Familiarisation Training

GP and Practice Manual

Better Outcomes in Mental Health Care Initiative

Australian Divisions of **General Practice**

Familiarisation Training GP and Practice Manual
Second Edition, June 2003
Better Outcomes in Mental Health Care Initiative

Funded by the Commonwealth Department of Health and Ageing.

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Further information on the Better Outcomes in Mental Health Care Initiative can be obtained by referring to the following website, www.adgp.com.au

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GP Views

On the Better Outcomes in Mental Health Care Initiative

"I've only just starting using the initiative. It's been six months since I went to the training, I wasn't sure what was involved and was too busy to get started. When a GP colleague mentioned it was easy and worth doing, I decided I better give it a try. Now I'm on a roll, I don't find it difficult to integrate into my practice. I find it useful, well accepted by my patients and it allows me to reflect on what I and other providers are doing."

GP, Hobart

"I have found the initiative very useful for patients who wouldn't ordinarily be able to access allied health professionals. I have referred several patients to a psychologist with good results. Patients are thrilled as they are receiving access to treatment they have needed for years and, as a GP, I have found them easier to manage because of their improved mental health."

GP, Brisbane

"I would definitely say to GPs who are thinking about taking up the new mental health initiative, to give it a go. It is well worth it, it is certainly not difficult, it is a very well thought out logical way of dealing with mental health in general practice and it can be fitted into most ways of practising for most patients."

GP, rural New South Wales

Foreword

More than one in ten of all general practitioner consultations in Australia are for mental health related problems and these numbers are only going to increase with rising rates of illness and the willingness of people to seek help for their problems.

The Better Outcomes in Mental Health Care Initiative is an important first step in addressing the problems identified by general practitioners in the delivery of primary mental health care to their patients. These problems include better remuneration for general practitioners and increased access to allied health services.

The process of obtaining better systems to support general practitioners however, is one of evolution and it takes time. We would welcome your input on how we can make improvements to this initiative so that general practitioners can continue to deliver quality primary mental health care to their patients.

Dr Rob Walters

Chair, Australian Divisions of General Practice

The Australian Divisions of General Practice is represented on the Better Outcomes Implementation Advisory Group, the body responsible for overseeing the implementation and review of the Better Outcomes in Mental Health Care Initiative. To raise your ideas and concerns about making this initiative work for general practice, please contact the Australian Divisions of General Practice by email, mentalhealth@adgp.com.au or phone, 02 6228 0800.

Development of the Initiative

The 2001 Federal Budget initiative: Better Outcomes in Mental Health Care, seeks to improve the mental health care available to Australians by building a strong system of primary mental health care. General Practitioners (GPs) are important providers of this care.

The findings from a number of national and international research projects conducted throughout the 1990s positioned mental health as a major focus of health policy development and implementation. The 'Global Burden of Disease' study conducted by the World Health Organisation (WHO) (Murray & Lopez 1996) predicted that by the year 2020 mental illness will account for 15% of disease burden worldwide and that, in the future, depression will be a leading cause of disease burden, second only to ischaemic heart disease. This indicates an increase in the prevalence of mental health disorders worldwide (Murray & Lopez 1996).

Two Australian studies, the National Profile of Mental Health & Well Being (Australian Bureau of Statistics 1997) and the Australian Burden of Disease Study (Mathers & Stevenson 1997), confirmed the high incidence of mental health morbidity for the Australian community and the associated high degree of disability caused, in particular, by depressive disorders. For example, data from the National Profile of Mental Health & Well-Being study indicated that approximately 20% of the Australian population over the age of 18 years met the criteria for a mental health problem or disorder (Australian Bureau of Statistics 1997). Importantly, the data from the ABS study showed that only 38% of these people sought help and most of those who did seek help (75%) sought help in the first instance from a GP (Andrews et al. 1999, p.37). This research confirmed the important role of GPs as providers of mental health care.

