

Better Access to Mental Health Care initiative

Orientation manual for clinical psychologists, psychologists, social workers and occupational therapists

The
Australian Psychological Society Ltd



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The APS has made every effort to ensure that, at the date of publication, the Better Access to Mental Health Care Orientation manual for clinical psychologists, psychologists, social workers and occupational therapists is free from errors and omissions and that all opinions, advice and information have been given in good faith. Any feedback on the content and structure of this manual from allied mental health professionals who use it would be appreciated.

The information is considered to be consistent with applicable laws at the time of publication. However, it does not constitute legal advice. Individuals concerned about their legal rights and obligations under this initiative should seek their own independent legal advice.

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Foreword

On 1 November 2006, the Australian Government introduced the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule initiative, known as the Better Access to Mental Health Care initiative. This provided new Medicare items for psychological services for people with mental health disorders to be able to access affordable mental health care. Under the new Medicare scheme, clinical psychologists can provide assessment and psychological therapy, and psychologists, accredited social workers and occupational therapists can provide Focussed Psychological Strategies. The Better Access initiative promotes a team approach to mental health care, with general practitioners, psychiatrists and paediatricians encouraged to work with psychologists, social workers and occupational therapists, as well as mental health nurses, to increase the availability of mental health care.

The Australian Psychological Society (APS) has developed this Orientation manual for allied mental health professionals who are eligible to provide services under the Better Access initiative. The development of this manual has involved consultation with OT AUSTRALIA (Australian Association of Occupational Therapists), the Australian Association of Social Workers (AASW), and the Australian General Practice Network (AGPN).

The Orientation manual aims to cover the fundamental components of the initiative for allied mental health professionals, such as their Medicare registration requirements, Medicare Benefits Schedule (MBS) item numbers and billing requirements, and also to cover broader professional issues that underpin high quality interdisciplinary mental health care. The manual aims to provide a valuable tool for clinical psychologists, psychologists, social workers and occupational therapists to efficiently and effectively deliver evidence-based treatment for positive mental health outcomes for their clients.

The APS strongly supports the Better Access to Mental Health Care initiative, and welcomes the opportunity for clients with mental health disorders to receive interdisciplinary mental health care. The introduction of the Better Access initiative has been a historical and significant step by the Government of Australia to support individuals, their families, and communities in the treatment of people with mental disorders.



**Professor Lyn Littlefield OAM, Executive Director
The Australian Psychological Society**

1. The Better Access to Mental Health Care initiative

1.1 Background to the Better Access to Mental Health Care initiative

Mental health in Australia

Good mental health has been identified as fundamental to a person's wellbeing. People who suffer from mental illness often experience diminished quality of life and can be at an increased risk of suicide. In the 1997 Australian National Survey of Mental Health and Wellbeing (ABS, 1999) it was reported that 18% of the adults in the community had a psychological disorder in the previous twelve months. This figure, representing approximately one person in every five, is now thought to be an underestimation of the mental health problems in the Australian community (Australian Institute of Health and Welfare, 2006). Notwithstanding the possibly understated prevalence rates, the 1997 survey found that the most common mental health disorders in Australia are anxiety disorders (9.7%), substance abuse disorders (7.7%), and affective disorders (5.8%), which include depression and bipolar disorders (ABS, 1999). Psychoses are less prevalent (3%), but have a major impact on people's lives.

In addition to the most prevalent mental health disorders, such as anxiety and depression, there is a wide range of other psychological disorders that impact on the everyday lives of Australians. Some of the less prevalent but important disorders include conduct disorder, phobias, post-traumatic stress disorder, eating disorders, bereavement disorders, sexual disorders, sleep problems, and unexplained somatic complaints. Most importantly people with mental health disorders need access to treatment. The management of individuals with any type of psychological disorder is guided by the type and severity of the presenting problem, and the resulting impairment to their personal, social or occupational functioning.

Development of the initiative

The Australian Government's contribution to the Council of Australian Governments (COAG) mental health package is \$1.9 billion over five years, to provide families, schools and health professionals with more support in recognising and addressing mental illness, and new assistance to people living with mental illness and their families/carers. The Government's new Better Access to Mental Health Care initiative, costing \$507 million over five years, operates mainly through the introduction of new Medicare items to provide better and more affordable mental health care. These new Medicare services promote a team approach to mental health care, with GPs encouraged to work with psychiatrists and allied mental health professionals to increase the availability of care.

The new mental health Medicare items introduced on 1 November 2006 enable individuals with diagnosed mental disorders to access rebates for a new range of mental health services. Under the changes, Medicare rebates will be available for GPs to provide early intervention, assessment and management of clients with mental disorders as part of a GP Mental Health Care Plan. As a large component of this initiative, Medicare rebates are now available for clients with an assessed mental disorder to receive treatment from an allied mental health professional. New Medicare items also support psychiatrists to see more new clients.

The new Medicare Benefits Schedule (MBS) items pave the way for a range of other Australian Government mental health initiatives to be implemented, including \$191.6 million over five years for mental health nurses to support private psychiatrists and GPs in caring for people with severe mental illness.

Relationship to the Better Outcomes in Mental Health Care initiative

The Better Outcomes in Mental Health Care (BOiMHC) Program has been a successful foundation for the new COAG Mental Health Better Access to Psychiatrists, Psychologists and General Practitioners through Medical Benefits Scheme Initiative.

The Australian Government introduced the BOiMHC Program in July 2001 in recognition of the important role of general practitioners in managing mental health problems. Initial funding of \$120.4 million over four years was allocated to the Program with a further \$142.7 million provided over four years to continue and expand the Program to 2008-09.

The BOiMHC Program aims to improve the quality of care provided through general practice to Australians with a mental illness. Divisions of General Practice act as fundholders for the Access to Allied Psychological Services (ATAPS) component of the BOiMHC Program. ATAPS enables GPs to refer clients to appropriately qualified allied health professionals (psychologists, mental health nurses, social workers, occupational therapists and Aboriginal and Torres Strait Islander health workers) who deliver Focussed Psychological Strategies.

Divisions of General Practice are allocated an annual budget to broker allied mental health services for patients of general practitioners who would not otherwise access these services. Divisions are able to adopt a model that best suits their local arrangements and as a result a number of service delivery models are being used across the country.

ATAPS provides an alternative referral pathway to Medicare funded psychological services for people seeking assistance, via their GP for treatment of their mental illness.

Earlier this year the Australian Government announced that funding for the BOiMHC Program is to be ongoing.

1.2 Aims of the Better Access to Mental Health Care initiative

The Better Access to Mental Health Care initiative aims to:

- Encourage more GPs to participate in early intervention and management of clients with mental health disorders, and to streamline access to appropriate psychological interventions in primary care;
- Encourage private psychiatrists to see more clients;
- Provide referral pathways for appropriate assessment and treatment of clients with mental disorders, including by specifically qualified clinical psychologists, psychologists, and accredited social workers and accredited occupational therapists;
- Provide people with mental health disorders with access to a maximum of 12 individual sessions of psychological therapy or Focussed Psychological Strategies and 12 group services per calendar year, as appropriate; and
- Support GPs and primary care providers with education and training to better diagnose and treat mental illness.

1.3 Overview of the Better Access to Mental Health Care initiative

The Better Access to Mental Health Care initiative is designed to provide the public with better access to mental health services through Medicare. Specifically, this initiative involves the delivery of Medicare-funded mental health services by psychiatrists, GPs, psychologists, social workers and occupational therapists.

On 1 November 2006, Medicare rebates were introduced for GPs to provide assessment and management of clients with mental disorders as part of a GP Mental Health Care Plan. GPs can refer clients with mental health disorders to allied mental health providers for treatment under a GP Mental Health Care Plan or under a psychiatrist assessment and management plan. In addition, psychiatrists and paediatricians can directly refer eligible clients with mental disorders (from an eligible Medicare service) to allied mental health professionals for services attracting a Medicare rebate.

Allied mental health services under this initiative include psychological assessment and therapy provided by eligible clinical psychologists, and Focussed Psychological Strategies provided by eligible psychologists, social workers and occupational therapists. New items are available for up to 12 individual and/or 12 group allied mental health services per calendar year, delivered in sets of up to six sessions, to clients with an assessed mental disorder.

This initiative promotes greater interaction between medical practitioners and allied mental health professionals and encourages team-based mental health care in primary care, with clinical psychologists, psychologists, social workers, and occupational therapists working alongside GPs, psychiatrists and paediatricians. This initiative also includes funding for education and training to help to ensure that the relevant professionals are well-equipped to recognise and treat mental illness.

2. Eligible allied mental health practitioners

The allied mental health professions able to provide services under the Better Access to Mental Health Care initiative are psychologists, social workers and occupational therapists who are able to meet the eligibility criteria. Descriptions of the expertise of clinical psychologists, psychologists, social workers, and occupational therapists involved in mental health care are listed in Appendix A.

