**Mental Health Services in Primary Care**

**Summary of Service Types (2019-2021)**

The ***Mental Health Services (MHS) in Primary Care*** funded by the Hunter New England Central Coast Primary Health Network (HNECCPHN). The aim of the MHS in Primary Care program is to provide greater access to mental health services for those people living with mental ill health in the HNECC region, including people who live in Residential Aged Care Facilities (RACFs).

Services are designed to give priority to the following population groups who have particular difficulty in accessing mental health treatment in the community:

* Residents of RACFs;
* People who are less able to pay fees to access private mental health services, and are unable to access Medicare subsidised mental health services;
* Children under 12 years of age with mental, emotional or behavioural disorders;
* Women with perinatal depression;
* Aboriginal and Torres Strait Islander people with mental disorders;
* People of Cultural and Linguistically Diverse backgrounds;
* Individuals who have self- harmed, attempted suicide or who have suicidal ideation, and are able to be appropriately managed in the primary health care setting, and
* People living in rural and remote areas.

The objectives of the program are to:

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

**REFERRAL PATHWAYS**

From the 1st July 2019, all referrals for HNECCPHN funded primary mental health services in the Hunter and Mid Coast regions will be processed through the local PRIMA team based in Warabrook (Newcastle). All clients referred (by GPs and other health professionals) will be assessed daily by an experienced mental health team to determine the level of care (refer to Appendix 1). Depending on the level of care indicated by the assessment, patients will be referred to the most appropriate primary mental health service provider.

**SERVICE DELIVERY MODELS**

***A. Psychological Therapy***

The primary intervention provided under the psychological therapy service type is focused psychological strategies, which are time-limited, and evidence based psychological treatments. These short-term therapies are particularly suitable for common mental disorders.

**Eligibility for Psychological Therapy services**

Referral to the Psychological Therapy services is to include a Mental Health Treatment Plan completed by a GP, psychiatrist or paediatrician where the patient is assessed to benefit from a short term focussed psychological intervention. This is not required in the case of referrals for individuals who meet the criteria for a provisional referral (e.g. women experiencing perinatal depression, children, Aboriginal and Torres Strait Islander people, people living in rural and remote areas, or people who are homeless and access to GPs is prohibitive to receiving psychological treatment).

In the case of provisional referral, a person must have a GP Mental Health Treatment Plan completed as soon as practicable to be eligible to continue receiving services. Children under 12 years of age who do not have a diagnosed mental, childhood behavioural or emotional disorder can access Psychological Therapies, however there must be clear clinical evidence that they are at significant risk of developing a disorder.

Psychological therapies funded under the HNECCPHN are not designed to offset or top up services delivered under Better Access (Medicare). People who have already completed ten sessions of individual services under Better Access in a calendar year should **not** access the MHS in Primary Care program to access additional services.

A person is no longer eligible for Psychological Therapies when they have expended their session allocation for the year, have achieved their treatment goals, or are clinically determined to be best engaged in another level of care. Where the severity or chronicity of a person’s condition indicates that more extensive treatment will be required, the individual should be referred for treatment under another appropriate mental health service.

**Number of Services**

Referred clients can be offered up to 6 initial sessions. On completion of the course of 6 sessions, the provider is to provide a written report to the referring GP. The written report is to include information on assessments carried out, treatment provided, the individual’s outcomes and recommendations on future management of the individual’s mental disorder. Following receipt of the report, the referring GP will consider the need for further treatment and if clinically required refer the individual for an additional 1-6 sessions. This repeat referral may be arranged with the GP via telephone or electronic messaging, and does not require a face to face consultation. Where referral for additional sessions is obtained by telephone, the provider is to document the GPs agreement to the continuation of treatment. Further services should not be provided without referral or agreement by the GP for these sessions.

On completion of psychological therapy, the mental health professional will provide a letter to the referring health professional, including information on assessment, treatment provided and the individual’s outcomes, and provide recommendations on future management including recommendation for referral to a higher or lower intensity service if required.

Referred clients who do not attend a booked session without giving 24 hours’ notice will have that session counted as one of their available set of 6 sessions, unless the provider at their discretion decides otherwise.