In the past there have been many obstacles which have made it difficult for GPs to provide effective mental health care. Some of these obstacles include the time constraints in general practice, insufficient training in mental health care and the difficulty GPs experience when trying to access services from other mental health care providers.

ADGP is one of nine peak national organisations that have been working collaboratively with the Department of Health and Ageing on the development of reforms to primary mental health care. The aim is to make it easier for GPs to provide mental health care. The collaborating organisations include:

- The Australian Divisions of General Practice;
- The Rural Doctors' Association of Australia;
- The Australian College of Rural and Remote Medicine;
- The Royal Australian College of General Practitioners;
- The Mental Health Council of Australia;
- The Australian Psychological Society;
- beyondblue (The National Depression Initiative);
- The Royal Australian and New Zealand College of Psychiatrists; and,
- The Australian Medical Association.

The Initiative: in a Snap Shot

The Better Outcomes in Mental Health Care Initiative

The Commonwealth Government has provided $120.4 million over four years for the Better Outcomes in Mental Health Care Initiative. The initiative aims to support GPs in improving the quality of care provided through general practice to Australians with a mental health disorder. This will be achieved through the provision of mental health education and training for GPs and more support for them from allied health professionals and psychiatrists.

This initiative has five major components. Together, the components form a comprehensive system of primary mental health care, which is focussed on continuity of care and quality mental health outcomes. The 3 Step Mental Health Process offers time and a process for managing care through an assessment, a mental health plan and a review.

The 3 Step Mental Health Process forms the basis of the initiative from which further components can be accessed.

The five components are:

1. 3 Step Mental Health Process – a Service Incentive Payment (SIP) is provided to encourage effective management of mental health problems by GPs through a 3 Step Mental Health Process that includes an assessment, a mental health plan and a review;
2. Education and Training for GPs – to familiarise GPs with the initiative and to increase the mental health skills of GPs;
3. Focussed Psychological Strategies – to encourage appropriately trained GPs to provide evidence based focussed psychological strategies (FPS) through the provision of Medicare Benefits Schedule (MBS) rebates;
4. Access to Allied Health Services – to enable GPs to access psychological and other allied health services to support their patients with mental health disorders; and,
5. Access to Psychiatrist Support – to better enable psychiatrists and GPs to participate in case conferencing and for psychiatrists to provide timely patient management advice.

Eligibility

Which doctors are eligible to participate?

The doctors eligible to participate in the Better Outcomes in Mental Health Care Initiative are medical practitioners including GPs, but excluding specialists and consultant physicians. For the purposes of brevity, future references in this manual to GPs include Other Medical Practitioners (OMPs) unless otherwise specified. These doctors need also to have completed the relevant training requirements and to be working from a PIP or accredited practice to register for the initiative.

Which patients are eligible to participate?

Under the Better Outcomes in Mental Health Care Initiative the patient group eligible for care is:

> 'all patients with a mental health disorder, including those with co-morbidity, who present in the general practice setting.'

A mental health disorder has been defined as, 'a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder.' The ICD-10 PHC version informs this definition[1].

The following disorders, taken from the ICD-10 PHC version can be treated under this initiative:

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

Please note, dementia, delirium, tobacco use disorder and mental retardation are excluded.

Footnote:

1. World Health Organisation International Statistical Classification of Diseases and Related Health Problems: Chapter V, Classification of Mental and Behavioural Disorders: Primary Health Care Version.

The 3 Step Mental Health Process

The 3 Step Mental Health Process

"I have found the 3 Step Mental Health Process has enhanced my therapeutic relationship with my patients and it has been quite flexible in terms of adapting it to normal GP consultations. With a little bit of planning, it's not difficult at all.

Originally, mental health problems would often come up in a normal consult and I would often feel constrained to leap in and try and deal with it at that consultation which was often only a 15 minute consultation. What the 3 Step Mental Health Process has made me realise is that slowing down is not only much more comfortable, but a lot more information isn't missed by actually devoting half an hour to just a mental health problem.

