice to guide mental health referrals.
- It offers a standardised, consistent, evidence-based and objective approach for the initial assessment and referral in mental health care, ensuring consistency across Australia.
- Without a national standard, GPs and clinicians use varying methods for assessing and assigning care, leading to inconsistencies and discrepancies in care. The IAR-DST provides a necessary, transparent referral process.
- Used alongside a comprehensive mental health assessment, the tool evaluates severity across eight domains—four primary and four contextual—to determine the appropriate level of care using a clinically informed algorithm.
- The tool identifies 5 Levels of Care based on resource intensity needed, not the treatment format or provide.
- The IAR-DST help facilitate informed, shared decision-making between referrer and patient, improving patient empowerment and adherence to care.
- MHPs must complete mandatory IAR-DST training as part of the PSS program. IAR-DST training dates can be found on the CESPHN website here.
- The IAR-DST is **NOT**:
    - An assessment tool.
    - Diagnostic.
    - Prognostic.
    - A replacement for clinical judgement.
- IAR Resources.

- IAR National Guidance
- IAR Snapshot
- IAR GP FAQ sheet
- CESPHN IAR Training Flyer
- Department of Health IAR Decision Support Tool
- IAR-DST Webinar - Open Learning instructions
- IAR-DST Online Training - Zoom instructions

3.4. Psychological Treatment

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

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

- **Interpersonal Psychotherapy (IPT)** – Is a brief, structured approach addressing interpersonal issues. The underlying assumption of IPT is that mental health and interpersonal problems are interrelated. The goal is to help Individuals understand how these problems, operating in their current life situation, lead them to become distressed and put them at risk of mental health problems.

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

- **Family-based Interventions – Child referrals** - Defined as any psychotherapeutic endeavour that explicitly focuses on altering interactions between or among family members and seeks to improve the functioning of the family as a unit, or its subsystems, and/or the functioning of the individual members of the family. This is not Family Therapy.

- **Mindfulness-Based Cognitive Therapy (MBCT)** –MBCT was developed to interrupt patterns of ruminative cognitive-affective processing that can lead to depressive relapse. In MBCT, the emphasis is on changing the relationship to thoughts, rather than challenging them.

- **Acceptance and Commitment Therapy (ACT)** – Is based on a contextual theory of language and cognition known as relational frame theory and makes use of several therapeutic strategies, borrowed from other approaches. ACT helps Individuals increase their acceptance of the full range of subjective experiences, including distressing thoughts,

beliefs, sensations, and feelings, to promote desired behaviour change that will lead to improved quality of life.

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

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

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

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

- **Short-Term Psychodynamic Psychotherapy** – a brief, focal, transference-based approach that helps Individuals by exploring and working through specific intra-psychic and interpersonal conflicts. It is characterised by exploration of a focus that can be identified by both therapist and Individual.

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

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

- **Relaxation strategies** - This includes progressive muscle relaxation and controlled breathing as part of overall treatment.

- **Skills training** - This includes problem solving skills and training, anger management, social skills, communication training, stress management and parent management training.

For further information, please see:

- Medicare Benefits Schedule Provision of Individual Focused Psychological Strategies Services by Allied Health Providers - Associated Notes
- Australian Psychological Society - Evidence-based Psychological Interventions in the Treatment of Mental Disorders: A Literature Review

3.5. Client Information Management System (CIMS)

The CIMS chosen by CESPHN is called rediCASE.

- CIMS is used to support central intake, triage and allocation, session data and financial management of PSS. CIMS also supports the National Primary Mental Health Care Minimum Data Set (PMHC-MDS – see **section 3.11. Minimum Data Set (MDS)**) reporting to the ADoHAC, and its use is a mandatory requirement of MHPs delivering PSS.
- Access to, and training in, the CIMS system will be provided to Providers by the CESPHN Mental Health Team, and the Providers are required to train all new MHPs.
- CESPHN will support the Provider with access to relevant reports and data summaries via the nominated CIMS to ensure that the Provider has adequate tools to monitor progress and achieve their administration duties as outlined in the PSS Guidance.
- In addition to the CIMS user guide, CESPHN will support the training of MHPs in the use of CIMs via pre-recorded videos explaining how to meet specific data entry requirements to ensure data quality.
- CESPHN may, at its absolute discretion, change or amend the existing record management system, or introduce a replacement record management system. CESPHN will provide training on any newly developed management system which replaces the current CIMS.
- CESPHN pulls the monthly MDS Data on the **6th day of the new month**. Therefore, all MDS data is to be entered by the MHP into the CIMS before this.
- CESPHN CIMS is not to be used for MHP PSS clinical case notes. Case notes are to be kept by MHP as directed by the Provider.
- CESPHN triage will write clinical notes in the Admin Notes section for review by the Provider and MHP.
- Non-clinical notes can be added to CIMS for the purpose of communicating relevant information or actions related to the referral, e.g. reason for declining a referral, MHP gender preference, area of service, out of area.
- Within the non-clinical notes tab of a referral, there are pre-set options MHPs can use to record activity types. E.g., to identify that an attempt has been made to contact the client or that an appointment has been made.

- MHPs must ensure they record session dates and times correctly, as two assessments recorded on the same date will be picked up in MDS as one assessment, hence creating an error.
- Referrals should only be assigned and reassigned by the Provider and CESPHN. MHPs should not reassign referrals in rediCASE.

- **Please note:** Non-clinical notes can be reported on and thus should not contain any identifying information.

- GPs and other referrers DO NOT have access to CIMS and thus are unable to view any documentation or notes uploaded to each file.

3.6. Documentation

- Each MHP must document all PSS sessions in their own private CIMS. CESPHN CIMS (rediCASE) is not to be used for clinical case notes.

- An entry must be made in the MHP private CIMS for each Individual. Entries should reflect the level of assessment and intervention undertaken. Issues of significance must be sufficiently detailed. This includes issues relating to:

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

- Documentation must provide an accurate description of each Individual's contact with the MHP. CESPHN requires that these health care records are available for every Individual accessing PSS. MHPs must maintain adequate and legible records of all services provided as part of the PSS services in their own preferred CIMS.

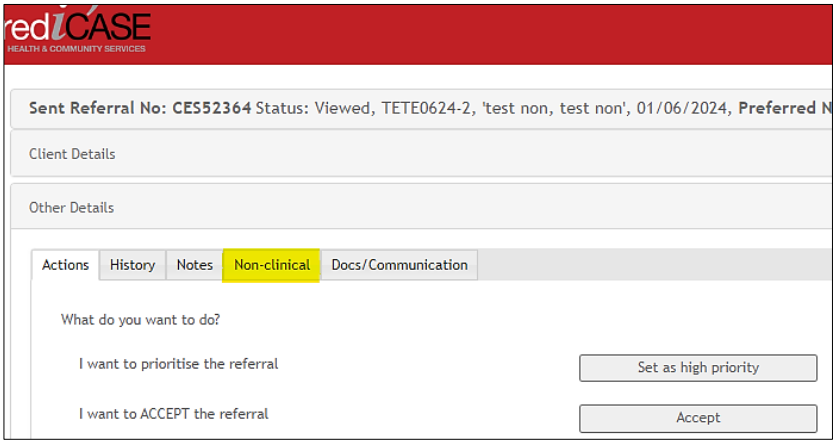
- All entries made by the MHP for an Individual's records (in their own CIMS) must be:

- Contemporaneous:

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

3.7. Referral to Initial Appointment

- MHPs are recommended to view the CIMS regularly for new referrals and review notes on each referral.
- **Referrals should be accepted or declined by the MHP within 72 hours of receiving the referral. Do not leave the referral to accept on the first appointment.** Accepting a referral is an acknowledgment that you will take on the Individual and attempt to book in an initial assessment.
- **Referrals must be accepted before contacting the Individual**. If an appointment time is unable to be found, the MHP should contact their Provider to request reallocation to a more appropriate clinician.
- The first appointment needs to be booked within 4 weeks of the MHP accepting the referral.
- A Consent form must be signed by the Individual. MHPs must update any changes to consent in the client's CIMs file.
- Useful information to provide the Individual at the first appointment:
    - PSS flyer
    - Statement Rights and Responsibilities
    - Australian Charter of Healthcare Rights
- Emergency contacts are **essential** and must be noted in the CIMS. On the first appointment, emergency contacts should be confirmed or added if not provided with the referral information. This is done by adding a note of the emergency contact details in the Special Conditions section of the Client Details Tab of the referral.
- All attempts to contact the Individual are to be logged via the non-clinical tab in the CIMS. This allows CESPHN Intake to respond to referrers when enquiring about Individual(s).



- Please update the CIMS when there are any changes in the Individual's details, so the MDS is accurate.

- Once an Individual is allocated and accepted by the MHP the duty of care rests with that MHP and the Provider. MHPs with clinical issues relating to current PSS Individuals should address their concerns with the Provider Clinical Lead.

3.8. CESPHN Communication

- The Admin Notes section of the CIMS is used by CESPHN Mental Health team to make any relevant notes during the intake, triage, and allocation process. This ensures that the Individual's journey through the centralised intake system can be tracked, and information shared.
- The CESPHN Mental Health team will include a note on each file relating to the number of sessions the Individual currently has remaining.
- The Notes section should be viewed by the Provider to assist in appropriate MHP allocation as requests, e.g., gender, location, availability and preferred MHP will be documented here.
- If the MHP does not think an allocated referral can be serviced within the program timeframes, a note should be written in the CIMS Notes section, and MHP contacts the Provider immediately for reallocation.
- If the MHP does not feel the referral is appropriate for the program, they should discuss this with the Provider Clinical Lead. If it is not appropriate for PSS, the MHP is to inform the GP of alternative pathways and close the file.
- MHPs should contact the Provider for administrative questions relating to new referrals or current PSS Individuals and for CIMS related correspondence (CIMS).
- Once an Individual is allocated and accepted by the MHP, the duty of care rests with that MHP and the Provider.

3.9. Referral Communication

- Referrers can nominate a Preferred Provider MHP. If unavailable, the MHP must document this in CIMS and contact the Provider to reassign the case. Be mindful that the Individual may expect a specific MHP; please acknowledge this when introducing yourself.
- The CIMS generates an automated email to the referrer, notifying the referrer their referral **has been accepted by the MHP.** For example,

  Dear Dr XX,
  PSS - Young Person (12-25) REFERRAL NOTIFICATION
  This email is to confirm that your referral on 07/02/2022 for services through the program for Referral: CES3410118, client XX N, DOB 07/01/1989, Gender Female has been accepted and is being processed by APMHA – John Smith. If you require any further information, please contact the team on: Email: mentalhealth@cesphn.com.au
  Regards, rediCASE

- CESPHN will keep referrers informed of all processes and any changes to the PSS program as they occur.

- Please note: Referrers, including GPs, **DO NOT** have access to CIMS (rediCASE), thus cannot see any notes. Correspondence must be directly sent to the referrer.

3.9.1 Medical Practitioner (MP) Referrer Communication

- The MHP is to provide the referring MP with a timely and comprehensive assessment and treatment plan report, between sessions 1 and 3, and at session 10.
- If an individual changes or finds a new GP, the MHP is to discuss with the client where current and future correspondence should be directed.
- Please ensure a copy of all MP reports and letters are uploaded into CIMS, otherwise a delay will occur in processing reviews.
- Correspondence to the MP is required:
    - **Between session 1 and 3** to outline a comprehensive assessment and treatment plan.
    - **At completion of allocated sessions or after the 10th session**, whichever comes first, as a review of progress against the initial comprehensive assessment and treatment plan.
    - **At episode end or the point of discharge** to outline treatment summary and outcomes, relapse plans and any further referral recommendations.
- When **stepping up or down of an Individual between PSS and SPS**, once approval has been obtained from the Provider Clinical Lead.
- A referral (and accompanying MHTP) is valid until the referred number of sessions have been completed, regardless of whether an individual chooses to change their MHP.
- Additional sessions up to a total of 18 are only provided after the MHP has provided the GP with a detailed progress report, entered an updated outcome score (K10+, K5, SDQ), and received approval from the Provider Clinical Lead. MHPs are **NOT** to provide sessions beyond the 10th session without approval.
- Notification of approval for further sessions will be sent to the Provider to communicate to their MHPs.
- The Provider will communicate the outcome to the MHP who will then inform the Individual's GP.
- MHPs are not to contact MPs requesting PSS referrals for their Individuals, this is always at the MP's discretion to determine the most effective treatment options.

3.9.2 Non-Medical Practitioner (NMP) Referrer Communication

- Approved NMP referrers:
    - School Welfare Staff
    - Youth Mental Health Services
    - Headspace Clinical Staff
    - Child and Maternal Health
    - Perinatal Mental Health
    - TWBSS
    - Tertiary Welfare Staff
    - Multicultural Community Health Services
    - Non-Governmental Organisation
    - Mental Health Clinician
    - Community of Neighbourhood Centres
    - Aboriginal Community Controlled Health Services (ACCHS)
    - House Parents of Kirinari Hostel (Sylvania)
    - Directors of Early Childhood Services
    - Aboriginal Health and Wellbeing Worker

- NMP can refer for commencement of service with a PSS registered MHP **prior** to the development of an MP Mental Health Treatment Plan.

- Once an NMP referral has been accepted, the MHP still needs to complete the initial comprehensive assessment and treatment plan within the first 3 sessions. If it is relevant for a copy to be sent to the NMP referrer, please send and upload a copy to the client file in the CIMS. This document can be forwarded to the treating MP once they are on board.

- If additional sessions are required after the 10th session, to finalise treatment, the Individual will need to see their MP for a MHTP (either via a PSS referral or a general GP MHTP) before further sessions can be approved, subject to the individual's circumstances meeting the criteria and Provider approval.

- If the Individual doesn't have an MP, please assist in linking them to a MP as soon as possible.

- **Please Note:** PSS MHP are not permitted to refer individuals into the PSS program due to conflict of interest.

3.10. Mandatory Reporting

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

3.11. Minimum Data Set (MDS)

- Accurate data collection is important. The data collected in the CIMS is used to demonstrate the effectiveness of the focused psychological interventions that are delivered as part of the

PSS program, which in turn ensures ongoing funding to the PSS program. Conversely, inadequate, or inaccurate data collection places ongoing funding at risk.