All allied mental health professionals must be registered with Medicare Australia and have a Medicare Provider Number to be eligible to provide services under this initiative. The 'Application for an initial Medicare provider/registration number for an Allied Health Professional' form can be downloaded from the Medicare Australia website (http://www.medicareaustralia.gov.au/providers/forms/medicare/apps_for_provider_number.htm). Allied mental health professionals who are already registered with Medicare Australia do not need a new Medicare Provider Number to provide services under the Better Access initiative.

2.1 Eligibility to provide mental health Medicare items

The mental health Medicare items involve two categories of services: (1) psychological therapy services which can only be provided by clinical psychologists; and (2) Focussed Psychological Strategies (FPS) which can be provided by all eligible allied mental health professionals.

Eligibility to provide psychological therapy services

Registered psychologists who are qualified to use the title 'clinical psychologist', as determined by membership of the Australian Psychological Society's (APS) College of Clinical Psychologists, or demonstrated eligibility for membership of the College, are eligible to deliver psychological therapy services.

The Australian Government has contracted the APS to administer the process of confirming the status of current Clinical College members, and assessing the eligibility of other psychologists for Clinical College membership.

Assessment of eligibility process

Psychologists seeking to provide psychological therapy services under Medicare need to apply to the APS for assessment of eligibility through the online application process. There are a number of different pathways for assessment of eligibility depending on the qualifications of the applicant. Psychologists should identify the appropriate application pack for assessment of eligibility for membership of the Clinical College based on their qualifications.

The APS assesses applications on a case-by-case basis to determine whether the eligibility criteria have been adequately met, and whether the evidence as a whole demonstrates eligibility for membership of the Clinical College. Currently the standard route for entry into the College is via an accredited and approved Doctorate degree in clinical psychology, or an accredited and approved Masters degree in clinical psychology with additional post-Masters clinical experience. Psychologists who do not have such a degree need to demonstrate that their training and experience in clinical psychology is effectively equivalent to that obtained via the standard route.

There is a fee associated with applying to have current Clinical College membership confirmed or eligibility for Clinical College membership assessed by the APS. Further information and guidelines for applicants can be found on the APS website (http://www.psychology.org.au/medicare/providing_services/).

Maintenance of eligibility

To maintain eligibility to provide psychological therapy services as a clinical psychology provider once this has been established, clinical psychologists must accumulate a minimum of 60 Professional Development (PD) points over a two-year period. Of these 60 points, a minimum of 30 specialist points in clinical psychology need to be accrued, although practitioners may fulfil the entire requirement through specialist PD activities. Specialist points are those points related to PD activities that meet criteria for endorsement or have been endorsed by the APS College of Clinical Psychologists as continuing education in that specialist area. Further information about the PD requirements can be found on the APS website (www.psychology.org.au).

Eligibility to provide Focussed Psychological Strategies

Psychologists, eligible social workers and eligible occupational therapists can provide Focussed Psychological Strategies (FPS). These professionals must have the knowledge, skills and experience to competently deliver approved FPS.

Psychologists

To be eligible to register with Medicare Australia to provide FPS, a psychologist must be fully registered with the Psychologists Registration Board in the State or Territory in which s/he is practising. Probationary psychologists are NOT able to register with Medicare Australia to provide FPS under this initiative. Students who are under the supervision of fully registered psychologists are also not eligible to provide psychological services under Medicare (unless the student is already a fully registered psychologist).

For further information, go to the APS website (www.psychology.org.au) or contact the APS on 1800 333 497.

Social workers

To be eligible to register with Medicare Australia to provide FPS, a social worker must be a member of the Australian Association of Social Workers (AASW), who has been certified by the AASW as meeting the standards for mental health set out in the AASW's Standards for Mental Health Social Workers 1999.

For further information, go to the AASW website (www.aasw.asn.au) or contact the AASW on 1800 630 124.

Occupational therapists

To be eligible to register with Medicare Australia to provide FPS, an occupational therapist must be a full or part-time member of OT AUSTRALIA with a minimum of two years' full time (or equivalent) supervised practice as an occupational therapist working in mental health, who meets the Australian Competency Standards for Occupational Therapists in Mental Health (1999). All occupational therapists wishing to provide services under the FPS Medicare items must complete and sign a statutory declaration stating that they meet the eligibility criteria.

For further information, go to the OT AUSTRALIA website (www.ausot.com.au) or contact OT AUSTRALIA on (03)9415 2900.

3. Eligible clients

3.1 Eligibility criteria

Allied mental health Medicare services can only be provided to individuals with ‘an assessed mental disorder’ who have been referred by a GP, a psychiatrist, or a paediatrician from an eligible Medicare service.

Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual’s cognitive, emotional or social functioning. Table 1 presents a list of eligible mental disorders. It is the responsibility of the referring medical practitioner to determine that the client is eligible, and that his/her condition would benefit from a mental health care plan and would also benefit from allied mental health services.

Table 1. Mental disorders eligible for treatment under the better access initiative (based on the ICD-10, Primary Care Version)

Chronic psychotic disorders	Eating disorders
Acute psychotic disorders	Panic disorder
Schizophrenia	Alcohol use disorders
Bipolar disorder	Drug use disorders
Phobic disorder	Mixed anxiety and depression
Generalised anxiety disorder	Dissociative (conversion) disorder
Adjustment disorder	Neurasthenia
Unexplained somatic complaints	Sleep problems
Depression	Hyperkinetic (attention deficit) disorder
Sexual disorders	Enuresis (non-organic)
Conduct disorder	Obsessive compulsive disorder
Bereavement disorder	Mental disorder, not otherwise specified
Post-traumatic stress disorder	
Note: <i>Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these Medicare items</i>	

To be eligible for mental health services delivered by an allied mental health professional, a client must be referred by a GP who is managing the client’s condition under a GP Mental Health Care Plan or under a psychiatrist assessment and management plan, or directly referred by a psychiatrist or a paediatrician from an eligible Medicare service.

Note that before a rebate can be paid for the allied mental health service, Medicare Australia must have already processed the claim for the relevant item. If there is any doubt about a client’s eligibility, Medicare Australia will be able to confirm whether a GP Mental Health Care Plan and/or a psychiatrist assessment and management plan is in place and has been claimed, or an eligible psychiatric or paediatric service has been claimed. Medicare Australia will also be able to confirm the number of allied mental health services already claimed by the client in the calendar year. Allied mental health providers can call Medicare Australia on 132 150 to check this information, while unsure clients can seek clarification by calling 132 011.

3.2 Clients receiving services in publicly-funded programs

The allied mental health Medicare items do not apply for services provided to clients under any other Commonwealth- or State-funded programs. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Services or State/Territory Government health clinic, these items can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with Medicare Australia. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

4. Allied mental health Medicare services

4.1 Allied mental health services to be provided

The allied mental health Medicare services that are allowed to be provided under the Better Access initiative fall into two categories: (1) psychological therapy services provided by clinical psychologists only; and (2) Focussed Psychological Strategies (FPS) provided by all allied mental health professionals. Within these categories, services can be provided in individual sessions or group therapy sessions.

GPs determine to whom a client is referred for allied mental health Medicare services. Depending on the assessment of the mental health problem, the GP will refer the client for either FPS from one of the eligible allied mental health providers or psychological therapy services provided by a clinical psychologist. Generally, clients with complex and co-morbid mental health disorders would be referred for treatment by a clinical psychologist using the psychological therapy items, and clients with less complex conditions would be referred for FPS. Please note that all allied mental health professionals who are accredited under the Better Access initiative can provide FPS.

Psychological therapy (clinical psychologists only)

Psychological therapy can only be provided by clinical psychologists who have been deemed eligible through the assessment process conducted by the APS. Clinical psychologists are able to undertake assessment and treatment of clients presenting with more complex mental disorders and those co-existing with drug and alcohol problems. These clients need more complex, comprehensive and integrated forms of psychological therapy.

Cognitive behaviour therapy (CBT) has the most research evidence of effectiveness for a wide range of mental health disorders, so it is recommended that this form of treatment is used when providing psychological therapy services. However other evidence-based therapies – such as interpersonal therapy (IPT), particularly for depression – may be used if deemed clinically relevant and there is evidence of their effectiveness. Narrative therapy has been identified as a mode of working of particular value to Aboriginal and Torres Strait Islander people. Clinical psychologists can also use psychoeducation and motivational interviewing as part of services provided under the Better Access initiative.

An overview of the main forms of evidence-based psychological therapy can be found in Appendix B.

Focussed Psychological Strategies (all eligible allied mental health providers)

A range of evidence-based psychological strategies known as 'Focussed Psychological Strategies' (FPS) has been approved for use by all eligible allied mental health professionals (psychologists, social workers and occupational therapists).