I have been surprised to find sometimes patients I have known for a number of years, we have uncovered without too much difficulty, hidden sorts of problems, like obsessive compulsive disorder, substance abuse problems or social phobia and I feel quite embarrassed that they have had these things for years and have never thought to mention them."

Dr Di Symmonds, GP Darwin

What is the 3 Step Mental Health Process?

The 3 Step Mental Health Process component of the Better Outcomes in Mental Health Care Initiative has been introduced to better remunerate GPs who take the time to effectively manage and provide quality mental health care, conducting a patient assessment, a mental health plan and a review.

The 3 Step Mental Health Process comprises of:

1. an assessment and formulation or diagnosis;
2. preparation of a mental health plan; and,
3. a review of the mental health plan.

What must the 3 Step Mental Health Process include?

Based on the MBS item descriptors, the 3 Step Mental Health Process must include:

- at least 3 consultations of more than 20 minutes each (ie. Level C or D) for a patient with a mental health disorder;
- at least two of the consultations to have been planned visits;
- an assessment and formulation or diagnosis of the mental health disorder/s;
- provision of a written mental health plan and appropriate education to the patient and/or carer (with patient's agreement); and,
- a review of the patient's progress against the goals outlined in the mental health plan, to be conducted a minimum of 4 weeks and a maximum of 6 months after the completion of the mental health plan.

The patient's medical record should include documentation of each of these requirements and the clinical content of the patient-held mental health plan. All consultations conducted as part of the 3 Step Mental Health Process must be rendered by the GP claiming the incentive payment.

Refer to Appendix G to review a copy of the MBS descriptors for the 3 Step Mental Health Process.

How many consultations are required to complete the 3 Step Mental Health Process?

Multiple consultations may be required for any or all steps. At a minimum, one consultation of more than 20 minutes (ie. Level C or D) is required for each step.

What must be included in the assessment?

Assessment of a patient for the 3 Step Mental Health Process must include:

- taking a detailed biological, psychological and social history including the presenting complaint;
- conducting a mental state examination;
- conducting a risk assessment;
- a diagnosis and/or formulation; and,
- the administration of an outcome tool, except where it is considered clinically inappropriate.

A formulation is important for the development of a mental health plan and includes an assessment of the biological, psychological and social factors predisposing, precipitating, perpetuating and/or protecting against a mental health problem.

Where the patient has a carer, the GP may find it useful to consider having the carer present for the assessment or components thereof (subject to patient agreement).

How should the assessment be billed?

Consultations conducted as part of the assessment (Step 1) should be billed under the normal Attendance items. At a minimum, one consultation of more than 20 minutes (ie. Level C or D) is required for the assessment.

What is an outcome tool and why should I use it?

An evidence based approach to mental health requires some measure of the patient's symptoms and how they may change over time. Outcome tools are considered essential to high standards of patient care and are important to both the patient and the clinician. For consumers, they are able to monitor progress, for clinicians, they can monitor the patient's progress and their own performance as a clinician.

An outcome tool is to be used during the assessment and the review stages of the 3 Step Mental Health Process, except where it is considered clinically inappropriate.

What outcome tools can I use?

The choice of outcome tools to be used is at the clinical discretion of the GP. The following are examples of outcome tools available at no cost:

- Kessler Psychological Distress Scale (K10);
- Depression Anxiety Stress Scale (DASS);
- SPHERE questionnaire
- Edinburgh Post Natal Depression Questionnaire
- Alcohol Use Disorder

For further information on outcome tools talk to your Division of General Practice or refer to the ADGP website, www.adgp.com.au. For further information on accessing the ADGP website refer to page 50.

GPs using outcome tools should be familiar with their appropriate clinical use, and if not, should seek the appropriate education and training. It should be noted that outcome tools are not diagnostic tools.

GP experiences using the K10

"I find it easy to use, the patients are quite comfortable with the questions and I think for GPs as opposed to specialist psychiatrists, the questions are really quite relevant and they fit in well with the normal mental health assessment that we are used to doing. And it seems to be reasonably accurate as well, so I don't find a problem with it at all. I think it is quite appropriate and quite easy to use."