- The **Primary Mental Health Care MDS (PMHC-MDS)**, mandated by the ADoHAC and updated from time to time, outlines the requirements for data collection and reporting for each PHN. This is designed to monitor the progress of mental health reforms being led by PHNs. It is the responsibility of the PHNs to ensure that the collection and reporting requirements are met by all contracted Providers of commissioned mental health services.
- The PHN provides regular reports to the ADoHAC based on this data. This data is used by ADoHAC to evaluate the services commissioned by the PHN and determine future funding to mental health.
- Please note that all MDS mandates set by ADoHAC cannot be amended. CESPHN does not have the authority or scope to alter or remove these mandates.
- Data from the CIMS is linked directly to the MDS. It is therefore essential that all data entered in the CIMS is accurate. Data from the CIMS is also directly linked to the PHN contract management processes including invoicing, hence there is a further need for this data to be entered accurately and in a timely manner.
- MHPs are responsible for updating any MDS information that may change during their time with the individual. This is the information in the case file tab in the individual's file. All MHPs can access this and edit this tab at any time.

3.11.1 Relationship between MDS items and Key Performance Indicators (KPI)

- This following section describes the interrelationship between the MDS items and the Key Performance Indicators (KPIs) that ADoHAC uses to measure the effectiveness of the PSS program. Please read this section in conjunction with the **CIMS User Guide** to familiarise yourself with the key data collection items and their impact on PSS KPIs to ensure accurate data collection.
- **Table 1: MHP Guide for data entry to accurately capture the ADoHAC Mental Health Indicators** shows the correct values to record for each MDS field that contributes to the PSS KPIs.
- The remainder of this section highlights some common MHP data entry errors that interfere with accurate KPI reporting.

Timely and Accurate Recording

- If an individual has not been seen for 60+ days, the referral is considered inactive and must be closed. If there is a reason for service delays, this must be noted and approval from Provider Clinical Lead must be given for any file outside of this timeframe.

- CESPHN pulls the monthly MDS Data on the **6th day of the new month**. Therefore, all MDS data must be entered by the MHP into the CIMS before this.

Client Consent to Share De-identified Data

- Client consent to collect and share de-identified data is collected on the online PSS referral form and this field is automatically pre-populated into the CIMS from the form to ensure all suitable data is uploaded to the ADoHAC.
- At the first session, the MHP should confirm with the Individual that consent has been accurately recorded on the episode/commence page of the Individual's file.
- If the client consents to sharing anonymised data but the consent field is not checked, the data will not be uploaded to ADoHAC, resulting in inaccurate KPIs
- If the Individual would like to withdraw this consent at any time throughout their care, the MHP is able to go into the episode on the CIMS and amend the consent field.

Principal Focus of Treatment

- DO NOT change the prepopulated selection field Principal Focus of Treatment Plan "Psychological Therapy". This field should only be changed if the Individual identifies as Aboriginal or Torres Strait Islander or is being serviced through headspace.
- See "**Access to Services**" in **Table 1:** for the correct selection.

Suicide Referral Flag

- The "**Suicide Referral Flag**" option on the Episode Commence page should only be selected if the Individual has been referred under the PSS Suicide Prevention Service (SPS) and indicates that the Individual has acute needs.
- ADoHAC has specified that ALL episodes where the SUICIDE Referral Flag is ticked MUST have their initial MHP consultation recorded in CIMS (face to face or over the phone) within **7 days** of the date the referral was received by CESPHN and have **mandated a 100% adherence rate.**
- If an initial face to face session **cannot** be conducted within the 7-day period, the MHP will need to arrange an assessment via Tele- or Virtual-health. This contact with the Individual must include: an assessment including risk and completion of a safety plan as needed. **This will then be entered as a telephone-based service contact in CIMS.**
- Please DO NOT select this flag for Individuals that are under the General PSS program and have some suicidal risk.
- For more specific information about the SPS program **See Section 8: Guidelines Specific to PSS Suicide Prevention Service (SPS).**

Recording Clinical Outcome Scores

- The "**Clinical Outcomes**" section in **Table 1** refers to the collection of pre and post clinical data. The ADoHAC relies on the completion of this data to determine the effectiveness of the service provided. See Section 11: Outcomes and Satisfaction on how to correctly record outcome data in the CIMS.
- MHPs must ensure that they enter an appropriate clinical tool, i.e., K10+, K5 or SDQ at the first session, 10th session, and at the last session when they close the episode of care.
- The outcome measures recorded at the first and last session are paired in the MDS to measure program effectiveness. Only PAIRED outcome measures contribute to this KPI (i.e., any unpaired outcome measures are excluded).
- ADoHAC mandates a target of 70% paired outcome completion across the program. It is imperative that MHP enter this data into the CIMS.
- MHP must use the same specific **recommended outcome tool at episode start and episode end to be able to achieve a matched pair.** To be counted as a matched pair, the episode must:
    - Have a Start and End measure recorded in the CIMS, and these measures must be.
    - Both be the same i.e., both K10+, K5, or SDQ.
    - Completed and recorded in an attended service contact.
    - **Please note:** Only 1 measure can be completed per service contact and any measures with a value of 99 for the score will not be counted.
    - Be closed as "Treatment Concluded" through the final service contact within 7 days:
    - Select the option "No further sessions are planned for the client in the current episode", to return the prompt "Do you want to close this episode of care?"
    - Select 'Yes' to return the closure window with instructions for closing the episode.
    - **Please note:** Selecting 'No' at the prompt will save the service contact but **does not close the episode.** In this instance, the MHP **must return to close the episode as "Treatment concluded" within 7 days** of entering the last service contact otherwise the outcome measure will not be counted.
- **See Section 11.1 Clinical Outcomes** for further information.

Table.1. MHP Guide for data entry

MHP Guide for data entry to accurately capture the ADoHAC Mental Health Indicators. Table 1 below summarises the ADoHAC mental health indicators embedded in the CIMS. There are 3 main indicators that we are all working towards - Access to service, Appropriate of service and Clinical Outcomes.

ADoHAC MENTAL HEALTH INDICATORS	SUB INDICATORS	MEASURED BY	TO BE COMPLETED	CESPHN SERVICE ADoHAC TARGETS
Access to services. **Principal Focus of Treatment Plan**	Psychological Therapies delivered by MHP	*Number of **persons, based on Episodes** accessing psychological therapies*	**Select:** **Psychological therapy**	Service Underserviced Groups - Adult (low income), Mild Intellectual Disability, Multicultural, SPS, PND, LBGTIQ, children.
Selected at episode commence.			**Select:** **Indigenous-specific mental health services**	Service Aboriginal and Torres Strait Islander People and Project PSS-54
Appropriateness of services	Service to Aboriginal and Torres Strait Island People	***Service contacts count** delivered by a MHP who has completed recognised cultural competency training or recorded as of Aboriginal or Torres Strait Islander origin*	Cultural Competency Awareness training mandatory and CESPHN notified to be entered into CIMS	Target 100%
(Suicide referral flag elected at episode commence)	Suicide Prevention Services	***Number of Episodes** that are followed up within 7 days of referral*	Service contact needs to be entered into CIMS within the **7 days of date of referral**. Completed via face to face, Telehealth or Telephone session.	Target 100%
Clinical Outcomes	Psychological Therapies delivered by MHP	***Number of completed Episodes** with valid outcome measure completed at episode start and episode end.*	**Select: K5** for Aboriginal and Torres Strait Islander People (18+ yrs), intellectual disability or older adults if needed. **Select: K10+** for adults over 18+ **Select: SDQ** for Children (up to and including 17yrs)	Target 70% **Please note:** For persons under 18 years, clinician-discretion is allowed for use of K10+/ K5

4. Who Can Deliver PSS?

4.1. MHP Qualifications and Standards

- To ensure a high-quality standard of service delivery, MHPs delivering services must be appropriately trained and qualified health professionals.
- The MHPs are expected to hold Australian Health Practitioner Regulation Agency (AHPRA) registration or Mental Health Social Work Association Registration.
- Only PSS-approved MHPs can deliver PSS services/treatments.
- A completed Provider Information Form or equivalent needs to be collected for CIMS template.

The MHP is required to:

- Be fully qualified according to the requirements of their profession and credentialed in the field of Mental Health.
- Be members of a professional body with ethical and professional guidelines, and accountability and disciplinary procedures for dealing with malpractice, incompetence and unethical behaviour and agree to abide by their profession's Code of Ethics.
- Be adequately experienced in the field of mental health and trained in delivering psychological therapies; engage in clinical supervision as per their professional body's requirements for continuing professional development.
- Be currently or recently engaged in clinical practice in that field and have **2 years** of experience working in the field.
- Engage in ongoing professional development, including suicide prevention training for MHPs providing SPS services (**see Table 2** for approved training to be a SPS MHP).
- Complete Multicultural and IAR training requirements.
- Have sufficient insurance cover in place for malpractice, public and products liability.
- Have had a National Police Check undertaken before commencement.
- Have appropriate training and experience to deliver services to the identified target group(s). Provisionally registered allied health professionals or students are **not** eligible to provide suicide prevention services and services for Children.
- Promote recovery from mental illness, in line with the National Framework for Recovery Oriented Mental Health Services 2013.
- Obtain and provide the new Working with Children Check (WWCC) from Service NSW if the MHP is providing PSS Services to, or is likely to come into contact with, Young People and Children less than 18 years of age. CESPHN encourages all MHPs to have an up-to-date WWCC as there is always potential for incidental contact with Children and Young People.

4.2. Provisionally registered psychologists

- In some settings Providers may be able to offer provisionally registered interns the opportunity to provide services under PSS as part of their Psychology Provisional Registration. These interns can provide PPS under the direct clinical supervision of AHPRA approved clinical supervisors, and the nominated supervisor must ensure that referral complexity is commensurate with the intern's level of experience.
- Provisionally registered psychologists must be approved by CESPHN. The PSS program can have a small number of Intern providers as part of a predominantly fully registered and experienced workforce.
- Clinical Psychology Registrars in their final year of placement who have had some experience in working with the target group will be considered.
- Provisional Psychologists in the PSS program are not permitted to see Individuals under the SPS stream or Children without permission from CESPHN and the Provider.

4.3. Specific Training

- Specific training and/or experience is required when working with the client groups. **See Table 2. Training Requirements** below for a list of these training requirements.
- It is also highly recommended that the following training be completed for:
    - People with co-occurring mental health and drug and alcohol needs. Due to the high prevalence of co-occurring mental health and drug and alcohol needs, MHPs are recommended to review the National Comorbidity Guidelines and complete the associated online training at https://comorbidityguidelines.org.au/
    - LGBTIQA+ Individuals to be able to assist with Gender Dysphoria and associated mental health issues. There are several organisations that provide relevant training including The Gender Centre, Twenty10, and ACON. **See 7.4 LGBTIQA+**
- **Please note**: If you have equivalent or extensive training in these areas, please submit a request to your Provider's Clinical Lead to vet these against the mandatory training requirements.

Table 2. Training Requirements and Recommendations

It is the responsibility of the Provider to determine if the MHP has received suitable and relevant training.

Groups	Training Requirements
Aboriginal and/or Torres Strait Islander Peoples **This training is mandatory to MHPs who wish to work specifically with Aboriginal and or Torres Strait Islander clients.**	Recognised Cultural Competency training including those provided or endorsed by The Australian Indigenous Psychologists Association (AIPA) **or** Centre for Cultural Competence Australia (CCCA) Aboriginal and Torres Strait Islander Cultural Competence Course Trauma-informed Aboriginal and Torres Strait Islander Cultural Capability
Multicultural Communities	Previous comparable cultural training, bilingual and/or experience working with interpreters when working with people from Multicultural communities **Or** Minimum cultural competency training from the Transcultural Mental Health Centre is available through your Provider Organisation. For more information about cultural competency please see Framework for Mental Health in Multicultural Australia
Children and their Families	Recognised training in Child Mental Health includes online training from the Australian Psychological Society (APS) Information about Child Mental Health is also provided by Emerging Minds
LGBTIQA+	There are several organisations that provide relevant training, for example: Gender Centre Twenty10 Pride Training Rainbow Health Australia
Perinatal	Training and experience with Attachment Theory. Recognised training includes APS Perinatal Non-Directive Counselling Training V2 or FREE online training course for health professionals from COPE
Individuals at risk of suicide	APS Suicide Prevention training (CPD approved) Black Dog Institute Advanced Training in Suicide Prevention

4.4. Location of PSS Service

- MHP services are to be delivered from a professional setting.
- MHPs are to make services accessible to underserviced populations and hours of operation should reflect this.
- MHPs must provide their Provider with up-to-date lists of consulting locations or any changes to location.
- The Provider and MHP warrant that the location complies with all relevant Work Health and Safety (WH&S) Policies and appropriate insurance coverage is in place.
- MHPs may provide PSS to Individuals in an outside setting provided all relevant Work Health and Safety (WH&S) policies, meeting privacy legislation and quality and safety standards, and appropriate insurance coverage are in place. MHPs should seek approval from the Provider Clinical Lead prior to facilitating PSS sessions in an outside setting.

5. PSS Referral Process

- Referrals to the PSS program can be made by:
- **Medical Practitioners (MP)**: GPs, Psychiatrists, Paediatricians, Obstetrician-Gynaecologists, and any other Medical Doctor
- **Non-medical Practitioners (NMP):** **See Section 3.9.2. Non-Medical Practitioner Referrals**
- All referrals and reviews must come through the CESPHN Mental Health team via:
  - Online Service Referral Form
  - HealthLink **ID: CESPHNMH**
- CESPHN's emails are not encrypted end to end. Therefore, we cannot send or receive any emails with client's information as it is considered a breach of privacy. Referrals or correspondence containing an Individual's identifying information received via email **will not be accepted and will be deleted without action immediately.**
- MPs continue to play the central role in providing and coordinating physical and mental health care within the primary care setting. A Mental Health Treatment Plan (MHTP) from a MP is required and ongoing reviews encouraged.
- NMP referrals will allow MHPs to carry out up to 10 sessions to do a comprehensive assessment and treatment plan and facilitate a MP Mental Health Treatment Plan when appropriate.