A range of major psychological treatments shown to have evidence of effectiveness for a number of psychological disorders have been approved for use by allied mental health providers. These are:

1. Psychoeducation
2. Motivational interviewing
3. Cognitive behavioural therapy including:
 - Behavioural interventions
 - Behaviour modification (especially for children, including behavioural analysis and contingency management)
 - Exposure techniques
 - Activity scheduling (including pleasant events, mastery and time management)
 - Cognitive interventions
 - Cognitive analysis, challenging and restructuring
 - Self-instructional training
 - Attention regulation
 - Relaxation strategies
 - Guided imagery, deep muscle and isometric relaxation, controlled breathing
 - Skills training
 - Problem-solving skills training
 - Anger management
 - Stress management
 - Communication training
 - Social skills training
 - Parent management training
4. Interpersonal therapy (especially for depression)

There is flexibility to include narrative therapy for Aboriginal and Torres Strait Islander people.

A description of the approved FPS can be found in Appendix B.

Psychological assessment services

Allied mental health services provided under the Better Access initiative are expected to be for the purpose of providing treatment to eligible clients with an assessed mental disorder. Some assessment may, however, form part of the initial consultation with the client, for example, to enable the allied mental health professional to confirm and refine a differential diagnosis of the client, as well as to identify a baseline for establishing the client's progress in response to the treatment provided.

It is anticipated that any assessment provided will be appropriate to the client's presentation and the likely condition to be treated, and will be necessary in informing and directing provision of treatment for the client.

The term 'psychological assessment' refers to clinical interviewing and psychometric testing for the purposes of confirming or clarifying a mental health diagnosis. The Better Access Medicare items are not intended or designed to cover other forms of assessment, such as neuropsychological assessment and intelligence testing. Any assessment should occur in preparation for treatment of the client and generally should not extend beyond the initial consultation.

Group therapy services

Both psychological therapy and FPS can be provided by allied mental health practitioners as group therapy sessions under the Better Access initiative, if this is appropriate. The Medicare item specifies that the therapy group must have 6 to 10 clients participating. These participants can be made up of clients who are eligible for a rebate under the Better Access initiative, and clients who are not eligible for a rebate. The group session must be of at least 60 minutes duration.

The referral, reporting and medical practitioner review requirements for the provision of group services are the same as those listed for the provision of individual mental health services in the relevant sections of this manual.

4.2 Limits to number of services

Medicare rebates are available for up to 12 individual mental health services per client per calendar year, provided in two groups of up to six sessions. The referring medical practitioner can refer for an initial group of up to six services at the time of referral, however, the client may be referred for, or receive, less depending on their treatment needs. After the first course of treatment (up to six sessions), the allied mental health service provider is required to provide a written report to the referring medical practitioner managing the client. The referring medical practitioner must assess that the client will benefit from an additional course of treatment prior to additional services being provided by the allied mental health professional.

In addition, the referring practitioner may consider that in exceptional circumstances the client may require an additional six individual services beyond the 12 already provided (to a maximum total of 18 individual services per client per calendar year). Exceptional circumstances are defined as a significant change in a client's clinical condition or care circumstances that make it appropriate and necessary to increase the maximum number of services. In these cases a new referral should be provided, and exceptional circumstances noted in that referral. Invoices for services provided under exceptional circumstances must state that exceptional circumstances apply.

The calendar year limit of 12 individual services includes any other services provided by psychologists (FPS and/or psychological therapy services), or by eligible social workers or occupational therapists (FPS items), or by GPs (FPS items). Services received under the BOiMHC Access to Psychological Services (ATAPS) program are also included in the 12-service limit for allied mental health items. While services provided as part of the Allied Health and Dental Care initiative (for clients with chronic and complex conditions) are not included as part of the service limits for the Better Access Medicare items, it should be noted that most clients would not generally be accessing services under both initiatives. Where a client has an assessed mental disorder only, they should be managed under the Better Access items.

Clients are also eligible to claim up to 12 group mental health services (provided in two sets of up to six sessions) within a calendar year. These group services are separate from the individual services and do not count towards the 12 individual services per calendar year. The maximum of 12 group services includes clinical psychology items, and FPS items provided by psychologists or eligible social workers or occupational therapists.

If a client has not used all of their allowable services under a referral in a calendar year, it is not necessary to obtain a new referral for the 'unused' services. However, any unused services received from 1 January in the following year under that referral will count as part of the total of 12 services for which the client is eligible in that calendar year.

4.3 Restrictions on nature of services

Allied mental health services under the Better Access initiative are specified as 'professional attendance' and as such require face-to-face attendance with the referred client when providing the service. Other methods of service delivery, such as providing mental health services to clients over the telephone, internet, or via video link, are not allowable under the Better Access initiative.

The allied mental health Medicare items allow for professional attendances at places other than consulting rooms. It is expected that these would only be provided where treatment in environments other than the practitioner's consulting rooms is necessary to achieve therapeutic outcomes. Services cannot be provided to an admitted patient at a hospital or day hospital facility, including a private psychiatric ward.

Services provided by eligible allied mental health professionals must be within the specified time period within the Medicare item descriptor (see relevant tables on the following pages).

4.4 Allied mental health Medicare items, schedule fees and rebates

The Medicare Benefits Schedule (MBS) items for clinical psychologists, psychologists, social workers, and occupational therapists providing mental health care are outlined in Tables 2, 3, 4 and 5. Allied mental health professionals may set their own fees, however, for each item there is a schedule fee and Medicare rebate.

Table 2. MBS items for psychological therapy provided by clinical psychologists

Individual sessions of psychological therapy provided by a clinical psychologist			
MBS item number	Service length	Schedule fee ¹	Rebate ¹
80000	30-50 minutes	\$92.20	\$78.40
80005	30-50 minutes (Professional attendance at place other than consulting rooms*)	\$115.20	\$97.95
80010	50+ minutes	\$135.30	\$115.05
80015	50+ minutes (Professional attendance at place other than consulting rooms*)	\$158.30	\$134.60
Group psychological therapy services provided by a clinical psychologist			
MBS item number	Service length	Schedule fee ¹	Rebate ¹
80020	60 minutes minimum (6-10 people)	\$34.35 per group member	\$29.20 per group member

Table 3. MBS items for Focused Psychological Strategies (FPS) provided by psychologists

Individual sessions of Focused Psychological Strategies provided by a psychologist			
MBS item number	Service length	Schedule fee ¹	Rebate ¹
80100	20-50 minutes	\$65.30	\$55.55
80105	20-50 minutes (Professional attendance at place other than consulting rooms*)	\$88.80	\$75.50
80110	50+ minutes	\$92.20	\$78.40
80115	50+ minutes (Professional attendance at place other than consulting rooms*)	\$115.75	\$98.40
Group sessions of Focused Psychological Strategies provided by a psychologist			
MBS item number	Service length	Schedule fee ¹	Rebate ¹
80120	60 minutes minimum (6-10 people)	\$23.50 per group member	\$20.00 per group member

Table 4. MBS items for Focussed Psychological Strategies (FPS) provided by social workers

Individual sessions of Focussed Psychological Strategies provided by a social worker			
MBS item number	Service length	Schedule fee¹	Rebate¹
80150	20-50 minutes	\$57.55	\$48.95
80155	20-50 minutes (Professional attendance at place other than consulting rooms*)	\$81.00	\$68.85
80160	50+ minutes	\$81.25	\$69.10
80165	50+ minutes (Professional attendance at place other than consulting rooms*)	\$104.70	\$89.00
Group sessions of Focussed Psychological Strategies provided by a social worker			
MBS item number	Service length	Schedule fee¹	Rebate¹
80170	60 minutes minimum (6-10 people)	\$20.65 per group member	\$17.60 per group member

Table 5. MBS items for Focussed Psychological Strategies (FPS) provided by occupational therapists

Individual sessions of Focussed Psychological Strategies provided by an occupational therapist			
MBS item number	Service length	Schedule fee¹	Rebate¹
80125	20-50 minutes	\$57.55	\$48.95
80130	20-50 minutes (Professional attendance at place other than consulting rooms*)	\$81.00	\$68.85
80135	50+ minutes	\$81.25	\$69.10
80140	50+ minutes (Professional attendance at place other than consulting rooms*)	\$104.70	\$89.00
Group sessions of Focussed Psychological Strategies provided by an occupational therapist			
MBS item number	Service length	Schedule fee¹	Rebate¹
80145	60 minutes minimum (6-10 people)	\$20.65 per group member	\$17.60 per group member

Providers should refer to the current Medicare Benefits Schedule for allied mental health professionals (available on the Department of Health and Ageing website at www.health.gov.au or by phoning 1800 020 103) for current information, including rebate levels.

*Professional attendances at places other than consulting rooms can be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

¹ MBS fees and rebates are indexed on 1 November each year

4.5 Medicare Australia auditing processes

Allied mental health practitioners who are providing services under Medicare may be subject to 'random compliance audits' conducted by Medicare Australia. These audits are conducted to check that the services that have been claimed under Medicare have actually been provided. The audit for allied mental health services involves three checks: (1) confirming with the referring doctor that the client was indeed referred; (2) checking with the allied mental health practitioner that the service was provided; and (3) verifying with the client that they actually received the service. The random compliance audit does not involve disclosure of any personal client information regarding the nature of the referral or the treatment that was provided. Random compliance audits are conducted across all service provider groups in the entire MBS program as part of Australian Government requirements. Approximately 2,000 random compliance audits are conducted every year.