A data management form will be provided for each session recorded (whether attended or not) when the invoice for those sessions is presented. No payment will be made for sessions not attended

***B. Psychological Therapy in Residential Aged Care Facilities (RACFs)***

The primary interventions provided under the psychological therapies in RACFs service includes:

* Individual assessment to help with diagnosis of common primary mental health conditions such as depression, anxiety, and adjustment disorder.
* Individual therapy with a resident who presents with a problem such as depression, anxiety, bereavement, social withdrawal, chronic pain or adjustment difficulties.
* Group sessions that address commonly occurring issues such as adjustment to living in a residential facility.
* Consultation with aged care staff and liaison with local health services as appropriate about mental health care needs for individual residents.

**Eligibility for Psychological Therapies in RACFs services**

To be eligible for service, a person must reside in a Commonwealth Funded RACF and meet the eligibility criteria for the psychological therapy and/or clinical care coordination service types. Referral to this service should be via GP referral, but local referral pathways may include referral by senior facility clinicians such as the Director of Nursing and/or Registered Nurses.

Referral to the service is made via the PRIMA Service. Residents with complex psychiatric and/or behavioural presentations (such as dementia) are not eligible for services and will be referred on to specialised older people mental health services.

**Number of Services**

The number of services will be determined by clinical assessment, however, the focus of service delivery is on the provision of brief focused psychological strategies.

On completion of the initial course of 6 sessions and for every sixth session (including the end of care) the mental health professional will provide a letter to the referring health professional, including information on assessment, treatment provided and the individual’s outcomes, and provide recommendations on future management of the individual’s mental disorder.

A data management form will be provided for each session recorded when the invoice for those sessions is presented.

***C. Clinical Care Coordination services***

The primary intervention provided under the Clinical Care Coordination service type is care coordination for people diagnosed with complex and enduring mental illness. Key interventions will include:

* Providing clinical nursing or other evidence based services for clients with severe mental disorders;
* Liaising closely with family and carers as appropriate;
* Regularly reviewing the client’s mental state;
* Administering (nurses only), monitoring and ensuring compliance with prescribed medication;
* Providing information on physical health care to clients;
* Maintaining links and undertaking case conferencing with GPs, psychiatrists and allied health workers such as psychologists;
* Coordinating services for the patient in relation to GPs, psychiatrists and allied health workers, including arranging access to interventions from other health professionals as required;
* Contributing to the planning and care management of the client; and
* Liaising and establishing links with organisations that provide psychosocial support services as appropriate and where available.

Services will be provided in a range of settings, such as in clinics, public place or at a patient’s home.

**Eligibility for Clinical Care Coordination services**

Referral to Clinical Care Coordination is limited to people with more complex and enduring mental illness. Eligible people will have a diagnosis of mental illness and associated factors that significantly impact their social, personal and work life. The person must have been to hospital at least once for treatment of their mental illness, or are at risk of needing hospitalisation in the future if appropriate treatment and care is not provided

Referral to Clinical Care Coordination must include a Mental Health Treatment Plan completed by a GP, psychiatrist or paediatrician. Where there are genuine difficulties in meeting the Mental Health Treatment Plan requirement, including where there is difficulty accessing GPs, with providing treatment to homeless people, or in some Aboriginal and Torres Strait Islander communities, provisional referrals may be accepted with the expectation that clients will be assisted to have a GP review within to have a Mental Health Treatment Plan prepared as soon as possible.

**Number of Services**

Each individual receiving Clinical Care Coordination services is eligible for service for an initial period of 9 months at a frequency that is determined during care planning and is clinically indicated. Services are to be delivered in a recovery orientated framework. A second period of 9 months is available based on clinical need and identified goals of continuation.

A client is no longer eligible for Clinical Care Coordination services in the following circumstances when the individual:

* Has achieved their treatment goals or;
* Is clinically determined to be best engaged in a lower intensity or support service or
* Mental disorder is no longer causing significant disablement to their social, personal and occupational functioning

For clients who require longer term care coordination, application to the National Disability Insurance Scheme should be explored.