5.1. Individual Sessions

- Individual sessions can be face-to-face, by phone, or via telehealth, based on the individual's preference. Sessions must be evidence based, focused psychological strategies (FPS).
- Each session lasts at least 50 minutes, plus 10 minutes for administration. If on a rare occasion a session needs to exceed 60 minutes, pre-approval from the Provider Clinical Lead is required. In exceptional cases like SPS critical events, pre-approval may not be possible.
- Individual sessions include providing evidence-based interventions for people who have attempted, or are at risk of, suicide or self-harm where access to other services is not available or appropriate.
- All PSS referrals can include up to 2 x care coordination sessions as part of the episode. MHPs can allocate the sessions as needed to equal a total of 10 sessions. For example, use all 10 allocated sessions for therapy or use 9 x sessions for therapy and 1 x session for care coordination, or 8 x sessions for therapy and 2 x sessions for care coordination.
- New referrals receive 10 sessions upon approval by CESPHN. Up to 8 additional sessions may be approved under extenuating circumstances by the Provider Clinical Lead.
- A **maximum** of up to 18 sessions is permitted for each individual if needed.
- MHPs must send a GP letter when sessions begin and provide a comprehensive assessment and treatment plan by session 3. A GP progress letter is required by session 10 and/or end of care. Outcome scores should be entered at session 1, session 10, and/or end of care.
- To access additional sessions the MHP needs to provide a GP progress letter at/before session 10, upload a copy into the CIMS, and enter outcome scores. The MHP must also seek approval and confirmation from the Provider Clinical Lead for additional sessions. Failure to do so may result in a decline in further sessions.
- Additional sessions beyond 10 are not guaranteed and are subject to the Provider Clinical Lead approval.
- At the end of care, the MHP Is required to send a final GP letter with a care summary and recommendations and upload it to CIMS.
- To ensure MDS data is current and accurate, we request inactive files be closed. If an individual has not been seen or their file has been inactive for 60+ days, it must be closed. If the Individual wishes to return, please refer to **Section 5.10. Request to Return to Care**.
- **Sessions cannot be scheduled or commence in advance** without first being approved by the CESPHN Mental Health team and Provider Clinical Lead. This includes sessions before the review has been approved.
- The most accurate way for MHPs to check the total number of sessions provided is in the **Service Contact** tab of CIMS. The tally at the top of the page - Approved Service Contacts Used - shows approved and used sessions. E.g., 3 sessions have been used out of 10 (Approved Service Contacts Used: 3/10). **Please note** that this is not always accurate and there may be notes associated with this in the notes section.

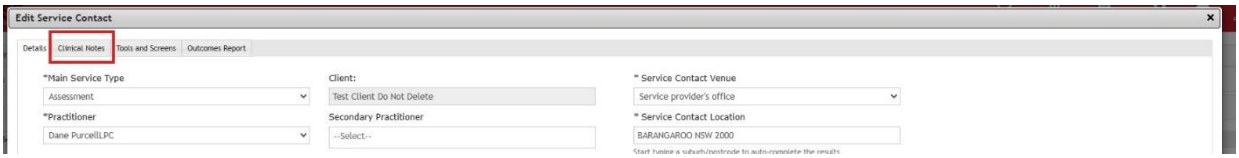
- **Please note** if the Individual is having difficulty obtaining a GP MHTP, please discuss with your Provider Clinical Lead, who may request exemption from CESPHN Clinical Lead.
- For PSS SPS sessions please refer to **Section 8: Guidelines Specific to PSS Suicide Prevention Services (SPS).**

5.2. Episodes of care

- PSS provides short to medium term psychological intervention to Individuals with mild to moderate mental health needs. As such, Individuals who require longer term intervention are not eligible for this program.
- An "**episode of care"** is defined as the period that an Individual is receiving psychological support for a specific mental health issue.
- For most Individuals entering PSS, 10 sessions of intervention for an episode of care will be sufficient, as they are presenting with mild to moderate levels of need.
- Once an individual has reached the maximum sessions under PSS they will exit the program. Individuals cannot return to PSS unless there is a new diagnosis or treatment need.
- PSS is not for repeated access and does not renew annually.
- If during the initial comprehensive assessment and treatment plan, a MHP identifies that a client may require more than 10 sessions due to a more moderate presentation, the MHP should flag this need with the Provider Clinical Lead early.
- **Please note** that SPS sessions do not contribute to session counts. Individuals can be stepped up to receive SPS sessions, and then stepped down again.

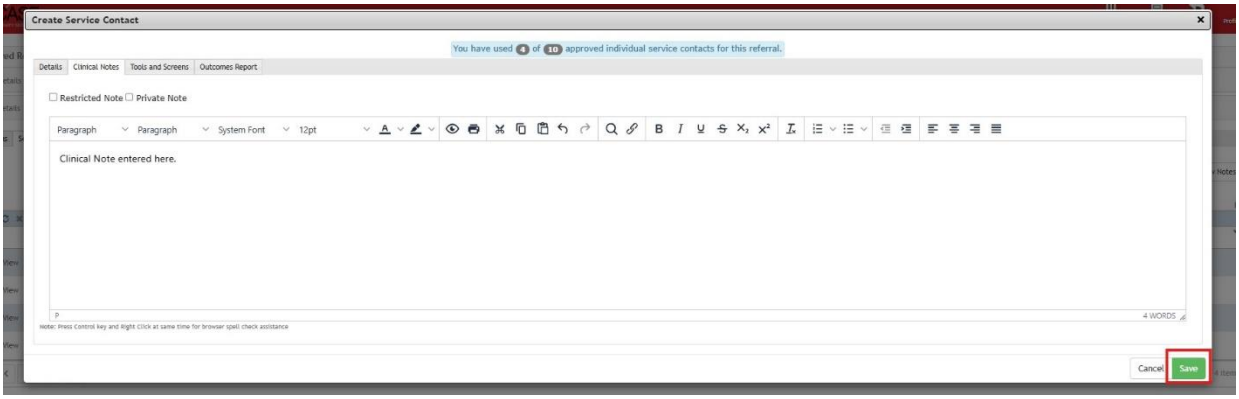
5.3. Clinical Notes

- Clinicians are able to utilise the Clinical Notes tab within a Service Contact to log all clinical notes in relation to the session delivered.
- To enter a clinical note, log on to the CIMS and click on the details tab of the client. Once the client file is open, click on the 'Add Service Contact' selection.
- All mandatory Service Contact details must be completed before a clinical note can be saved. It is recommended to complete the Service Contact in its entirety prior to entering a clinical note.
- Once the Service Contact has been completed in full, click on the 'Clinical Notes' tab at the top of the screen.



- After the Clinical Note tab has been selected, a free-text box will appear where you can now enter your clinical notes.

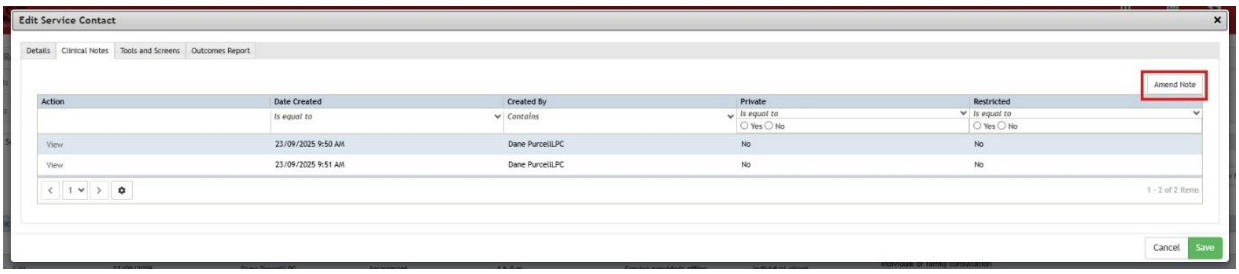
- **Please note** do not select the 'Restricted Note' or 'Private Note' options. These functions are not operational.



- After you have entered your clinical note, you may select the green save button located at the bottom right of the screen. Selecting Save will close the Service Contact as being completed. Please ensure all information has been entered into the clinical note prior to saving.

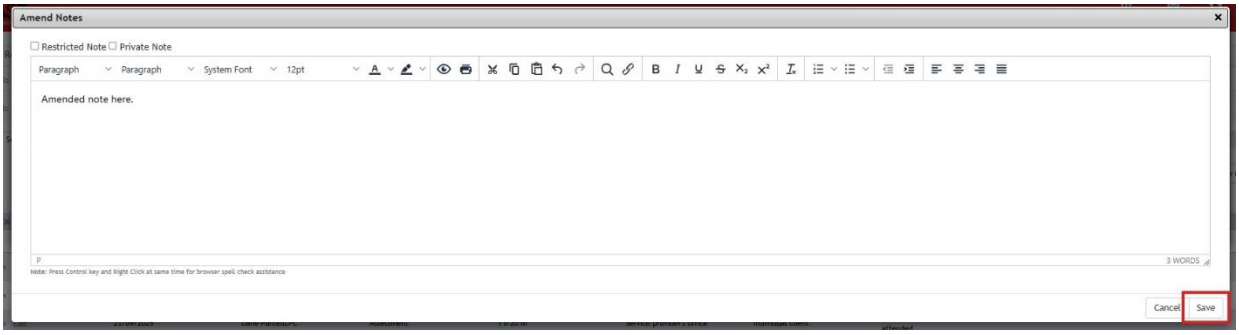
- **Please note** once a clinical note has been saved it will be locked and cannot be edited or removed.

- You may also Amend any clinical notes that have been entered previously by clicking on the edit button of the respective Service Contact, clicking the Clinical Notes tab and finally clicking the 'Amend Note' button.

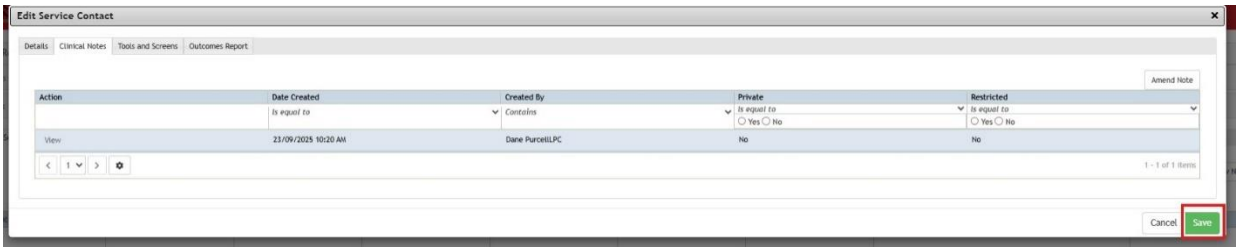


- A free-text box will appear where you may now enter additional information into the Clinical Note. Once all Information has been entered, click the 'Save' button at the bottom right of the screen.

- **Please note** amending the clinical note will not override the original note, it will merely include additional information you enter.



- You will now return to the Clinical Note tab where you can select the green 'Save' button to close the Service Contact screen.



5.4. Additional Sessions

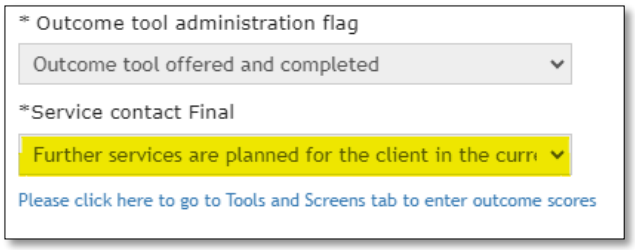
- In some cases, additional sessions beyond the initial 10 may be needed for an Individual to complete their treatment goals or to transition to alternative care, as a result of changes in an Individual's circumstances.
- When an individual utilises 10 sessions (or part thereof), the treating MHP can apply for up to 8 additional sessions, if circumstances such as job loss or bereavement have delayed treatment outcomes. Additional sessions require clinical justification for the need and a plan for how to move to another service or exit the program.
- If an individual requires more than 18 sessions, a step up of care may be needed. Please discuss this with the Provider Clinical Lead so they can review the clinical needs and discuss the possibility of transferring care or access to more appropriate services.
- The Provider will use a combination of all assessment and treatment plans in CIMS (comprehensive assessment and treatment plan information, outcome scores, discharge planning, GP report, and the requested number of additional sessions) to assess and approve additional sessions (up to a maximum of 8).
- Clinical parameters for additional sessions:
    - Significant changes in the Individual's clinical condition or care that require further support towards achieving their treatment goals.

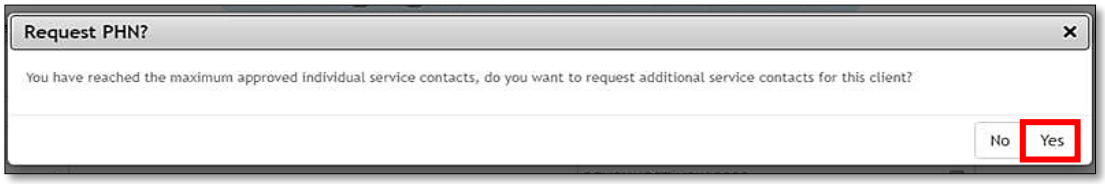
- Significant impact arising from a negative event change in life circumstances (e.g., becoming homeless, death of a loved one, etc.)
- Essential treatment is needed for a new care requirement.
- Re-entry into the program with a new diagnosis.
- Delay in accessing ongoing support (e.g., NDIS).
- Support a warm handover where appropriate.

- The Provider Clinical Lead must document approval for additional sessions (1-8) in CIMS, with an Admin Note indicating the total approved sessions (up to 18 in total) per care episode.
- The Provider Clinical Lead and CESPHN Mental Health team will ensure that all mandated outcome scores and documentation are completed before approving the final set of sessions.

5.5. Requesting Additional Sessions

- Sessions in rediCASE are set up initially releasing 10 sessions. For additional sessions to be requested, the MHP:
- Must seek approval from the Provider Clinical Lead and ensure all mandated outcome scores and documents are uploaded to CIMS.
- Must enter the 10th session service contact including the outcome score and complete *Service Contact Final field.
- Choose "further sessions are planned for the client…"
- Once this has been chosen, a "Request PHN?" box will appear.