Medicare Australia also conducts more detailed 'research audits' to determine compliance with the requirements of various MBS programs.

For Medicare Australia auditing purposes, a requirement of providing services under Medicare is that for each client seen under the MBS, allied health practitioners are required to retain documentation of the medical practitioner's referral for 24 months from the date the first service under that referral was provided.

Further information is available from the Medicare Australia provider enquiry line on 132 150.

5. Referral procedures

Eligible clients must be referred for Better Access allied mental health services by a GP, psychiatrist or a paediatrician who has seen the client at an eligible Medicare service. Referring medical practitioners are not required to use a specific form to refer clients for these services. The referral may be a letter or note to an eligible allied mental health provider signed and dated by the referring practitioner, and should also include sufficient information to enable the allied mental health professional to provide the appropriate treatment. With the client's permission the GP may also include a copy of the GP Mental Health Care Plan. The allied mental health provider must be in receipt of the referral at the first allied mental health consultation.

5.1 Referral from a GP

Under the Better Access to Mental Health Care initiative, GPs must refer a client for allied mental health services through a GP Mental Health Care Plan, or less commonly, through a psychiatrist assessment and management plan.

The GP Mental Health Care Plan

The GP Mental Health Care Plan is written for clients with a mental disorder who would benefit from a structured approach to the management of their mental health care needs. With the client's agreement, the GP will make a formal assessment of the client's mental health and develop a plan for the management of their condition, including, where appropriate, referral for allied mental health services. It is the responsibility of the medical practitioner to determine the client's eligibility for both the care planning service and the referral for allied mental health services.

Preparation of a GP Mental Health Care Plan involves both assessing the client for suitable mental health care management and preparing the GP Mental Health Care Plan document. An assessment of a client must include:

- Taking relevant history (biological, psychological, social) including the presenting complaint;
- Conducting a mental state examination;
- Assessing associated risk and any co-morbidity;
- Making a diagnosis and/or formulation;
- Administering an outcome measurement tool, except where it is considered clinically inappropriate; and
- Recording the client's agreement for the GP Mental Health Care Plan service.

The preparation of a GP Mental Health Care Plan must include:

- A discussion of the assessment with the client, including the mental health formulation and/or diagnosis;
- The identification and discussion of referral and treatment options with the client, including appropriate support services;
- Agreeing on goals with the client including what should be achieved by the treatment, and any agreed actions the client will take;
- The provision of psycho-education;
- The development of a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;

- Arrangements for required referrals, treatment, appropriate support services, review and follow-up; and
- Documentation of the results of assessment, client needs, goals and actions, referrals and required treatment/services, and the review date in the client's GP Mental Health Care Plan.

There is no required format for preparing the GP Mental Health Care Plan, however a suggested template has been developed and is available from the Department of Health and Ageing website at www.health.gov.au.

A copy of the GP Mental Health Care Plan may be provided to the allied mental health practitioner with the client's consent and GPs are encouraged to do so to assist smooth transition for the client's mental health care.

There is a restriction of one GP Mental Health Care Plan per client in a 12-month period under the Better Access initiative. Where a client has had a GP Mental Health Care Plan developed by a GP who is no longer managing the client's care, the new GP should attempt to access the client's existing plan from the previous GP and update the plan using the GP Mental Health Care Plan Review item. If this is not possible and the GP considers that exceptional circumstances apply, the GP could develop a new GP Mental Health Care Plan within the usual minimum period of 12 months. However, there should be clear reasons why a new plan needed to be developed.

5.2 Referral from a psychiatrist or paediatrician

Psychiatrists and paediatricians can independently refer a client with an assessed mental disorder for allied mental health services under Medicare. In order to refer clients for allied mental health Medicare services, psychiatrists and paediatricians must first assess whether their client would benefit from the specific mental health services that can be provided through the Better Access to Mental Health Care initiative. If services are deemed appropriate, paediatricians and psychiatrists are then required to provide a letter of referral to the appropriate allied mental health professional.

A psychiatrist or paediatrician in private practice can directly refer a client for allied mental health services as long as they use their private Medicare Provider Number and charge a Medicare attendance item for the referring consultation. Referrals must be made from an eligible Medicare service (any of the items 104 to 109 for psychiatrists or paediatricians, items 293 to 370 for consultant psychiatrists or items 110 to 131 for consultant paediatricians) in order for Medicare to recognise that the client is eligible for Medicare rebates for allied mental health services.

Medicare Australia must have processed a claim for the referring consultation before a rebate for the allied mental health services can be paid. Unlike under the arrangements for a referral from a GP (where a GP Mental Health Care Plan must be completed), there is no formal assessment item that psychiatrists or paediatricians must have billed. Psychiatrists and paediatricians operating in the public sector cannot refer public clients for Medicare rebateable allied mental health services under the Better Access initiative.

6. Reporting requirements

6.1 Reporting and medical practitioner review requirements

Allied mental health practitioners must provide a written report to the referring medical practitioner on completion of a course of treatment (which will be a maximum of six services, but could involve less than six services depending on the nature of the referral). The written report should include information on:

- Any assessments carried out;
- Any treatment provided;
- Recommendations for additional treatment, if considered appropriate for the mental health care of the client; and
- Future strategies for the management of the client's mental health problem.

Following receipt of the allied mental health professional's report the referring medical practitioner should consider the need for further services. A subsequent set of up to six mental health services needs to be approved by the referring medical practitioner before they can be provided.

It is generally expected that the referring practitioner will consider the need for further services in a face-to-face consultation with the client. However, in some instances the referring practitioner may consider that an attendance is not necessary. Where this occurs, the allied mental health professional should document any telephone conversation with the referring doctor and seek written authorisation from him/her to ensure that the validity of the second set of services can be substantiated at a later date, if required.

A written report must also be provided to the referring medical practitioner at the completion of each subsequent course/s of treatment.

The amount of detail in the report to the referring medical practitioner is not specifically mandated. However, the Medical Benefits Schedule Explanatory Notes do state that the report should include information about assessments carried out, treatment provided and recommendations on the future management of the client's disorder. In meeting these requirements, the allied mental health practitioner should use clinical judgement on what information is appropriate to include in the report.

Although not a requirement, it is good practice for the mental health professional to send a letter to the referring medical practitioner after the first appointment with the client to acknowledge the referral, confirm that the client attended the appointment, confirm the main focus for treatment, and the date it is anticipated that the client will require review by the medical practitioner (or when it is anticipated that the sessions will be completed). This will help to develop a good working relationship with the referring medical practitioner.

6.2 Client confidentiality

The reporting processes are a mandatory requirement of the Medicare Better Access initiative. In view of this requirement, clients should be made aware of the communications between the mental health professional and the referring medical practitioner before consenting to treatment. This will ensure that the client is aware of the limits to confidentiality, and that the progress and closure reports written by clinical psychologists, psychologists, social workers and occupational therapists will become part of the client's medical record at the medical practice.

7. Billing for services provided under Medicare

There are two choices for billing services provided under Medicare: private billing of clients and bulk billing (direct payment from Medicare via assignment of the benefit voucher). It is the decision of providers to determine which billing method they use for each client.

Allied mental health practitioners providing services under Medicare may set their own fees but the Medicare rebate for each item is a set amount. Providers are encouraged to bulk bill clients who are Health Care Card holders.

7.1 Private billing

When clients are billed privately for services, the settlement of the account is the responsibility of the client. Clients may claim a rebate by lodging a claim through Medicare. When a client is billed they can:

- Pay the full amount of the consultation and use their detailed receipt to claim a Medicare rebate;
- Pay the difference between the Medicare rebate and the total account amount upfront, and claim the rebate from Medicare to forward to the provider later; or
- Claim from Medicare using their unpaid account and forward the rebate and the difference to the provider later.

It should be noted that it is up to the provider to determine which of these methods they will use for each client.

Evidence of the mental health service having taken place must be provided in the form of an account if unpaid, or an account/receipt if paid in full. The account must clearly indicate whether or not it has been paid. The following information must be included on the account or receipt:

- Name of the client who received the mental health service
- Date on which the service was provided
- MBS item number and/or description of the service
- Name and practice address, or name and provider number, of the allied mental health provider who actually provided the service
- Name and provider number of the referring medical practitioner and date of referral
- Amount charged, total amount paid, and any amount outstanding in respect of the service.

7.2 Bulk billing

If the provider decides to use the bulk billing method, clients assign their right to a benefit to the provider as full payment for the mental health service. The provider cannot make any additional charge for this service if it has been bulk billed, and will receive the relevant Medicare rebate or 'benefit' from Medicare Australia for the service provided as full fee for that service.

When bulk billing is used, the provider receives direct payment from Medicare by completing direct billing forms for each service provided to the client. These direct billing forms consist of:

- A claim form (Non-hospital clients allied health professional - DB1N-AH)
- Assignment of benefits form (Bulk bill voucher (Allied Health Professional) - DB2-AH).