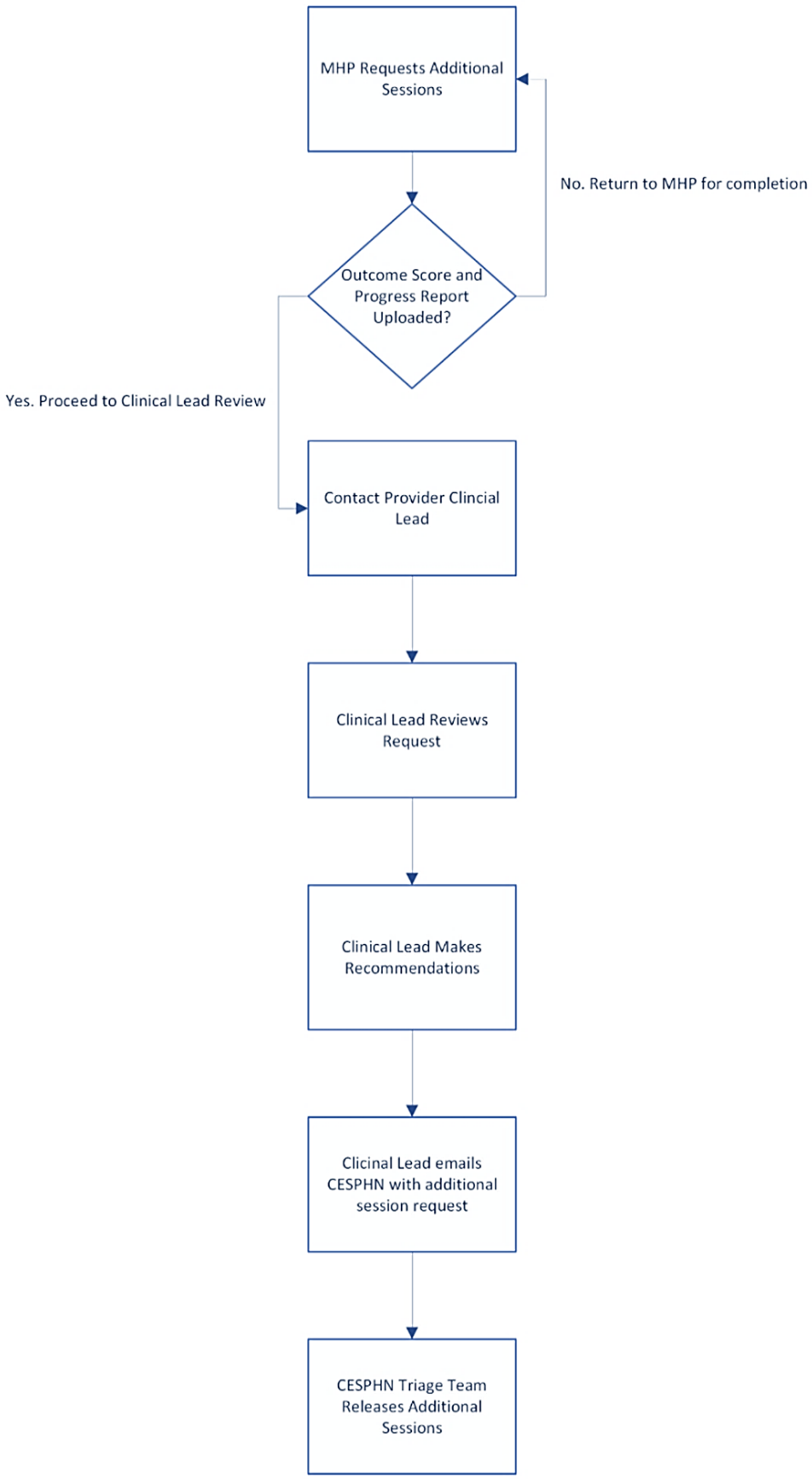




- Once this is requested by the MHP a notification will be sent to the CESPHN Mental Health team. The MHP will need to ensure that all mandated outcome scores and documentation are completed in the system before additional sessions are approved. **See CIMS User Guide**
- The requests for additional sessions are reviewed daily by the CESPHN Mental Health team.

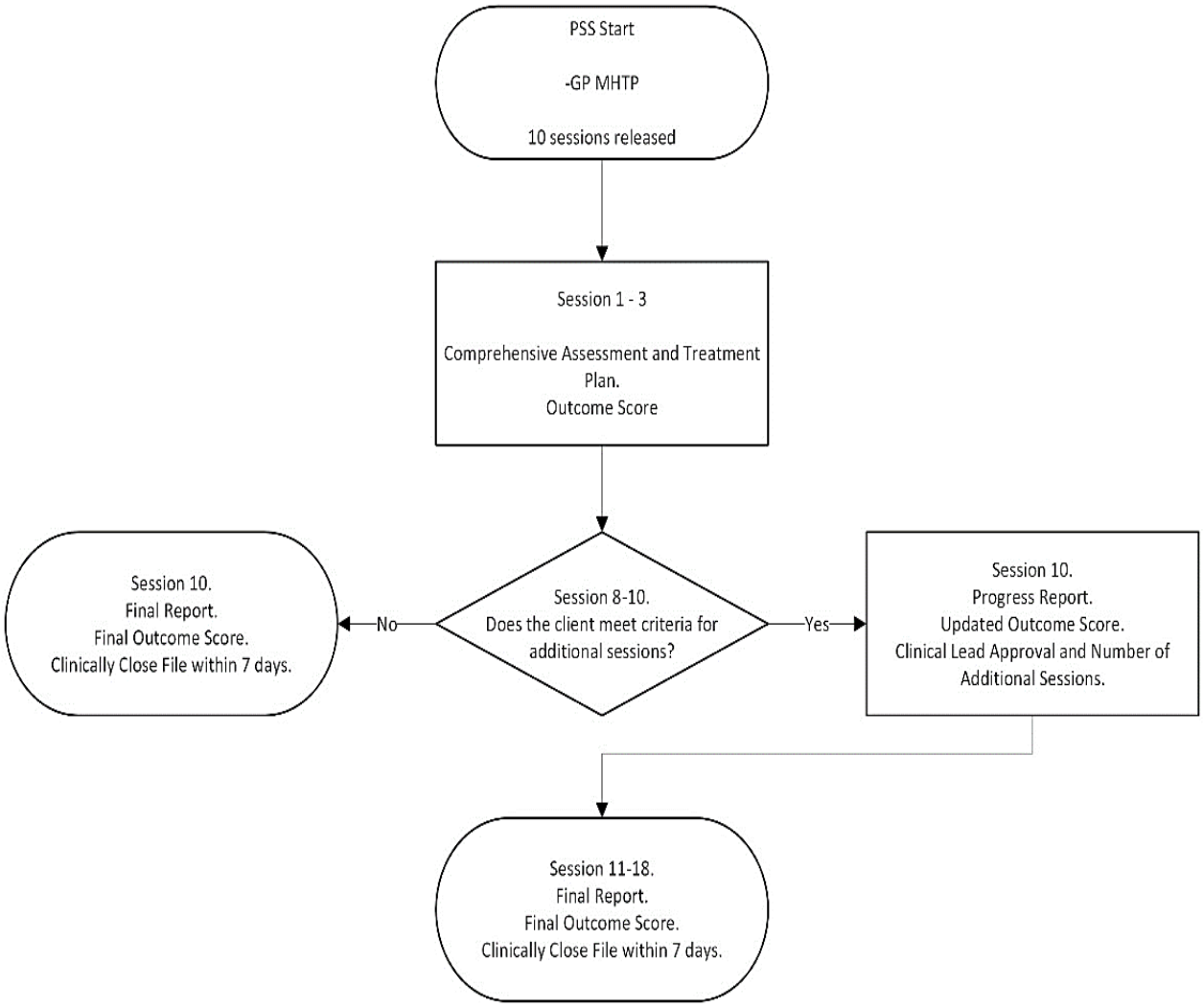
Please note:

- If you are adding mandated outcome scores or documentation AFTER this box has been completed, you must notify CESPHN for your request to be processed.
- The Provider will approve further sessions and the number of approved sessions. If ongoing clinical needs cannot be addressed in limited additional sessions, the individual should be referred to a more appropriate service.
- CESPHN Mental Health team will not release additional sessions unless there is an approval note Admin note in rediCASE from the Provider.
- The MHP cannot provide additional sessions to the client until formal approval is granted by the Provider Clinical Lead and the approved number of sessions has been added to the client rediCASE file by the CESPHN Mental Health team.

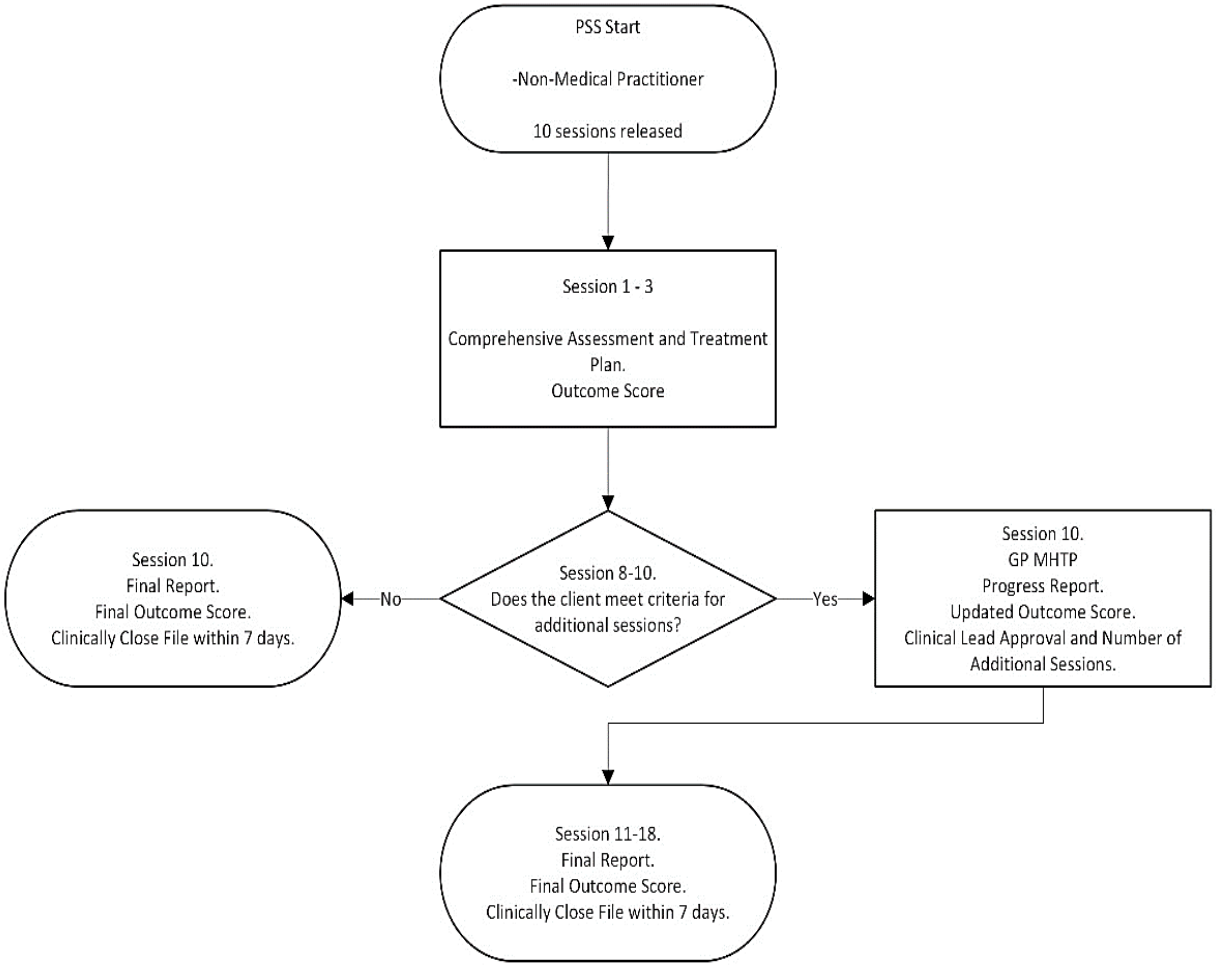


5.6. Referral Workflow

GP Referral Workflow



NMP Referral Workflow



5.7. Time Frames

- Recommended time frame guide.

GENERAL PSS REFERRALS		
FROM	**TO (completion of task)**	**Days (after receiving referral)**
1. Referral sent to CESPHN	Triage and allocation	Up to 72 hours
2. Provider	Allocate to MHP	24 hours
3. MHP	Needs to accept referral in CIMS	72 hours
4. MHP	Initial Individual appt	Within 4 Weeks

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

- **Please Note:** All SPS referrals received after 12pm on a Friday afternoon is not guaranteed to be assigned to a MHP until the following Monday (Tuesday if Public Holiday prevails).
- **Please Note:** All referrals marked as "treatment concluded" **must be closed** within 7 days of the final Service Contact to ensure accurate data capture.

5.8. MHP Unable to Contact an Individual

- A MHP must accept a PSS referral if they have the capacity to do so. MHPs should not wait until they have made contact with the individual before accepting the referral.
- When a MHP has accepted a referral, they have assumed the duty of care for that Individual.
- After three contact attempts over a two-week period, It Is reasonable to conclude that the Individual In unreachable.
- The MHP must communicate with the referrer, updating them of the non-engagement with the Individual and document this as a discharge letter in CIMS.
- An entry must be made in the non-clinical notes section of the CIMS for each attempt to contact the Individual.
- The referral can then be administratively closed by the MHP, adding a note in CIMS of the reason, e.g. unable to contact the Individual.
- The MHP must communicate to the referrer that they were unable to engage the individual and document this in the Admin Note section in CIMS **before closing the episode.**
- **Please note** -Only referrals where no MDS data and no Service Contacts entered can be reopened by CESPHN. If you have a file that fits these parameters, please contact the Provider Clinical Lead to request the file is reopened.
- For SPS referrals:
    - The MHP and MP to discuss if further action is required. For example, the MP makes attempts to contact the individual and if not successful to contact the emergency

contact and the referrer. If there is no emergency contact for the individual the MP may need to contact the NSW Mental Health Access Line to follow up with the individual.