The DB1N-AH comes in a duplicate carbon copy (provider and Medicare copy), and the DB2-AH comes in a triplicate carbon copy (provider, Medicare, and client copy). Information on completing the forms is included with each supply of forms.

The name and provider number of the referring medical practitioner and date of referral must appear in the 'referral details' box on the DB2-AH form. Clients must sign the DB2-AH (assignment of benefit) form after the service has been provided and the form completed. A copy of the completed assignment form must be given to the client.

More information on Medicare claiming is available from Medicare Australia, who can be contacted on 132 150.

Obtaining direct billing forms

The direct billing forms (and instruction sheets) can be ordered from Medicare by calling 1800 067 307. A form for ordering direct billing forms can also be downloaded from the Medicare Australia website (<http://www.medicareaustralia.gov.au/>).

Completed stationery re-order forms should be sent to:

Leigh-Mardon

by fax: (02) 6230 0477

or by mail to:

Medicare Australia

Locked Bag 4444

Tuggeranong, ACT 2901

Submitting bulk bill claims

All assignment of benefit claims (bulk billing claims) must be lodged within six months of the date of service. All bulk billing claims should be mailed to Medicare (GPO Box 9822 in each capital city) or can be left at Medicare offices.

Payment of bulk billing claims

A benefit cheque or an EFT bank transfer will be sent to the allied mental health service provider.

A statement of benefit will be provided to the mental health service provider, and will show:

- A listing of all services being paid
- A reason code for any rejected services
- Where the benefit paid differs from the benefit claimed
- When a Medicare number has changed or was not present on the assignment form
- When a Medicare card is about to expire.

7.3 Medicare Safety Net

Clients may incur out-of-pocket costs if they are charged a fee in excess of the Medicare rebate for services received from an allied mental health provider. It should be noted that these out-of-pocket costs will count towards the Medicare Safety Net for that client.

The Medicare Safety Net protects high users of health services from big out-of-pocket costs. Once the client or their family has reached the relevant threshold in the calendar year, Medicare benefits will increase to 100% of the schedule fee under the original Safety Net, and 80% of total out-of-pocket expenses for out-of-hospital services under the extended Medicare Safety Net.

7.4 Private health insurance and Medicare

Some private health insurance companies provide ancillary cover for psychological services. This usually applies to services provided by registered psychologists, however, providers or clients who want to know what a private health insurer covers should check directly with the insurer. Clients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for psychological services they receive. Clients with private health insurance can either access rebates from Medicare by following the claiming process or claim where available on their insurer's ancillary benefits. It is the client's choice, not that of the health insurance company or the allied mental health provider.

Where the client chooses to claim against their health insurance (e.g., may receive a better rebate, has exhausted the 12 Medicare sessions, or does not have a specified mental health disorder), the practitioner can assist the client and the health insurance company by not using the Medicare item numbers and marking on the account 'Not claiming under Medicare'. Such a process will ensure that any confusion will be removed for the private health insurance company and the client's claim will be processed promptly. No such confusion will arise where electronic claiming (HICAPS, IBA) is being utilised, as the very act of claiming against one of the collaborating health insurance companies electronically should make the client's intentions clear.

Clients cannot use their private health insurance ancillary cover to pay the gap between the Medicare rebate and the charge for allied mental health services.

7.5 Circumstances where a Medicare rebate will not be paid

A Medicare rebate for services provided by an allied mental health practitioner will not be paid under the following circumstances:

- An invalid referral, where the client was not referred by a medical practitioner managing the client under a GP Mental Health Care Plan, and/or a psychiatrist assessment and management plan, or referred by a psychiatrist or paediatrician. This includes a client referred by a psychiatrist or paediatrician in the public sector where the referring specialist or consultant physician did not bill an eligible Medicare service for the referring consultation.
- Treatment by an allied mental health practitioner who did not have a Medicare Provider Number

- Treatment by a non-eligible allied mental health practitioner i.e. one who was not accredited as eligible to provide the services that were delivered
- The client has exceeded the number of rebateable allied mental health services allowable per calendar year.

It is important to note that before a rebate can be paid for allied mental health services, Medicare Australia must have already processed the claim for a GP Mental Health Care Plan item or other relevant medical practitioner referral item. If the GP Mental Health Care Plan or referral items have not been claimed first, a rebate for allied mental health services will not be paid.

8. Matters related to service provision

8.1 Medical practitioner referral issues

Referring clients to GPs

Allied mental health professionals may believe that in some instances existing clients may benefit from receiving a GP Mental Health Care Plan and referral for Medicare rebateable allied mental health services. The process of recommending that a client see a GP for these services requires considerable sensitivity and must acknowledge that it is the GP's decision as to whether the client is appropriate for referral under the MBS.

When allied mental health providers are considering suggesting to clients that they approach their GP to discuss the appropriateness of a GP Mental Health Care Plan and referral for Medicare rebateable allied mental health services, the following procedure is recommended:

- Find out the contact details of the client's GP
- Either write a note for the client to take to the GP, or, with the client's permission, make contact by phone or email explaining why it has been suggested that the client discuss the appropriateness of a GP Mental Health Care Plan assessment and possible referral for allied mental health services. A brief history of treatment and rationale would be of assistance to the GP.
- Explain to the client that when making the appointment they should mention to the receptionist that a longer appointment may be necessary. It may also be useful to explain to the client what the GP may do if they were to decide to complete a GP Mental Health Care Plan.

Inappropriate referrals

Referrals for treatment under the Better Access initiative are for psychological intervention and therefore referrals for medico-legal issues are not appropriate. Similarly, treatment under the Better Access initiative is not appropriate for Workcover clients or for clients seeking insurance assessments. It should also be noted that the initiative is not intended to provide rebates for neuropsychological or intellectual/educational assessments. Referrals for the support of clients with very chronic and particularly complex mental health conditions may also not be appropriate. Unless a discrete problem that could respond to short-term intervention can be identified, these clients may be better seen by other services or under a different Government scheme.

Sometimes an allied mental health practitioner will consider that a referral is not appropriate for them to accept on the basis that the client they are being referred requires services that are not within the clinician's area of expertise. If for some reason a referral is declined, it is important that the reasons for declining the referral are made clear to the client and the referring medical practitioner.

These issues highlight the importance of discussion with the medical practitioner when establishing the professional relationship before referrals are made. While such discussions may not happen as a matter of course, allied mental health providers should encourage the medical practitioners with whom they are working to discuss potential clients before making a referral. Such procedures may help to minimise the number of inappropriate referrals made and misplaced expectations about what can be achieved in six to twelve sessions.

8.2 Understanding the primary care context

The vast majority of referrals for allied mental health services under the Better Access initiative come from GPs, so it is essential for allied mental health providers to understand the primary care context.

GPs' role in coordination of care

Under the Better Access initiative, GPs are the main coordinators of primary mental health care. While the GP may refer a client to an allied mental health professional for one type of treatment, the GP retains ongoing coordination responsibility for the client's management. Once the allied mental health treatment is finished, the GP will be responsible for the client's ongoing management. Therefore, it is essential for allied mental health providers to keep the GP informed of the client's progress and future needs, and to make it clear to clients that they must return to their GP after the first course of treatment (which is a maximum of six sessions) and after any subsequent courses of treatment.

GP workloads and time constraints

GPs are typically the first contact for assistance for the great majority of people who experience a mental health problem. This means that GPs usually address such problems under conditions of high client volume and tight time constraints. For many GPs, the pace of their everyday workload has an effect on the breadth and depth of the services they can offer. These workload demands may also mean that they have little time for communication, particularly for informal information exchange with other professionals. While fee for service funding for general practice comes through Medicare, like other professionals in private practice GPs must fund their own infrastructure costs and other unmet expenses, and hence their time must be used judiciously.

Ways of preparing to work in the general practice context

The provision of collaborative care within a general practice setting may be a relatively new model of service delivery for some allied mental health professionals. There may be differences in the conceptualisation and approach to mental health care between GPs and allied mental health providers, and in some instances this may lead to a misunderstanding of issues. It is important to be respectful of the GP's professional practice (e.g., the use of medication) and to be prepared to work collaboratively. Of course, this mutual collaboration should work both ways.

8.3 Provision of services within the limited sessions framework

Flexible approach to treatment

Allied mental health professionals providing services under the Better Access initiative will need to ensure that they can deliver effective psychological interventions within the constraints imposed by session limits. Treatment goals may need to be prioritised with the client to enable selection of the most meaningful change that can be achieved within the time frame. Usual intervention techniques may need to be adjusted to ensure that an outcome is achieved within the 'six-session plus six-session' framework.

Management of client expectations

Working within the limited sessions framework requires management of client expectations of outcomes within the time available, and the responsible planning for, and handling of, termination of the therapeutic intervention. It is therefore important to work with clients to determine what can realistically be achieved within a short time frame.

8.4 Adherence to legal, ethical and professional obligations

Informed consent

Informed consent must be gained from the client before any service is provided. This entails clear communication and consultation with the client about the nature of the assessment and treatment proposed, the length of treatment, the expected outcomes, the limits of confidentiality, the storage of records and the proposed use of any evaluation data obtained. Consent must be obtained directly from the client; the fact of referral by a medical practitioner does not substitute for this requirement. Allied mental health professionals should respect the right of the client to withdraw consent to an intervention after it has commenced.

Confidentiality and limits of privacy

All health professionals are bound to respect clients' confidentiality within the confines of relevant State and Federal legislation and therefore must be familiar with these requirements. Most States throughout Australia have enacted Health Privacy legislation and there are also National Privacy Principles. Most privacy legislation relating to health records contain a number of principles that relate to the collection, storage, accuracy, access, use and disclosure of a client's health information. Allied mental health professionals should be fully aware of relevant privacy legislation and the limits to confidentiality that may exist, such as in cases involving potential harm to the client or others, or where the release of information is required by law.

The nature and extent of information to be provided back to the referring GP needs to be agreed to by the client. Discussions about privacy and confidentiality obligations should be used in a positive way to clarify, plan and maximise the outcome for the client.

Access to, disclosure of, and storage of records

Access to, and disclosure of, health-related records is regulated by relevant State and Federal legislation. Professionals need to be familiar with these regulations. The relevant professional associations should provide members with information on these issues. General privacy principles indicate that upon request, clients should have reasonable access to their records and that client consent is required for the disclosure of records to others. It should be noted that the courts might subpoena the records of allied mental health providers, as these records are not privileged or unconditionally confidential.

Allied mental health professionals should also be aware of issues associated with the storage of client records. Providers are responsible for storing clients' records according to State legal requirements. It should be noted that in at least some States, the law requires the retention of adult records for seven years and child records until the person is 25 years of age.

Adherence to the professions' codes of conduct

State Registration Boards (where applicable) maintain a register of qualified practitioners, uphold professional standards and investigate complaints. These Boards typically issue codes of conduct that specify minimum standards for professional conduct. For instance, the professional code of conduct for psychologists requires that services offered must be restricted to areas of competence and that professional skills must be maintained at acceptable levels, that client privacy and confidentiality are appropriately managed, and that professional propriety is observed. For those allied mental health professionals who do not have State registration, the various professional associations usually stipulate the requirements for professional conduct.

Allied mental health professionals must observe the codes of ethics and conduct required by their individual professions, as well as addressing any additional ethical responsibilities entailed by offering services under the Better Access initiative. Allied mental health professionals must only agree to provide services for which they are fully trained and experienced. Part of this professional obligation entails keeping up-to-date with the theoretical developments, research and training in evidence-based practice relevant to the treatment being offered through engaging in continuing professional development activities.

Procedure for complaints

There are a number of avenues that clients and professionals can pursue in the event that there is a complaint regarding the conduct of a medical or other health professional delivering treatment under the Better Access initiative. In all States and Territories except South Australia, there is an independent government-funded body that assists clients with health service complaints involving the public or private sector. Information about how to make a complaint may be accessed at www.complaintline.com.au. In South Australia, complaints against public sector providers and private sector providers are currently dealt with separately. Once again, contact details can be accessed from the above website.

In addition, in States and Territories where there is mandated registration of health practitioners (this applies in all States and Territories for medical practitioners, nurses and psychologists and in some States for occupational therapists), complaints may be directed to the respective Registration Boards in the State in which the professional is practising.

8.5 Providing services in special contexts

Rural and remote communities

GPs working in rural and remote communities are often in particular need of the expertise of allied mental health providers, as specialist mental health services may be severely limited or subject to high staff turnover and staff shortages. Due to a lack of mental health resources, GPs may themselves be doing much of the initial and ongoing mental health care. GPs in this situation have emphasised the need for all service providers to work collaboratively and to communicate effectively.

Allied mental health professionals working in rural and remote locations should also be aware that they may experience professional isolation. Many rural and remote services find it very difficult to recruit mental health workers and there may be limited opportunities for professional networking, ongoing professional education, and professional supervision. Privately practising allied mental health providers may be able to get together for peer supervision and support, in addition to accessing professional supervision from their own profession via teleconferencing or email and professional development by electronic means.

Aboriginal and Torres Strait Islander clients

The cultural background of Indigenous clients impacts on their expression and experience of mental health problems, beliefs about the origin of problems, views about alternative forms of treatment and support, and their willingness to seek treatment. The centrality of family and kinship to the lives of Aboriginal and Torres Strait Islander people also needs to be understood. It is vital for allied mental health professionals to develop an understanding of Aboriginal and Torres Strait Islander clients' cultural, social and family environment, and to involve family and other community members in assessment, treatment and management, if appropriate. Where possible, assessment and treatment should occur within the client's own community, given the importance of relationships and context to Indigenous people. The utilisation of Aboriginal and Torres Strait Islander mental health workers or other Indigenous professionals in the mainstream health system may be of some assistance with the delivery of services to Aboriginal and Torres Strait Islander clients. Also, where appropriate, providers could consider seeking support and assistance from the Aboriginal and Torres Strait Islander community controlled health services.

A culturally appropriate and safe environment should be provided to enable Indigenous clients to address mental health problems. Flexibility of services is also extremely important in order to meet the needs of Indigenous clients. Allied health professionals should ensure that they have access to, and use, interpreters when working with Aboriginal and Torres Strait Islander people who are not proficient in English. Providers also need to be aware that there are many different cultural groups within the Indigenous population, and therefore it is important not to make assumptions based on one cultural group and expect this to be automatically transferable to another context or, at times, even to other groups within the same geographical area.

Further information on working with Indigenous clients can be accessed from the Australian Network for Promotion Prevention and Early Intervention for Mental Health (<http://auseinet.flinders.edu.au/atsi/index.php>). The historical context of recent history and complex relationships between Aboriginal and Torres Strait Islander people and non-Indigenous professionals requires understanding by providers wishing to assist Indigenous clients with mental health problems through the Better Access initiative.

Culturally and linguistically diverse (CALD) clients

There is a wide range of cultural groups in Australia who differ in their religion, race, language and ethnicity. The two terms used to refer to clients from such cultural groups are CALD (culturally and linguistically diverse) and NESB (non-English speaking background). As is the case with Indigenous clients, the cultural background of CALD clients may also affect the expression and experience of

mental health problems, beliefs about the origin of their difficulties, views about alternative forms of treatment and support, and willingness to seek treatment. It is likely that many CALD clients with mental health problems are isolated due to language and cultural barriers.

When providing therapeutic interventions to CALD clients, it is very important for allied mental health professionals to understand the cultural, social and family environment of their clients, and where appropriate to involve family and other community members in assessment, treatment and management. Providers should use interpreters for clients with diverse ethnic and cultural backgrounds if they cannot deliver services in the appropriate language.

There are many resources that can be used when preparing to work with different ethnic and cultural groups. Many of these can be accessed from Multicultural Mental Health Australia (www.mmha.org.au).

8.6 Education, training and support for allied mental health providers

Under the Better Access initiative, a range of information, education and training projects for GPs, psychiatrists, psychologists, social workers and occupational therapists are being funded to cover (1) the use of the Better Access Medicare item numbers and (2) the multidisciplinary model of mental health care. Two projects on the Better Access initiative and interdisciplinary collaborative care have been designed to add more capacity and resources to support professionals who are providing, or considering providing, services to people with a mental disorder. The first project includes the development of the current Orientation manuals (for GPs and allied mental health professionals), and the roll-out of training sessions in the use of the Medicare items through each Division of General Practice. The second project is titled the 'Mental Health Professionals' Association (MHPA): National Multidisciplinary Education and Training Resources Package' for the new mental health arrangements. This package focuses on multidisciplinary teamwork and will provide training based on discussion of the assessment and treatment of a wide range of mental health problems and comorbidity.

8.7 Locating allied mental health Medicare providers

Medicare Australia is not able to provide a listing of registered allied mental health Medicare providers, but lists of eligible psychologists, social workers and occupational therapists are available from the websites of the relevant professional associations.

Psychologists who are registered as Medicare providers can be located through the APS web site (http://www.psychology.org.au/prac_resources/medicare/providerlists/). This link provides listings by State and Divisions of General Practice.

Social workers and occupational therapists who are registered as Medicare providers can be located on www.aasw.asn.au (social workers) and www.ausot.com.au (occupational therapists) respectively.

Some Divisions of General Practice may also maintain lists of Medicare registered allied mental health providers in the local area.

9. Further information about the initiative

Providers should refer to the current Medicare Benefits Schedule book for allied health professionals for up-to-date information on the requirements of the Medicare services. This can be accessed on line at www.health.gov.au/mbsonline, or in hard copy by contacting the Department of Health and Ageing on 1800 020 103 or (02) 6289 4297. Information can also be accessed from Medicare Australia by phoning the provider inquiry line on 132 150.