- The Provider Clinical Lead is recommended to review closed SPS IDs in CIMS weekly to ensure communication processes have been carried out by MHP to MP.

5.9. Definition of a No-Show

- A 'no show' is defined for the purposes of the MDS, as an Individual not giving 24 hours' notice of non-attendance.
- No-shows should be entered for any appointment the Individual was scheduled to attend but did not, without advising the MHP beforehand.
- Please **See CIMS User Guide** for instructions on how to enter a "No show" session into CIMS.

5.10. Request for change of MHP

- When a request to change provider is received:
  - CESPHN Mental Health team will record the request details including who made it and the reason why.
  - The Provider will be notified of the request.
- It is the Provider's responsibility to:
  - Contact the current MHP and advise them of the request for change.
  - Ensure the current MHP updates the file with all relevant MP reports, notes and MDS before the transfer.
- Once the file is complete, the MHP should notify the Provider Clinical Lead.
- If the referral has **been accepted**, the Provider will reallocate the Individual to a new MHP within the same organisation via the Actions Tab so that it shows the change in the File History, and by updating the **Case File tab** and editing the Lead Practitioner.
- If the referral has not been accepted, the MHP should contact the Provider for reallocation.
- If the Provider is unable to reallocate, they should decline the referral. This will notify CESPHN Mental Health team to assign the referral to a different Provider organisation. If the referral is accepted, the MHP must close the ID after uploading all MDS data and the Provider organisation will inform the CESPHN Mental Health team to create a new file.

5.11. Request to Return to Care

- Individuals can return to the PSS program to complete treatment if they still have sessions available within their initial 10 sessions approval. They must return within 12 months, and approval will depend on their current needs.
  Please note Sessions beyond the initial 10 sessions are not guaranteed.
- Re-referral back to PSS after the initial 10 sessions is contingent on a new diagnosis or treatment need. For instance, an Individual treated for anxiety may return for support with post-natal depression.
- Contact your Provider to request approval for continuation of care. The Provider Clinical Lead will review the request to determine the client's information and provide further guidance.
- **Please note** to check if the Individual has any remaining sessions, MHPs can review closed IDs by searching for closed under the referral status filter along with the Individual's name.
- **Reminder:** If the client has used all approved sessions, returning to the program may not be permitted.

6. CESPHN Mental Health Team Intake Process

- CESPHN has a Mental Health team staffed by administrative and clinical staff. The team is responsible for all data entry, triage, and allocation of referrals to appropriate services and Providers. MHPs will only provide services to Individuals under the PSS program who are referred directly to the Providers by CESPHN.
- The CESPHN Clinical Lead monitors and oversees the process and workflow and manages any complex clinical issues or complaints.
- All relevant information obtained during the triage process is uploaded to the Notes or Document Sections of the CIMS, where Providers and MHPs can access these notes once they have been allocated.
- Any concerns about this process can be discussed with the Provider Clinical Lead, who will provide feedback to the CESPHN Clinical Lead - Mental Health Intake and Triage team.

7. PSS Program Types

- Program types are targeted underserviced and/or hard to reach populations in the local CESPHN region and as defined by ADoHAC.
- 2 x Care coordination sessions per episode are available for ALL PSS referrals. **See Section 9 Care Coordination Sessions.**

7.1. Child PSS

- CESPHN recognises that child health is a key priority issue, with higher rates of developmentally vulnerable children in the region compared to the national average.
- Appropriate psychological treatments for children often extend beyond the scope of focused psychological strategies (FPS) and may involve family-based therapies or other approaches. Child PSS addresses therapies such as behavioural therapy and parent training in behaviour management, which typically involve collaboration with parents. However, family therapy itself is **not** covered within the PSS scope.
- MHPs working with this cohort need to have completed relevant training and post-graduate experience working with children of **a minimum of 2 years** (this can include internships and placement). **See Section 4.3. Table 2. Training Requirements and Recommendations**
- If parents of a child require more sessions, they should be considered as separate Individuals and referred individually to PSS. It is recommended that in these situations the parent be referred to a different MHP.
- CESPHN supports inclusive practice and references to framework/strategies:
  - National Children's Mental Health and Wellbeing Strategy
- Other resources for mental health professionals
  - Emerging Minds Reframing Children's Mental Health - a communications toolkit
  - Raising Children Mental Health Resources for Professionals
  - Triple P Free Parenting Courses

7.2. Young People 12-25 Years of Age

- CESPHN commissions 5 headspace sites as alternative or complementary care options for young people, offering support for general health, mental health, substance use, and work/school/study issues.
- Non-Medical Professional (NMP) referrals can include but are not limited to headspace Youth Access Clinicians (YAC), school counsellors/psychologist and school Principals/Deputies, University and TAFE mental health clinicians/wellbeing coordinators to assist young people to access PSS.
- CESPHN supports inclusive practice and references to framework/strategies:
  - National action plan for the health of children and young people.
  - NSW Youth Health Framework.
- Other resources for mental health professionals
  - Orygen Training and Resources.
  - headspace Resources for Health Professionals.
  - ReachOut Resources.
  - InsideOut Institute for eating Disorders Resources.

7.3. Adult (Low Income)

- Target group is any adult (over 25 years) experiencing financial hardship (Individual income < $67,000; family income < $140,000) and unable to access other psychological supports.
- Poverty or income disadvantages have been found to be directly related to psychological distress and mental health. Those experiencing financial hardship are also less likely to be able to access services through Better Access due to gap payments.
- Poor mental health among low-income adults can negatively impact their ability to work, engage with family, or participate in the community. Access to PSS for this cohort can help improve their overall well-being, potentially leading to greater productivity, better relationships, and a more stable social environment.

7.4. LGBTIQA+

- Whilst specific data is not available to report the number on specific LGBTIQA+ cohort, it is recognised that the CESPHN region has a significant LGBTIQA+ population, due to social, cultural and historic factors.
- Due to the estimated sizeable cohort of LGBTIQA+ people living and working within the CESPHN region, we request PSS providers to approach and facilitate LGBTIQA+ - inclusive and affirming practice.
- Each letter of the acronym represents a distinct community that has their own specific health needs.
- Providing culturally safe and accessible services that value and affirm LGBTIQA+ people, their communities and their unique and shared experiences.
- LGBTIQA+ Inclusive Language Guide.
- Being aware of and use referral pathways that include MHP with expertise and experience with working with people who are LGBTIQA+. It is helpful to have a link to LGBTIQA+ resources on your website.
- Ensure you maintain understanding of LGBTIQA+ professional practices standards which align with your professional body
- Avoids assumptions that all individuals are heterosexual and/or cisgender.
- CESPHN supports inclusive practice and references to framework/strategies:
    - The NSW LGBTIQA+ Health Strategy.
    - Rainbow Tick Framework and standards.
    - Australian LGBTIQA+ Health and Wellbeing Strategy – In Progress.
- Other resources for mental health professionals:

- ACT Health Guidance to Support Gender Affirming Care for Mental Health: Click Here to Access.
- E-Learning Module: Trans Mental Health Care.
- Guidance to Support Gender Affirming Care for Mental Health.
- Intersex Health and Wellbeing and Intersex Inclusive Practice Standards.
- LGBTQA+ Inclusive and Affirming Practice Guidelines for Alcohol, Substance Use and Mental Health Services, Support and Treatment Providers: Click Here to Access
- Mental Health Rights Manual: Chapter 8 Section I: LGBTIQA+ people and mental health conditions: Click Here to Access
- Work with Pride: LGBTIQA+ Affirmative Interpersonal Skills.
- Other Services and Referral Pathways in the CESPHN Region can also be found through the Mental Health Directory or Headstart.

7.5. Perinatal Depression

- CESPHNS continues to support and improve access to psychological services for prevention and early detection of antenatal and postnatal depression.
- MHP working with this cohort are required to have received relevant training. **See 4.3. Specific Training.**
- MHP are to provide links to other appropriate services, especially local perinatal mental health services, within a stepped care approach to ensure people are matched to a service commensurate with their perinatal need.
- CESPHN supports inclusive practice and references to framework/strategies:
    - National Perinatal Mental Health Guidelines.
- Other resources for mental health professionals:
    - Gidget Foundation Australia, support the emotional wellbeing of expectant and new parents to ensure they receive timely, appropriate and specialist care.
    - Perinatal Anxiety & Depression Australia (PANDA).
    - Perinatal Infant Mental Health Services (PIMHS).
    - Centre of Perinatal Excellence - Health Professionals.
    - Emerging Minds - Perinatal Resources.

7.6. Aboriginal and Torres Strait Islander

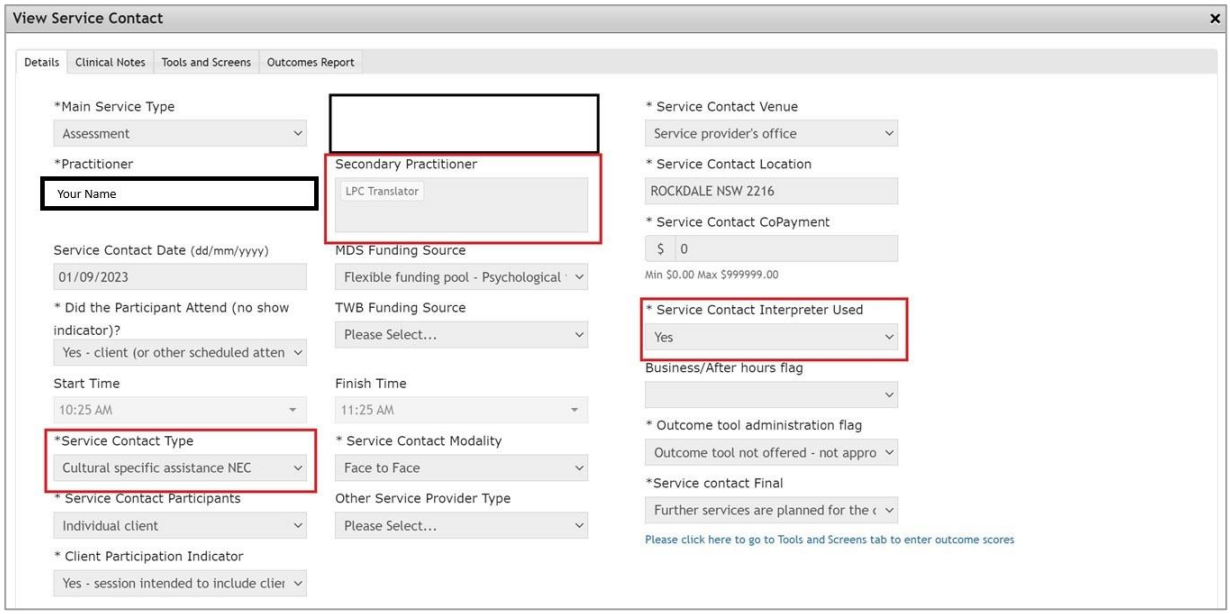
CESPHN acknowledges that Aboriginal and Torres Strait Islander peoples may present with a range of needs due to the ongoing impacts of colonisation and social policy in Australia. We are committed to working closely with providers to ensure that our services are culturally safe, responsive, trauma-informed and delivered in a social and emotional wellbeing framework, recognising the importance of addressing these historical and intergenerational factors in the delivery of mental health care.

- Aboriginal and Torres Strait Islander people experience significantly poorer health than that of non-Aboriginal people and are at higher risk of developing certain chronic disease and mental health concerns.
- PSS will support clinical evidence and be delivered by an appropriately skilled MHP. Culturally appropriate services require cultural awareness, cultural respect, cultural safety, and an understanding of the cultural determinants of health. Cultural training is mandatory for PSS MHP who deliver services to this cohort. **See Section 4.3. Specific Training Requirements.**
- Services are to complement and link with other closely connected activities, such as social and emotional wellbeing services, services provided by Aboriginal Community Controlled Health Services (ACCHS), the Aboriginal Medical Service (AMS), headspace, suicide prevention approaches, Local Hospital District (LHDs), and alcohol and other drug services.
- Project 54 in PSS aims to reduce barriers to accessing psychological support for Aboriginal and Torres Strait Islander peoples by providing outreach-based psychological support services via a culturally appropriate and responsive care model. It focuses on outreach to the La Perouse, Redfern, Sutherland Shire regions.
- CESPHN supports inclusive practice and references to framework/strategies:
  - National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental health and Social and Emotional Wellbeing 2017-2023.
- Other resources for mental health professionals:
  - Social and Emotional Wellbeing.
  - Cultural Awareness Self-Assessment Toolkit – ACT Council of Social Service Inc
  - Working with Aboriginal people and communities: Health and community services audit – Making Two Worlds Work.
  - CESPHN Aboriginal Health.
  - Demonstrating Inclusive and Respective Language Guide

7.7. Multicultural Communities

- CESPHN's population is marked by its cultural diversity. The regions that continue to have the highest proportion of Multicultural communities with low English proficiency are Canterbury, Hurstville, and Kogarah-Rockdale. These regions also have the lowest utilisation rates for Medicare psychological intervention, indicating barriers to Access psychological services.
- All PSS MHPs are required to complete cultural awareness training **See Section 4.3. Specific Training Requirements**.
- Translating/interpreter services must be made available when required. Individuals requiring this service need to have access facilitated by the Provider. Translating and Interpreting Service (TIS) is available free of charge to people delivering PHN funded programs. Providers will need to register for this service and ensure MDS is correctly filled out to record use of interpreters.

- How to enter a Service Contact where a Translator was used:
  - Enter all details as you normally would when entering a Service Contact, however, under the 'Secondary Practitioner' option select 'LPC Translator/APMHA Translator'. Under the 'Service Contact Type' option select 'Cultural Specific Assistance NEC' option.
  - Complete the remaining mandatory fields as you normally would.
  - Once all mandatory fields have been entered, click the 'Save' button.
  - **Please note:** Do not enter two Service Contacts into the CIMS for one session. This will cause issues with both data integrity and approved session count limits on the client file.