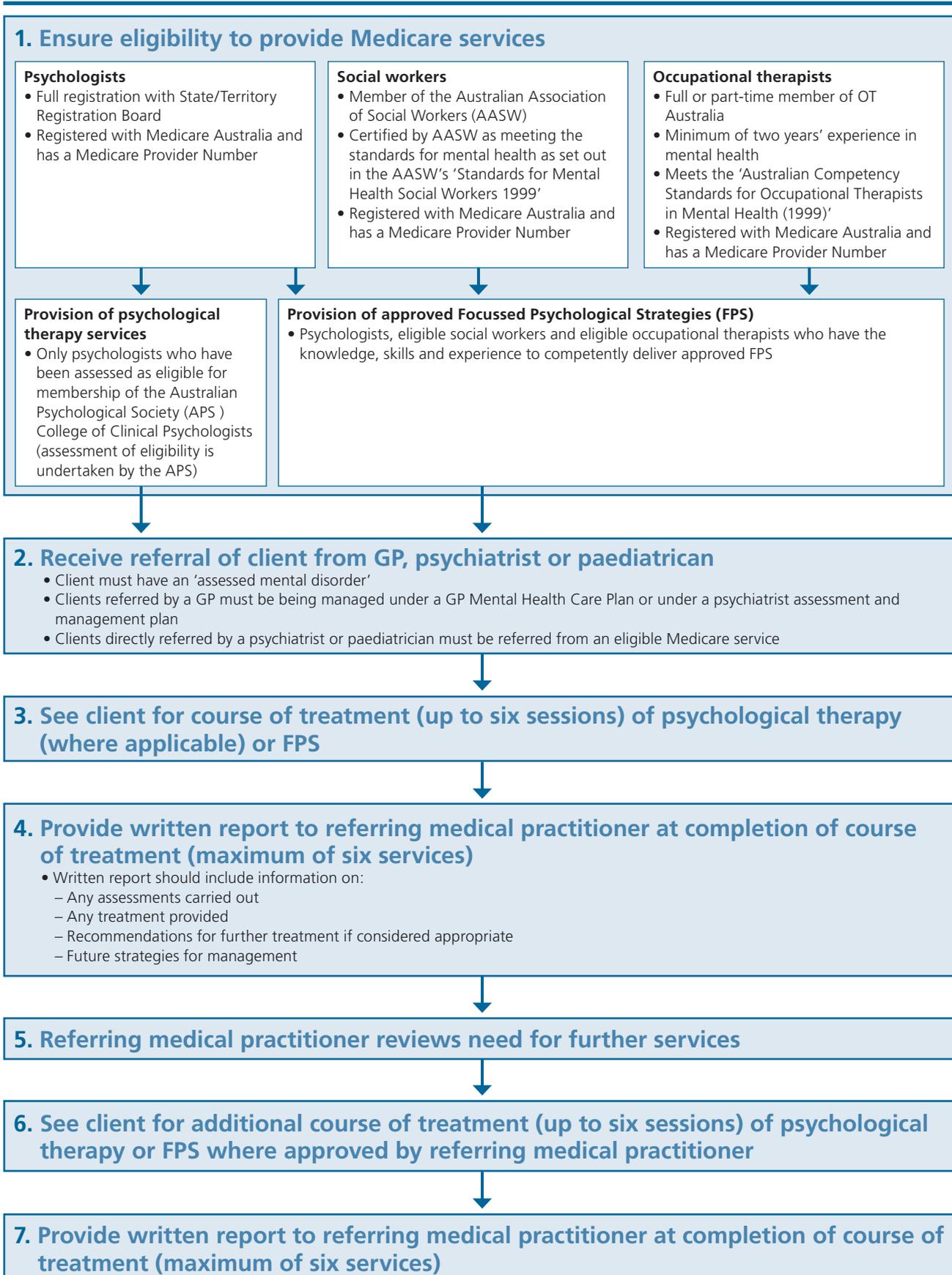
Further information can be found in the Questions and Answers documents prepared by the Australian Government Department of Health and Ageing:

- Allied mental health Medicare services: psychological therapy and Focussed Psychological Strategies
– Questions and Answers
<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pacd-amhpm-questions-answers.htm>
- GP mental health Medicare items – Questions and Answers
<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-gp-mental-health-care-medicare>

Information on the Better Access to Mental Health Care initiative can also be found on the following websites:

- Australian Government Department of Health and Ageing
www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-betteraccess-1
- Australian Association of Social Workers
www.aasw.asn.au
- Australian Psychological Society
www.psychology.org.au
- OT AUSTRALIA
www.ausot.com.au
- Australian General Practice Network
www.primarymentalhealth.com.au/site/index.cfm?display=15129

10. Quick guide to providing allied mental health Medicare services under the Better Access initiative



Providers should refer to the current Medicare Benefits Schedule for allied mental health professionals for details of the requirements for providing Medicare items.

Appendices

Appendix A: Definitions of allied mental health providers

Psychologist

Psychologists are experts in human behaviour, mental processes, and the way in which these can impact on a person's physical state, mental state, and their external environment. The goal of psychology is to describe, understand and assist individuals to manage their thoughts, feelings and behaviours. Psychologists work from the scientist practitioner model, by which psychological intervention is derived from evidence-based treatment. Psychologists possess a high level of knowledge and skills when entering the profession, with the minimum training and supervision requirement to become registered as a psychologist being six years. This includes training in psychopathology and therapeutic interventions for mental health disorders. Psychologists are trained to work with individuals of all ages, and with groups. Many psychologists undertake training in a specialist area of psychology, beyond the general or core area of training requirements.

Clinical psychologist

A clinical psychologist is a psychologist with specialised training in the assessment and treatment of mental disorders. Clinical psychologists are trained in a wide range of evidence-based interventions for mental health disorders that are supported by well defined theoretical models and frameworks. They are skilled in comprehensive assessment and diagnostic procedures that are needed for severe and complex mental disorders, and for individuals with co-morbidities of mental health problems and drug and alcohol issues. This training includes in depth knowledge of psychopathology and evidence-based treatments for people with complex and co-morbid mental health problems. The Clinical College requires members to maintain their experience and practice standards in clinical psychology through ongoing education and professional development.

Accredited mental health social worker

Accredited mental health social workers have particular expertise in helping individuals whose mental health difficulties co-exist with other problems such as family distress, drug and alcohol abuse, unemployment, disability, poverty and trauma. An accredited mental health social worker can provide Focussed Psychological Strategies and has a breadth of experience in working to bring about positive change with people experiencing psychological difficulty, including mental disorders. Response to these difficulties may range from individual counselling to family, group or community consultations, using skills and strategies drawn from a number of therapeutic approaches included in the Better Access initiative. The role of the mental health social worker is to work collaboratively with clients, carers, GPs and other members of the mental health team to resolve psychosocial problems associated with mental health disorders and improve quality of life. Continuing professional education is a requirement of accredited membership of the Australian Association of Social Workers.

Occupational therapist

Occupational therapists assess and treat the functional implications of health problems from a developmental and holistic perspective. They are evidence based specialists, whose academic training includes broad based education in physical and psychological components of mental health and wellbeing. Occupational therapists receive significant training in the Focussed Psychological Strategies on which the Better Access initiative is based. In addition to their academic training, occupational therapists develop specialist expertise through their clinical experience and like other allied health professionals are required to engage in ongoing professional development.

APPENDIX B: Descriptors of evidence-based psychological therapy and Focussed Psychological Strategies

I. Main forms of evidence-based psychological therapy

Cognitive behaviour therapy

Cognitive behaviour therapy (CBT) is a focussed approach that is based on the concept that cognitions influence feelings and behaviours, and that subsequent behaviours and emotions can influence cognitions. The therapist helps individuals identify unhelpful irrational thoughts, emotions, and behaviours. 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 or irrational patterns of thinking. Therefore, therapeutic interventions are aimed at replacing such dysfunctional thoughts with more rational cognitions, which leads to an alleviation of problem thoughts, emotions and behaviour.

Interpersonal therapy

Interpersonal therapy (IPT) is a brief, structured approach that addresses interpersonal issues and has evidence of effectiveness in treating depression. The causes of depression and psychological distress, according to this therapy, can often be traced to aspects of social functioning (relationships and social roles). Therefore, the underlying assumption with IPT is that mental health problems and interpersonal problems are interrelated. The goal of IPT is to help the person understand how these type of factors, operating in the person's current life situation, lead them to become distressed, and put them at risk of mental health problems. Specific interpersonal problems, as conceptualised in IPT, include interpersonal disputes, role transitions, grief, and interpersonal deficits. IPT explores clients' perceptions and expectations of relationships, and aims to improve communication and interpersonal skills.

Narrative therapy

Narrative therapy has been identified as a mode of working of particular value to Aboriginal and Torres Strait Islander people, as it builds on the story telling that is a central part of their culture. Narrative therapy is based on understanding the 'stories' that people use to describe their lives. The therapist listens to how people describe their problems as stories and helps the person to consider how the stories may restrict them from overcoming their present difficulties. It sees problems as being separate from people and assists the individual 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. Narrative therapy reframes the 'stories' people tell about their lives and puts a major emphasis on identifying people's strengths, particularly as they have mastered situations in the past.