- CESPHN supports inclusive practice and references to framework/strategies:
  - Framework for Mental Health in Multicultural Australia.
- Other resources for mental health professionals:
  - Transcultural Mental Health Centre Resources.
  - Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS).
  - NSW Multicultural Health.

7.8. Mild intellectual disability who may benefit from short term PSS.

- The NSW Mental Health Commission reports that approximately 125,000 people in NSW live with intellectual disability and up to 40% will experience a mental health condition within their lifespan. While there are some specialised services for their physical and mental health needs, these are scarce and not well integrated with mainstream services.

- Individuals with intellectual disabilities may exhibit mental health issues differently than those without such disabilities, often presenting behavioral changes that concern others. This can lead to 'diagnostic overshadowing,' where mental health issues are misattributed to the intellectual disability itself, resulting in under-diagnosis and undertreatment. Skilled mental health professionals are crucial for improving access, recognition, and treatment for these individuals.
- CESPHN requests Providers to approach and facilitate inclusive practice:
  - Intellectual Disability Mental Health Core Competency Framework
- Other resources for mental health professionals.
  - Intellectual Disability: information for health professionals
  - Intellectual Disability Mental Health Connect
  - Easy read and accessible mental health information
  - Making mental health information accessible for people with intellectual disability- A Toolkit

7.9. Suicide Prevention Service (SPS) (Non-Acute)

- PSS Suicide Prevention Service (SPS) is designed to assist individuals with recent risk who no longer have acute needs and who are best supported in the primary health care setting. This service is for individuals who would benefit from intervention that specifically focuses on suicide prevention, prevention of future risk taking, identifying early warning signs and triggers.
- PSS SPS is not designed to support people who are acute and at immediate risk of suicide or self-harm. Individuals at acute risk should be referred immediately to the relevant acute mental health team (or equivalent).
- This program is only available to MHPs who meet eligibility requirements and have completed the mandated training.
- SPS sessions do not contribute to the general PSS session count. Individuals can be stepped up to receive SPS sessions (up to 8 sessions only), and then stepped down again.
- A review by a GP is not needed to step up or down a client into the SPS program, however a GP review is highly encouraged where clinical need is indicated for the individual.
- MHP are still required to send a report to the GP advising of the Individual's step up and down to and from the SPS program. This report is to be uploaded into CIMS.
- **Reminder:** To access the All Hours Suicide Support Service (AHS). This service is an adjunct to care and provides a free service for CESPHN clients with low-to-medium risk of suicide. The service is designed to help at-risk people in your community access consistent mental health support in between appointments with their practitioner.
- MHP must strictly adhere to the ADoHAC mandated time frames for the SPS program. **See Section 5.6. Time Frames.**

8. Guidelines Specific to PSS Suicide Prevention Service (SPS)

- CESPHN provides priority access to the Psychological Support Services (PSS) Suicide Prevention Service (SPS) initiative for people who are considered at increased risk following a suicide attempt, currently self-harming or who have heightened suicidal ideation and are being managed in the primary health care setting. The PSS SPS complements other PSS services.
- In considering an Individual's eligibility SPS, providers should consider:
  - The complexity of the Individual's circumstances and the number of contributing factors.
  - The short-term nature of the SPS program, and
  - Whether the Individual is more appropriately supported by NSW acute mental health service.
- If in doubt about the Individual's risk, the mental health professional (MHP) is to contact the acute mental health team via the Mental Health Line.
- **This program is not intended to have the MHP take on the crisis intervention role, nor replace existing local acute mental health services.**

Access and referral to all NSW Acute Mental Health Care Services via

The Mental Health Line Ph: 1800 011 511

8.1. Eligibility Criteria

- Access to Suicide Prevention Support (SPS) is in line with PSS criteria, for **Individuals 18 years and over**. See 2.1. PSS Eligibility.
- Individuals 18 years and over who have attempted suicide or who have heightened suicidal ideation and are being supported in the primary health care setting, therefore are no longer considered at acute risk.
- Young People aged 15 to 18 years may need to request approval by the Provider Clinical Lead for a step up in care should the Individual's risk change during treatment
- This service is primarily designed for:
  - Individuals who, after an attempted suicide, have been discharged into the care of a Medical Professional (MP) from hospital, or released into the care of a MP from an acute care team (ACT) or an Emergency Department/Psychiatric Emergency Care Centre (PECC).
  - Individuals who have presented to acute care team or PECC after an attempted suicide or incident of self-harm and have been discharged to the community.
  - Individuals who are on general PSS and have appropriately been stepped up.

- This service may also provide support to those who are considered at increased risk in the aftermath of a suicide.
- For individuals with the following suicide risk ratings, **refer to** acute care or emergency services:
    - **Assertive Follow-up Services** - Individual has recently attempted suicide, and based on my clinical judgement, requires assertive, community-based, case coordination to keep them safe.
    - **Imminent Risk** - The Individual is at imminent risk of suicide. Based on my clinical judgement this Individual requires immediate / urgent assistance.

8.2. Who Can Refer?

- SPS is limited to Individuals referred by Medical Practitioners only.
- **Please note** there is no provisional/N-MP pathway into the SPS program.
- Current MHPs requesting a step up from general PSS with Provider Clinical Lead approval.
- Referral is as per PSS
- Online Service Referral Form or via HealthLink in their Best Practice or Medical Director software.
- MPs can refer by completing a PSS referral (Include MHTP here).
- Choose program "Individuals at non-acute risk (SPS) GP ONLY"

8.3. Mental Health Professional Qualifications and Experience

- **See Section 4: Who can Deliver PSS?**
- MHPs are required to be appropriately trained and experienced to deliver suicide prevention services and complete specific training **See 4.3. Table 2. Individuals at risk of suicide.**
- Only PSS-approved MHPs can deliver SPS services/treatments.
- Provisionally registered allied health professionals and students are **not** eligible to provide suicide prevention services.

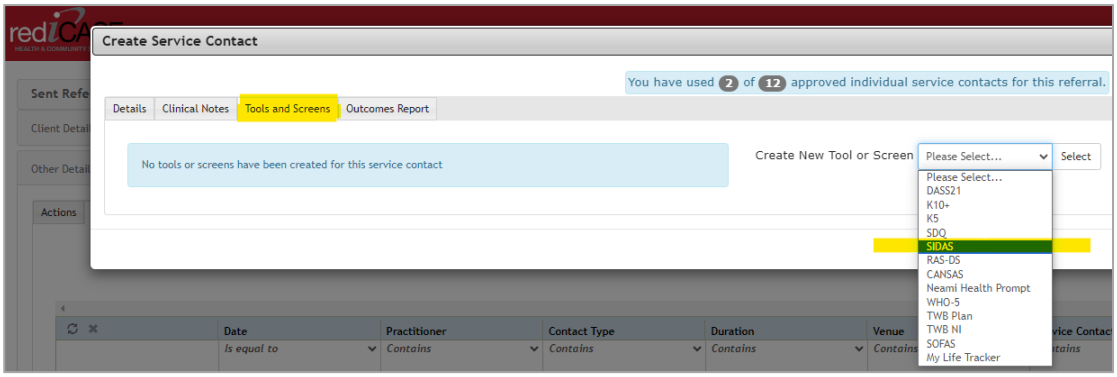
8.4. Terms of Sessions

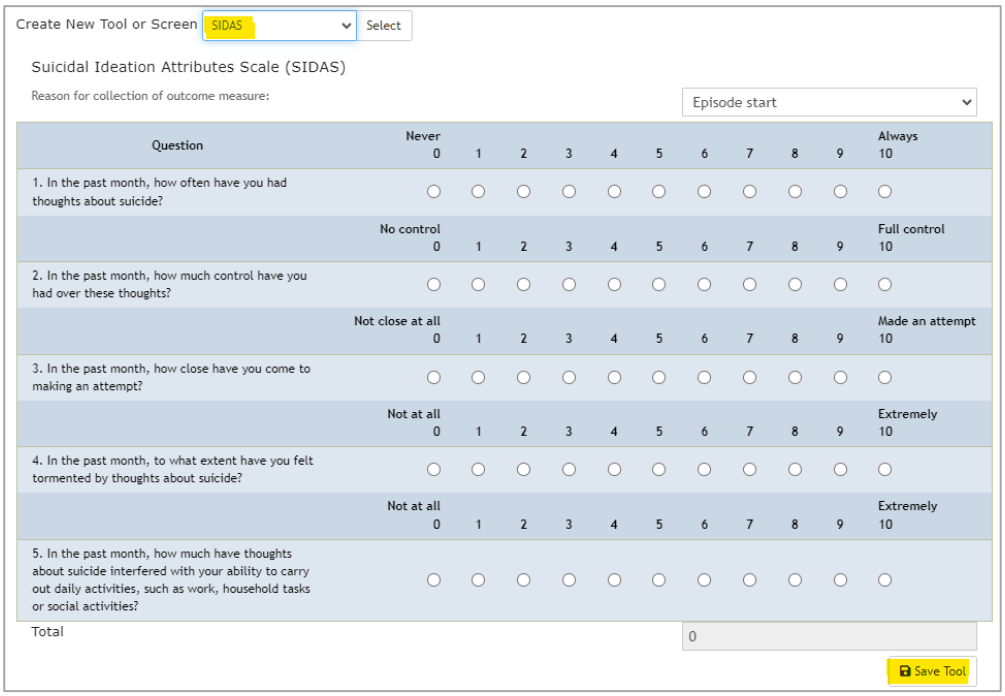
- The focus of SPS sessions is to manage any risk and provide Individuals with the necessary skills to manage major stressors and potential risk situations to reduce future risk.

- This may involve the use of specific crisis management strategies or elements of evidence based Focused Psychological Strategies (FPS) as indicated by the ADoHAC. These can include interventions such as:
    - Cognitive behaviour therapy (CBT)
    - Interpersonal psychotherapy (IPT)
    - Narrative therapy
    - Family-based interventions
    - Mindfulness-based cognitive therapy (MBCT)
    - Acceptance and commitment therapy (ACT)
    - Solution-focused brief therapy (SFBT)
    - Dialectical behaviour therapy (DBT)
    - Psychoeducation
    - For further information, please **See Section 3.4. Psychological Treatment**
- Care coordination sessions are included in SPS sessions. **See Section 9. Care Coordination Sessions**.

8.5. Episode of Care

- SPS sessions are limited to up to 8 sessions per Individual. This can include a combination of up to 2 care coordination sessions. For example, the MHP may choose to do 8 x SPS therapy sessions or 6 x SPS therapy sessions and 2 x care coordination sessions.
- All SPS sessions are only valid for a 3-month period, beginning from when the MHP accepts the referral.
- Extensions of SPS are no longer available and would indicate the Individual needs a step up in care to a more appropriate service. Multiple rounds of SPS are no longer available.
- Existing PSS Individuals can continue to be stepped up if clinically indicated. This will be supported by using the suicide screening tool.
- The SIDAS can be found in rediCASE, when entering a Service Contact. Choose tab - tools and screens. This is to be used on **step up and down** into SPS.




Create New Tool or Screen SIDAS Select

Suicidal Ideation Attributes Scale (SIDAS)

Reason for collection of outcome measure: Episode start

Question											
	Never 0	1	2	3	4	5	6	7	8	9	Always 10
1. In the past month, how often have you had thoughts about suicide?	○	○	○	○	○	○	○	○	○	○	○
	No control 0	1	2	3	4	5	6	7	8	9	Full control 10
2. In the past month, how much control have you had over these thoughts?	○	○	○	○	○	○	○	○	○	○	○
	Not close at all 0	1	2	3	4	5	6	7	8	9	Made an attempt 10
3. In the past month, how close have you come to making an attempt?	○	○	○	○	○	○	○	○	○	○	○
	Not at all 0	1	2	3	4	5	6	7	8	9	Extremely 10
4. In the past month, to what extent have you felt tormented by thoughts about suicide?	○	○	○	○	○	○	○	○	○	○	○
	Not at all 0	1	2	3	4	5	6	7	8	9	Extremely 10
5. In the past month, how much have thoughts about suicide interfered with your ability to carry out daily activities, such as work, household tasks or social activities?	○	○	○	○	○	○	○	○	○	○	○

Total 0

Save Tool

- SPS sessions do not contribute to the general session counts. Individuals can be stepped up to receive SPS sessions (up to 8 sessions only), and then stepped down again.
- A review by a GP is **not** needed to step up or down a client into the SPS program, however a GP review is strongly recommended where clinical need is indicated for the individual.
- MHP are required to send a report to the GP advising of the Individuals step up and down to the SPS program. This report is to be uploaded into CIMS.
- SPS files also adhere to K10+ outcome score requirements.
- **REMINDER:** To access the **All Hours Suicide Support Service (AHS)**. This service is an adjunct to care and provides a free 24/7 service for Primary Health Network (PHN) clients with low-to-medium risk of suicide, ensuring they have access to professional counselling around the clock if their allied health practitioner is not available. The service is designed to help at-risk people in your community access consistent mental health support in between appointments with their practitioner.

8.6. Time Frames

- As mandated by the ADoHAC, the first session with the Individual is to be conducted within **7 days of the referral date,** as recorded in the CIMS MDS. (This timeframe starts from the date the referral was entered into the CIMS not the original date of the referral).
- MHP must accept or decline referrals within 24 hours of allocation unless received after 12pm on a Friday. MHPs are to accept the referral based on their capacity, that is, before contacting the Individual. All attempts to contact the Individual must be recorded in the

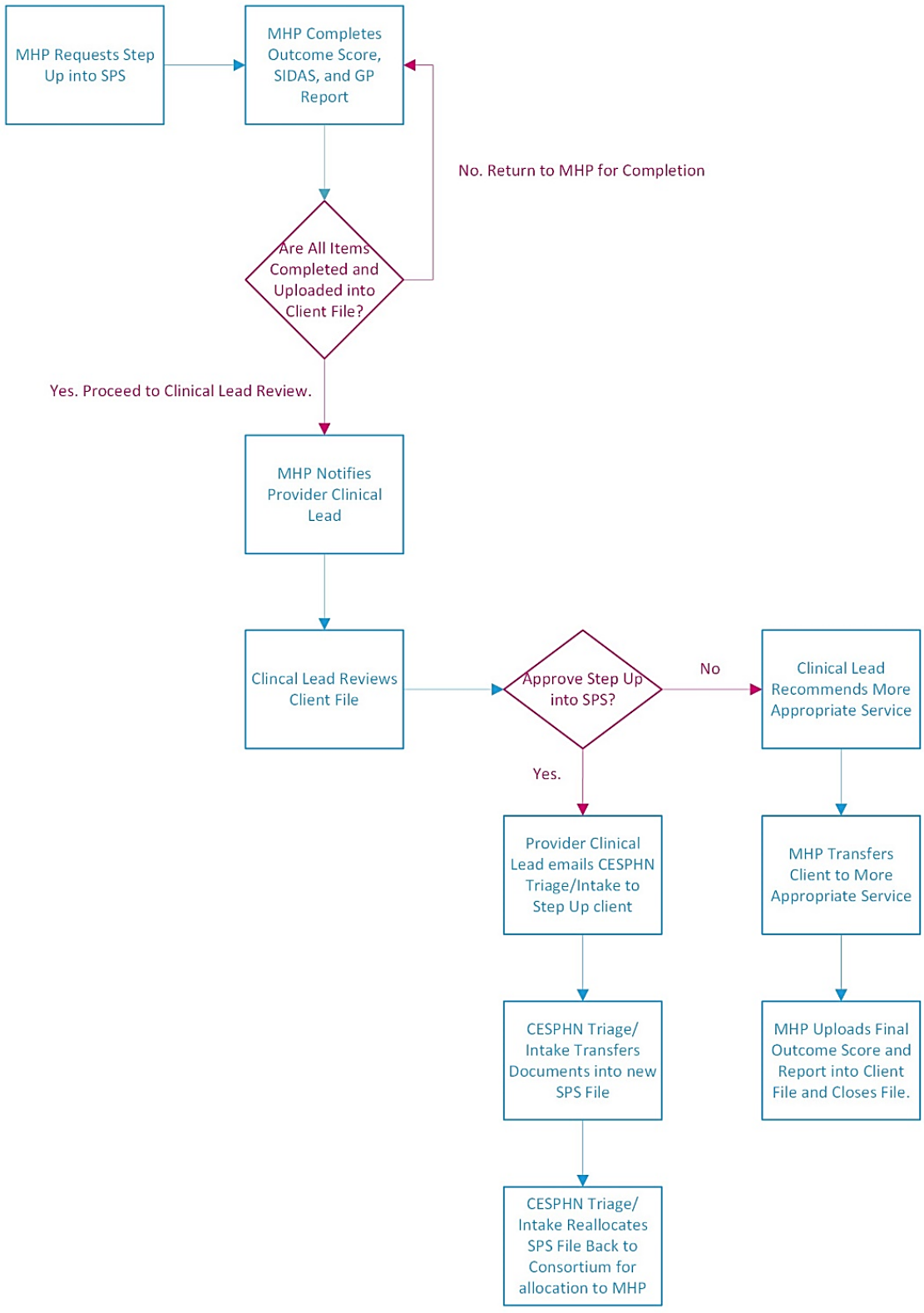
CIMS. If the MHP is unable to contact the Individual, please refer to the PSS Guidance **5.7. MHP Unable to Contact an Individual.**

- If an initial face to face session **cannot** be conducted within the 7-day period, the MHP will need to arrange an assessment via Tele- or Virtual-health. This contact with the Individual must include: an assessment including risk and completion of a safety plan as needed. **This will then be entered as a telephone-based service contact in CIMS.**
- All contact attempts must be recorded in the CIMs, including any care coordination prior to MHP accepting the referral.
- SPS sessions are to be provided within 3 months of the referral being accepted by the MHP. Please refer to **8.8. Special Circumstances.**

8.5. Step-up/Step-down Care: SPS <--> PSS

- The step-up process is now managed by the Provider.
- To request a **step up** to the SPS program, the MHP is required to:
  - Complete an outcome measure.
  - Complete the Suicide Ideation Assessment Tool (SIDAS - scores ≥ 21 indicated high risk of suicide behaviour).
  - Email the Provider Clinical Lead with request for step up.
- **Please Note:** The SIDAS tool can be recorded in any Service Contact the client attends. However, it is recommended to complete and enter the SIDA tool, along with the final outcome score, in the client's last Service Contact.
- Send GP report advising them of the step up and upload it to the CIMS.
- Young People aged 15 to 18 years may need to request approval by the Provider Clinical Lead for a step up in care should the Individual's risk change during treatment.
- For **step down** back to the PSS program (if sessions are still available):
  - Complete an outcome measure.
  - Complete the suicide ideation assessment tool SIDAS (Scores ≥ 21 indicated high risk of suicide behaviour).
  - Email the Provider Clinical Lead with request for step down.
  - Send GP report advising them of the step down and upload it to the CIMS.

SPS Approval Flowchart:



8.6. Limitations

- The SPS Service is designed to provide immediate and short-term support (up to 3 months) for Individuals during a period of increased suicide risk. The service is not designed to provide long-term support or treatment.
- Given the short-term nature of SPS, Individuals with the following presentations are **not** generally suitable for the program, including Individuals:
- with complex circumstances or numerous contributing factors that require case management.
- who are presenting with primary substance misuse.
- with persistent and recurring thoughts or behaviours of self-harm for months or years, as a feature of a mental disorder and who are at risk of acting on these thoughts.
- who present with conditions requiring long term intervention (some personality disorders, severe PTSD, and other experiences of trauma).
- With acute psychotic phenomena.
- If in doubt regarding the suitability of stepping up an Individual for referral to the PSS SPS please discuss your potential referral with your Provider Clinical Lead.

8.7. Individuals under 18 years of age

- Children and Young People under 15 years **are not eligible** for SPS. Children and Young People at risk can be referred to their local hospital Emergency Department or referred to the **Mental Health Line Ph 1800 011 511** to access the local Child and Adolescent Mental Health Services. Please also refer to **PSS Guidance 3.10. Mandatory Reporting**, if applicable.
- MHPs currently working with Children and Young People aged 15 and under, are not eligible for SPS. MHPs currently working with Young People aged 15 to 18 years may need to request approval by the Provider Clinical Lead for a step up in care should the Individual's risk change during treatment. Please **See Section 8.5. Step-up/Step-down Care: SPS <--> PSS** of this guidance for specific instructions on how-to step-up care for these Young People.

8.8. Special Circumstances

- If the MHP requires leave (unexpected) during the care period:
  - Individuals need to be made aware of and agree to this before they commence any SPS sessions.
  - If an MHP has an extended period of unexpected leave during this period, the MHP must:
  - Advise the Provider Clinical Lead of their unexpected need for leave and coordinate care for the Individual for the anticipated period of absence.

- The Provider Clinical Lead and current MHP make a clinical decision about whether allocation to a new provider is appropriate given the expected period of absence and make necessary arrangements for reallocation.
- If the Individual is not assigned a new SPS provider, the MHP needs to ensure the Individual is linked in with an MP and has the capacity to arrange alternative care in their absence. For example, weekly appointment with the MP, safety plan and link into **All Hours Suicide Support Service** if extra support is required.
- The risk will be held with the allocated MHP during this time as the Individual is under their care.
- Consider other programs or ACT.
- Consider **All Hours Suicide Support Service.** **See Section 8.10. All Hours Suicide Support Service.**
- In circumstances where the Individual requires unexpected significant leave during the period of care under SPS; for example, a hospital admission including short term crisis/risk admission, travel, or competing responsibilities such as university exams. The MHP and Provider Clinical Lead will need to determine whether SPS sessions continue during this period, or whether the episode of care is closed.
- The MHP will need to conduct a risk assessment and if the Individual is presenting as at risk of harm, a management plan is to be agreed with the Individual and treating team before pausing or closing treatment**.** **Please note** that this is for significant leave where the Individual cannot attend sessions. The MHP can reassess risk once the Individual is able to attend sessions again and can request SPS sessions should they be required. If the unexpected leave is for more than 7 days and Individual has a risk management plan in place, agreed with the treating team, then it is suggested to close the file until reassessment of eligibility can be arranged.

8.9. Data Requirements

- Please refer to the PSS Guidance **3.11. Minimum Data Set (MDS)** in the PSS guidance for the general PSS data entry requirements.
- Additional data entry specifications for SPS include:
- On the “Commence Episode” page in the CIMs, the MHPs need to select “Psychological Therapy” as the Principal Focus of Treatment plan and the Suicide Referral Flag must be “Yes”.
- All contact attempts are to be entered into the Notes section of CIMS.
- SPS sessions longer than 60 minutes must be entered as two separate entries into CIMS. Both sessions should equal a minimum of 50 minutes each. Where possible the MHP must get prior approval for a two-hour session by their clinical lead. If the MHP enters one occasion of service for the two hours, they will only be paid for 1 session.

8.10. All Hours Suicide Support

- All Hours Suicide Support Service (AHS) is a free phone counselling service that supports PHN clients with low-to-medium risk of suicide. It is designed to help at-risk people access consistent mental health support in between appointments with their practitioner or when their allied health practitioner is not available.
- AHS provides support to clients 24 hours a day, seven days a week, ensuring they have access to professional counselling around the clock. These calls can occur once a day for up to two weeks at a time. If additional calls are required, this will need to be confirmed with AHS. AHS is not responsible for the ongoing case management of a client.
- Only clients referred to or receiving PHN psychological therapy services are eligible for the All-Hours Suicide Support Service. In addition:
- All referred clients must be assessed as low-to-medium risk of suicide.
- All clients must be 15 years or older.
- Clients need to have an ongoing treating practitioner or are in the process of being linked in with one.
- The Allied Health Practitioner must be registered with a PHN and should have successfully completed their Suicide Prevention Service Training.
- **PSS MHPs must register with AHS** before referring. See Registration Link.
- To refer a PSS Client - See referral form.
- Individuals from a multicultural background can access interpreter services through teleconference if an interpreter is needed.
- Allied health practitioners who are registered with a PHN can refer their clients to AHS to provide short-term interim counselling when:
    - A new client must wait over three days to receive their first appointment.
    - A client is going through a difficult period and needs support after-hours.
    - A client has a long gap between appointments.
    - A practitioner is going on leave and won't be able to see their client for a while.
    - GPs who have referred their patients to a PHN for psychological therapy services can also use AHS if the PHN practitioner has a long waiting period.
- Accessing individual notes:
    - If Consent is provided, the Individual's information will be securely emailed to the MHP as a password protected PDF attachment following an Individual's contact with AHS, or attempted contact with the Individual by one of the AHS counsellors. This is done immediately after each contact.
    - The password protected PDF will be a snapshot of the information the counsellor collects on the call, including case notes. While meeting Privacy requirements, this will also be a more efficient way of providing you with the information you need.

- All PDF attachments containing Individual call information and case notes will be password protected. The password for opening each PDF is AHS plus the month and year of the call record. The call received date will be in the email subject line. So, the password format is: AHSMMYYYY. For example, for an email notification received on 04 December 2024, the password would be AHS122024.

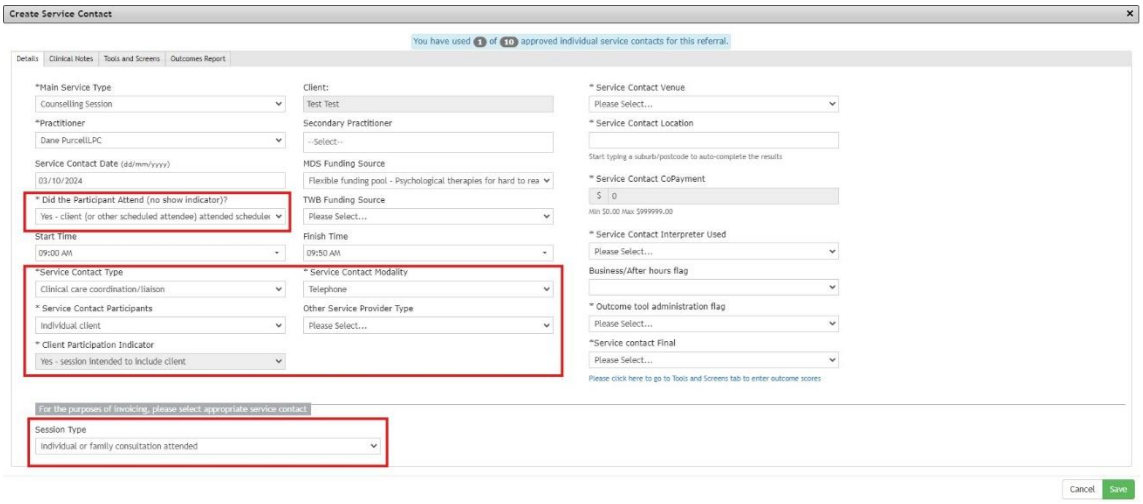
- For further information, contact AHS Team on 1800 859 585 or AHSS@lifeline.org.au

8.11. Further Suicide Prevention Support

- 13YARN 13 92 76
- Lifeline 13 11 14
- Suicide Prevention and Postvention Services
- The National Indigenous Postvention Service Ph 1800 805 801
- CESPHN Mental Health Service Directory
- headstart

9. Care Coordination Sessions

- 2 x Care coordination sessions per episode of care are available to all individuals referred to PSS. These sessions are available for MHPs to:
    - Work with family members, additional MH services, Medical Practitioners and other professionals involved in the Individual's care.
    - Work with other community and social services to support an Individual's mental health, including education, housing, other local community services, justice, and family violence services.
    - Enable coordination between services to ensure appropriate referrals are made including with child and adolescent specific care services, and Medical Practitioners.
- Two care coordination sessions (without the Individual present) can be provided within an episode of care once an initial session with the individual has been delivered. E.g., 10 FPS sessions or 8 FPS sessions + 2 care coordination sessions per episode of care.
- If care coordination sessions have been delivered without the individual present, the MHP must still select 'Yes client attended' to both the 'Did the Participant Attend' and 'Session Type' options in the CIMS.