II. Description of the approved Focussed Psychological Strategies

Psychoeducation

Psychoeducation is the provision and explanation of information to clients about what is widely known about characteristics of their diagnosis. Clients 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 in question. Information is provided about medications, prognosis, alleviating and aggravating factors. Information is also provided about early signs of relapse and how they can be actively monitored and effectively managed. Clients are helped to understand their disorder to enhance their therapy and assist them to live more productive and fulfilled lives.

Motivational interviewing

Motivational interviewing is a directive, person-centred counselling style that aims to enhance motivation for change in clients who are either ambivalent about, or reluctant to, change. The examination and resolution of ambivalence is its central purpose, and discrepancies between the client's current behaviour and their goals are highlighted as a vehicle to trigger behaviour change. Through therapy using motivational interviewing techniques a client is helped to identify their intrinsic motivation to support change.

Cognitive behaviour therapy – behavioural interventions

Behaviour modification

Behaviour modification starts with a thorough behavioural analysis, which involves specifying and measuring the behaviours to be altered, and identifying the antecedents and consequences controlling these behaviours. This analysis is followed by a systematic program which may include altering the stimuli triggering the unwanted behaviour, shaping up new adaptive (competing) behaviour, and contingency management (using reinforcers for increasing desirable behaviour and costs to decrease the unwanted/dysfunctional behaviour). After changing particular behaviours, techniques for generalisation and maintenance of gains are discussed, along with relapse prevention.

Exposure techniques

Exposure techniques are particularly used to deal with anxiety and phobias. Both imaginal and in vivo exposure may be used, often combined with relaxation and cognitive techniques. Graded exposure is the most commonly used technique. It involves identifying fears, and constructing a hierarchy of the least to most feared situations. The individual then agrees to be exposed in graded (from less to more fear-provoking) steps to the feared object or situation in vivo, such that the anxiety is heightened by not overwhelming. By remaining in this situation until the fear subsides, the person learns that it is groundless.

Activity scheduling

Activity scheduling is mainly used to assist with depression. It involves time management and scheduling in advance daily pleasant events, as well as activities which involve a sense of mastery and satisfaction. These activities are designed to provide enjoyment, change the person's self-perception and improve self-esteem. Doing planned activities distracts clients from their problems and negative thoughts, helps them to feel better, paradoxically less tired, more in control of their lives and able to make decisions.

Cognitive behaviour therapy – cognitive interventions

Cognitive analysis, challenging and restructuring of thoughts

Cognitive analysis involves identifying the dysfunctional thoughts which lead to unwanted emotions and problematic behaviour. This process firstly requires the person to become aware of the thoughts which produce the distressing feelings and behaviour and to uncover the beliefs which underlie the thoughts. These dysfunctional thoughts and beliefs are then challenged and replaced with more rational cognitions and supportive self-statements.

Cognitive therapy is most useful in treating internalising disorders (e.g., anxiety, panic disorder, phobias, OCD and depression). Often people with these disorders have cognitive schema which are faulty and they engage in distorted cognitive processes. Their dysfunctional thought patterns need to be challenged and replaced by more adaptive thoughts to enable them to stop worrying, experience positive emotions, cope with life, and feel successful. In cognitive therapy, clients are made aware of their irrational thoughts and evidence is gathered to dispute or counter the cognitive distortions underlying various disorders. Ultimately the aim is to assist the person to restructure the cognitive schema underlying their maladaptive thinking.

Self-instructional training

Self-instructional training involves replacing dysfunctional thoughts by self-talk which is functional and guides the person towards adaptive responses to situations they find difficult. The person is taught to think aloud and to replace negative thoughts with coping statements to guide their behaviour and produce a feeling of control. Self-instructional training produces a coping template which assists people to manage difficult situations and emotions and so improves self-efficacy and self-esteem.

Attention regulation

People with distorted cognitive processing often attend specifically to negative aspects of themselves, others and their environment, and not to neutral or positive aspects. They thus misinterpret events as unduly threatening or confirming of their inability to manage. They believe that others feel negatively towards them and hence that they are not worthwhile. Attention regulation involves teaching people to attend to the positive aspects of themselves, others and situations and to process events in a realistic way.

Cognitive behaviour therapy – relaxation strategies

Guided imagery, deep muscle relaxation and isometric relaxation

There are a number of relaxation techniques, including guided imagery, controlled breathing, deep muscle and isometric relaxation. Relaxation involves voluntarily releasing tension and reducing arousal of the central nervous system. Arousal may produce hyperventilation and so learning to breathe more slowly in a controlled manner counteracts this effect. Muscles also become tense when someone is anxious, so teaching awareness of excessive muscle tension followed by learning a series of exercises to progressively tense and relax muscles throughout the body can overcome this problem. Isometric relaxation is an abbreviated form of muscle relaxation which can be quickly invoked in anxiety-provoking situations. Guided imagery can assist with various forms of relaxation by providing a script and images of peaceful surroundings.

Cognitive behaviour therapy – skills training

Skills training involves carefully constructed combinations of various cognitive and behavioural strategies in a manner designed specifically to treat the particular disorder and/or the specific difficulties the person is experiencing. Training involves the development of skills needed to deal with the situation that is problematic.

Problem-solving skills training

In general, problem-solving skills training involves a structured series of steps. Firstly, the specific problem is identified and analysed in some detail, which may require taking different perspectives on the situation. Goals to be achieved by solving the problem are set. A long list of possible solutions is then generated by brainstorming, which involves being creative and non-judgemental. The potential solutions are then evaluated in terms of their consequences and how possible they are for the person to implement. Each course of action is assessed to establish how well it meets the goals. The action most likely to solve the problem, and which is practical for the person to carry out, is selected, planned in detail and then carried out. The outcome of taking this particular course of action is then evaluated, and if not successful, another course of action is planned.

Anger management

Anger management involves the addition of specific techniques to the basic steps of problem-solving to identify when anger is building, and to learn ways to deal with it. The additional steps include: establishing likely anger-arousing situations; learning to identify bodily sensations and thoughts that lead to feelings of anger and aggressive behaviour; and developing alternative strategies that reduce the angry feelings or distract the person to allow time to calm down and to think and behave more rationally. These strategies may include verbal self-instruction, coping statements, and relaxation and distraction techniques. Once self-control is established, the person can engage in problem-solving.

Stress management

Stress management firstly involves identifying the stressful situation or event, and establishing whether it can be altered or has to be lived with. Specific techniques are added to problem-solving skills in order to analyse the situations the person finds stressful, and to assist the person to cope with or manage whatever reactions the stress produces (e.g., anxiety, depression, somatic symptoms). Cognitions may have to be challenged and coping self-statements learned, as well as alternative behaviour in order to cope with the stressful reactions and be able to engage in problem-solving. In some cases, training in social skills, assertiveness, anger management and conflict resolution is also necessary.

Communication training

The aim of communication skills training is to teach people how to discuss their thoughts constructively and successfully. Effective communication requires: attention, active listening, accurately understanding, summarising and reflecting back, empathy, and responding with clear messages. Appropriate posture, facial expression, gestures, distance from speaker, eye contact, voice modulation and tone may also need to be addressed.

Social skills training

Social skills training involves the addition of further elements to communication training. These skills may include appropriate ways of approaching people, entering a group, conversation skills (how to start, maintain and close a conversation), co-operative behaviour (sharing and turn-taking), assertiveness and dealing with unpleasant reactions or rejections. Rehearsal with the therapist, planned practice in the person's social settings, feedback and reinforcement is an essential part of social skills training.

Parent management training

Parent management training involves teaching parents appropriate skills to assist in raising their children. Parents are given information about children's development and needs at different ages and stages and assisted to establish realistic expectations of them. Parenting training is based on behaviour management in which parents learn to monitor their children's behaviour and identify the antecedents and consequences that control it. They are then taught how to modify these variables in order to develop adaptive behaviour. They learn to set appropriate rules and limits, along with logical consequences for breaking these rules which must be consistently implemented. Parents are also encouraged to reward pro-social behaviour, spend quality time with their children, and to work together and support each other in parenting their family.

Interpersonal therapy (especially for depression)

Interpersonal therapy (IPT) is based on the theory that interpersonal relationships play a significant role in both causing and maintaining depression. IPT aims to identify and resolve interpersonal difficulties that are thought to be related to depression. These difficulties may include conflict with others, role disputes or role transitions, social isolation and prolonged grief following loss. IPT explores clients' perceptions and expectations of relationships, and aims to improve communication and interpersonal skills.

Narrative therapy (Indigenous clients only)

Narrative therapy has been approved as a psychological intervention only for Indigenous clients with mental health problems. Narrative therapy has been identified as a mode of working of particular value to Aboriginal and Torres Strait Islander people, as it builds on the story telling that is a central part of their culture. Narrative therapy is based on the notion that people arrange their life experiences in sequences across time in order to arrive at a coherent account of themselves and the world around them (referred to as a 'self-narrative'). The role of narrative therapy is to assist clients to move away from problem-dominated stories that leave them without solutions and towards stories that highlight possibilities and opportunities.

References

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