- Care coordination may take less than the allocated minimum 50-minute session requirements. If this is the case, care coordination sessions are to be entered into the CIMS once the total time incurred has reached a minimum of 50 minutes.
- When entering the care coordination session into the CIMS, the details of when the care coordination occurred needs to be recorded in the Notes section detailing:
    - Date the care coordination occurred
    - Duration
    - Description of the type of care coordination
- This accumulation of care coordination process is used only when care coordination is < 50 minutes and over several occasions. For example, a 20-minute phone call to child and adolescent services on one day, a 20-minute phone call to parents on another day, and a 15-minute phone call to the school counsellor on another day would only be entered ONCE into CIMS as a 55-minute session with the specific details listed in the Notes section.
- MHPs will only be paid for care coordination once at least 50 minutes are reached. Please do not bill increments of less than 50 minutes. **See CIMS User Guide.**

10. Psychiatry Support Line for GPs

- The Psychiatry Support Line for GPs is a free service for MPs to help manage the care of mental health Individuals, providing advice on diagnosis, investigation, medication and safety plan. It is not intended to be for triaging or referring individuals to a psychiatrist**.**
- **Please encourage GPs to use this service to support your work with Individuals.**
- This service is exclusive to MPs who practice within **Central and Eastern Sydney PHN region.**
- This free service is available Monday to Friday, 9 am - 5 pm. MPs can use it as many times as required. If a psychiatrist is not available at the time the MP calls, the service will respond to their enquiry within 24 hours.

- MPs need to register using their AHPRA Registration Number, and practice details. There are options to use Secure Messaging once registered.

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

11. Outcomes and Satisfaction

11.1. Clinical Outcomes

- It is a mandated KPI requirement from the ADoHAC to use specified outcome tools[1] pre and post service delivery with a target of 70% completion over the entire program. This is known as a paired outcome.
- In addition to a specific target for completing paired outcomes, the ADoHAC also sets specific targets around the percentage improvement in these outcome scores post-treatment. The ADoHAC reviews the completion and improvement scores for the PSS program to determine the effectiveness of the PSS program in making a significant difference to the mental health of Individuals accessing the program.
- **The ADoHAC mandates the use of the following outcome tools only:**
- K5 is validated for Aboriginal and Torres Strait Islander Peoples (18+ years), however it can be used for intellectual disability and older adults if needed.
- K10+ for adults over 18+
- SDQ for Children (up to and including 17 years)
- **Please note**: For young people, clinician's discretion is allowed, and that the K10+ or K5 (Aboriginal and Torres Strait Islander People only) may be used, even though the person is under 18 years.
- **The K10+ and K5 can be downloaded from the CESPHN website or from here for the SDQ.**
- Each Episode requires a relevant outcome tool completed at Start, Review and End. Please ensure that the correct reason from the "Reason for collection of outcome measure" field has been selected.
- All initial outcome scores are to be marked as "Start", subsequent outcome scores are to be marked as "Review", and the last outcome score is to be marked as "End".

[1] CESPHN Mental Health team acknowledges that these ADoHAC mandated tools may not be your clinical choice of outcome tool, however only the tools listed are indicated. Additional outcomes tools can be used to support your clinical work.

- Matched Pair Counting Rules.
- In circumstances where an Individual has completed treatment, but an outcome measure was not collected at the final session, the MHP must try to obtain an "End" outcome measure before clinically closing the file by contacting the Individual and administering the outcome measure via telephone or email. The outcome score is then entered into the last service contact made and marked as "End". The MHP can then clinically close the file by selecting "no further sessions are planned for the client".
- If the MHP is unable to contact the individual to obtain an outcome score following conclusion of treatment but there is a "Review" score on file, the MHP should amend this "Review" score to an "End" score and clinically close the file to generate matched pair.
- If only one outcome measure was administered at the initial session, please do not re-enter this score at the final session when clinically closing an episode/file. Not only will this negatively impact ADoHAC improvement targets, it will under-represent the efficacy of the treatment you provided.
- Where Individuals have been 'lost to care' or referred elsewhere for ongoing treatment, or where some time has lapsed between the last session and the MHP is closing the file in CIMS, it may not be possible or make clinical sense to obtain an outcome measure on discharge. If this is the case, please close the file administratively via the Actions tab. For circumstances in which the episode of care can be closed via the Actions tab please **See CIMS User Guide**
- **Please note:** MHPs are still expected to upload client discharge letters for these clients regardless of whether the file is administratively or clinically closed.
- MHPs should 'clinically' close the episode of care when entering the final session data by selecting the message 'No further sessions are planned' and ensuring that the "end" outcome tool score has also been entered into the same occasion of service, so that a paired outcome score is generated.
- **Please note: If you close an episode of care without opening an occasion of service, (i.e., administratively close the file via the "Actions" tab, this will not be counted in the MDS**. **See CIMS User Guide.**

11.2. Your Experience of Service (YES) survey

11.2.1. About the YES PHN Survey

- The YES PHN Survey is used to better understand the performance of service delivery and support quality improvement initiatives through feedback from Individuals using PSS. PSS services commissioned by the PHN are required to evaluate user experience. The survey comprises 26 items: 16 experience items, 2 open ended questions, and 8 demographic questions.
- The 16 experience items cover 6 broad domains:
- Making a difference: how the service contributed to outcomes for Individuals.

- Providing information and support: how the service works for the Individual.
- Valuing individuality: how the service meets Individual's needs.
- Supporting active participation: how the service provides opportunities for engagement, choice and involvement in service delivery.
- Showing respect: how the service provides the Individual with a welcoming environment where they are recognised, valued and treated with dignity.
- Ensuring safety and fairness: how the service provides Individuals with a physically and emotionally safe environment.
- The YES PHN Survey and Guidance for Use are available from the Provider and the AMHOCN website.
- Provider organisations are required to apply for their own licence via this link. There are no fees to obtain a license and approval is immediate. All applicants must agree to the terms and conditions for the use of the YES PHN Survey as set out in the license agreement. All applicants must agree to the terms and conditions for use of the YES PHN Survey as set out in the licence agreement.
- Once a license is obtained, a downloadable Word version of the survey can be accessed. Provider organisations may create an online version if needed.

11.2.2. Implementation

- Providers are expected to implement the PHN YES survey using one of the following options:
  - With every client prior to completion of their episode of care; or
  - Over a 2-week period at least twice annually with every client who receives a service during this period.

11.2.3. Reporting

- Providers are required to report on a 6-monthly analysis of the data, and any quality improvement activities planned and/or implemented as part of the contract KPIs, using the template supplied by CESPHN.

12. Discharge/Closing an Episode

- Individuals who have reached the maximum number of sessions or who have completed treatment will be exited from the PSS program.
- Before closing the episode, MHP must ensure they have entered all MDS, outcome tools, relevant notes, and uploaded all correspondence sent or received by the original referrer.
- **Please note** once an episode of care has been closed/ceased it **cannot be reopened** under any circumstances. Any Service Contacts not entered prior to the closing of a client's episode of care will be forfeited. MHPs will not be paid for Service Contacts that are not entered into the CIMS.
- Where a client episode of care was closed and the Individual returns to the program, a new episode of care (new ID) will be created.
- While a closed episode will not appear in a MHP active client list, a MHP can still search for and view closed episodes within the CIMS by selecting "Closed/Ceased" in the Referral Status field and using the Individual's name or ID number as a filter.
- If the individual requires a referral to another organisation for ongoing care and support, the MHP should make recommendations to the individual and gain consent to refer to the other service. It is essential that the referring MP is advised of this plan.
- The MHP should 'clinically' close the episode of care at the last Service Contact by selecting the message 'no further sessions required' and entering the final outcome score when closing the episode of care.
- Closing an episode of care now requires that the MHP selects the organisation type to which the client has been referred/discharged at the end of their treatment. If none, then MHP selects "none/not applicable". **See CIMS User Guide**

13. Better Access and PSS

- The PSS program is intended for individuals who cannot access Medicare Better Access services. This program is separate from Better Access and should not be used together or switched between.
- If an individual has used Better Access psychological therapy services but can no longer continue due to financial hardship, or needs additional services for clinical benefit, they may qualify for the PSS program. This is dependent on the individual meeting PSS eligibility criteria and demonstrating a clinical need that justifies entry to the PSS program.
- Expiring MBS sessions do not automatically qualify eligibility into the PSS program.
- **Please note:** A gap payment ***cannot*** be charged at any time during PSS.

- **PSS and Better Access are not to be used at the SAME time.**
- Group Therapy Sessions
    - Individuals who are accessing PSS *individual* sessions can access Better Access *group* sessions, using their existing MHTP.
    - Individuals who are accessing Better Access *individual* sessions can access PSS *group* sessions, if they meet eligibility criteria.
- PSS Group participants are also able to access PSS individual sessions during the group referral period.

14. Consent, Privacy, Confidentiality and Complaints

14.1. Consent

- Client consent to take part in the PSS program is obtained and recorded by the referrer, as part of the online referral form.
- At first session, the MHP must:
    - Ensure informed consent has been given and explained, and a Consent Form is signed.
    - Explain the Individual's rights and responsibilities.
    - An Individual's consent is also required prior to:
    - Undertaking any collaborative conferencing.
    - Referring to another service.
- Consent must be voluntary, current, and specific. Individuals have the right to withdraw consent at any time.

14.2. Confidentiality and Privacy

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

- CESPHN, Providers, and MHP must all undertake to observe Privacy requirements when engaging in activities under the Providers Agreement in accordance with the:
    - Privacy Act 1988 (Cth) (Privacy Act).
    - Australian Privacy Principles 2019 (APPs).
    - Health Records and Information Privacy Act 2002 (NSW) (HRIP Act).
    - Privacy and Personal Information Act 1998 (NSW).
    - Privacy Amendment (Enhancing Privacy Protection) Act 2012 (Cth).
    - The terms "personal information" and "health information" have the same meaning as is given to them in the Privacy Act and the HRIP Act.
    - The Provider or MHP undertakes to inform the CESPHN Project Officer immediately upon becoming aware that any breach of Privacy or security relating to information under its control has occurred.

- **The MHP must:**
    - Ensure that all confidential information is kept confidential and is not copied, published, disclosed, or discussed with any person other than its personnel who has a need to know and their authorised representatives.
    - Not use any confidential information except as required for the purpose of the Providers agreement and providing the services.
    - Not disclose any confidential information except as required by law.

14.3. Access to Information

- Individuals are entitled to request access to their own personal information. Access will be provided unless there is a sound reason under the Privacy Act 1988 or other relevant law to withhold access.
- Providers and MHPs will manage records in line with the best practice principles that align with the statutory requirements of the HRIP Act and State Privacy Manual.
- The collection and use of personal and health information must relate directly to the Individual's health care.
- Individuals must be aware of, or informed of, the purposes for which personal and health information is obtained.
- Personal and health information received and held must be up to date and records shown to be incorrect must be amended.
- Personal and health information must be stored securely.
- Third party access to personal and health information may only be granted in accordance with the Australian Privacy Principles (APPs):
- The APPs and the Privacy Act 1988 will be observed.

- Individuals registered with My Health Record (MHR) can choose whether they would like information regarding their mental health care to be uploaded to their MHR.
- For information about using My Health Record as an allied health practitioner see https://cesphn.org.au/allied-health/help-my-patients-with/my-health-record
- Retention and destruction of health records will be in accordance with the Health Practitioner Regulation (NSW) Regulation 2010.
- Any request to access records must be made in writing to the CESPHN CEO or CESPHN Clinical Services General Manager.

14.4. Storing Information

- MHP will need to take care to protect and hold securely personal information (whether electronic or on paper). All personal information held by the MHP must:
- If in paper form, be received and stored in a secure, lockable location with reference to the Health Records and Information Privacy Act 2002 (NSW).
- If in electronic form, be adequately protected according to best practice and relevant legislation.
- Be accessible by staff only on a "need to know" basis, and that access must be purposeful, appropriate, and legal; and
- Not to be taken from the offices unless authorised and for a specified purpose.
- Securely destroy or permanently de-identify personal information that is no longer required.
- Records are kept in accordance with the record-keeping obligations that apply to the category of record.
- MHP is to maintain and retain adequate and prudent records of all services provided as part of the PSS services **See Section 3.6 Documentation.** Such records by law must be kept for 7 years for adults, and in the case of Children until the child reaches 25 years of age, from the date that the Individual was last provided with a Service.

14.5. Complaints

- It is not the role of CESPHN, or its staff, to become involved in complaints by outside parties (consumers, carers, other providers, and organisations) about Providers or MHPs.
- For complaints about Providers and MHPs, the complainant should, in the first instance, discuss their concerns with that organisation. The complaints policy of the Provider will apply beyond this step.

14.6. Clinical Incident

- CESPHN requires that Providers have incident management policies and procedures in place to manage Clinical Incidents. MHPs can speak with their provider organisation as to incident reporting procedures and any subsequent escalation to CESPHN.

14.7. Legal Matters and Subpoenas

- The PSS program does not have the capacity to service Children and their families where the main area of concern is related to a current Family Law Court Matter.
- The PSS program does not provide medico legal reporting as part of the program.
- Subpoenas are the responsibility of the Providers. CESPHN Clinical Lead is to be notified by the Provider Clinical Lead of any subpoenas or significant legal matters related to the PSS program.

Review and Version Tracking

Version	Review	Date Approved	Approved by	Next Review Due
1.0	1/04/2019	12/12/2019	Belinda Ivanovski	20 January 2020
2.0	11/2/2020	03/3/2020	Belinda Ivanovski	1 July 2020
3.0	08/08/2021	23/11/2021	Belinda Ivanovski	1 November 2022
4.0	9/3/2023	10/5/2023	Catherine Goodwin	1 May 2024
1.01	12/7/2024	8/10/2024	Catherine Goodwin	1 October 2025
1.02	13/02/2025	13/02/2025	Chris Jones	1 October 2025
1.03	08/10/2025	8/10/2025	Chris Jones	3 December 2025
1.04	03/12/2025	3/12/2025	Chris Jones	2 March 2026
1.05	3/2/2026	3/2/2026	Mariam Faraj	6 April 2026