Dr Trina Gregory, GP rural NSW

"The only outcome tool that I have used with the initiative so far is the K10 and I find it a terrific adjunct to clinical expertise. The patients love filling out surveys and I have never had anybody refuse to do it. I have had some surprises in the results that I have obtained. Some of the surprises have been when patients who I have thought were profoundly depressed have in fact come up with quite good scores after a couple of weeks of treatment. This has shown that the treatment is much more effective and works faster than we would have assumed. Another surprise is when patients actually read their own scores and you give them the score and they actually change their earlier answers and acknowledge how depressed they have actually been."

Dr David Monash, GP rural Victoria

What is the K10 and how is it scored?

A copy of the K10 can be photocopied from Appendix B of this manual and retrieved electronically from the ADGP website.

The K10 is widely recommended as a simple measure of psychological distress and as a measure of outcomes following treatment for common mental health disorders. It can be patient or GP administered.

The K10 uses a five value response option for each question – all of the time, most of the time, some of the time, a little of the time and none of the time which can be scored from five through to one. The maximum score is 50 indicating severe distress, the minimum score is 10 indicating no distress.

Questions 3 and 6 are not asked if the proceeding question was 'none of the time' in which case questions 3 and 6 would automatically receive a score of one.

For further information on the K10 please refer to www.crufad.org or the following article:

Andrews, G., Slade, T. 'Interpreting scores on the Kessler Psychological Distress Scale (K10)', Australian and New Zealand Journal of Public Health: 2001; 25:6: 494-497.

What should be included in the mental health plan?

The development of a mental health plan must include:

- a discussion with the patient about the mental health formulation and/or diagnosis;
- a discussion with the patient on treatment options including appropriate support services;
- the provision of psycho-education;
- the written mental health plan must include a plan for treatment of the assessed mental health disorder/s and crisis intervention where appropriate; and,
- a plan for relapse prevention if appropriate at this stage.

Options could include psychological and pharmacological treatments, referral to and coordination with community support and rehabilitation agencies, mental health services and other professionals.

Who needs to be involved in the development of the mental health plan?

The mental health plan should be prepared in consultation with the patient and/or carer and have the agreement of the patient. A written copy of the mental health plan must be provided to the patient and/or carer (where appropriate) and a copy of the mental health plan must be kept in the patient's medical records.

The mental health plan is a plan between the GP and patient and does not require input from other professionals. However, if an assessment shows that it would be beneficial to involve other health professionals in the patient's care, it may be appropriate to claim an Enhanced Primary Care (EPC) multidisciplinary care plan item in replacement for the mental health plan. For details on EPC, refer to page 28.

How should the mental health plan be billed?

Consultations conducted as part of the mental health plan (Step 2) should be billed under the normal Attendance items. At a minimum, one consultation of more than 20 minutes (ie. Level C or D) is required for the mental health plan.

Alternatively, where a multi-disciplinary approach is required for a complex or chronic condition, GPs can bill for an EPC care plan. Refer to page 28.

What should be included in the review?

The review stage must include:

- a review of the patient's progress against the goals outlined in the mental health plan;
- modification of the mental health plan if required;
- check, reinforce and expand education;
- a plan for relapse prevention if not previously provided; and,
- re-administration of the outcome tool used in the assessment stage, except where considered clinically inappropriate.

Note: This review is a formal review point only and it is expected that there may be further consultations between the patient and the GP.

When should the review occur?

This step (Step 3) must take place a minimum of 4 weeks and a maximum of 6 months after completion of the mental health plan.

How should the review be billed?

At the review, (the only consultation at which the SIP payment is triggered) bill the MBS item numbers for the 3 Step Mental Health Process. Refer to the table on page 17 and Appendix G for the specific item numbers. The review must be billed between 4 weeks and 6 months after completion of the mental health plan.

What resources have been developed to support GPs in conducting the 3 Step Mental Health Process?

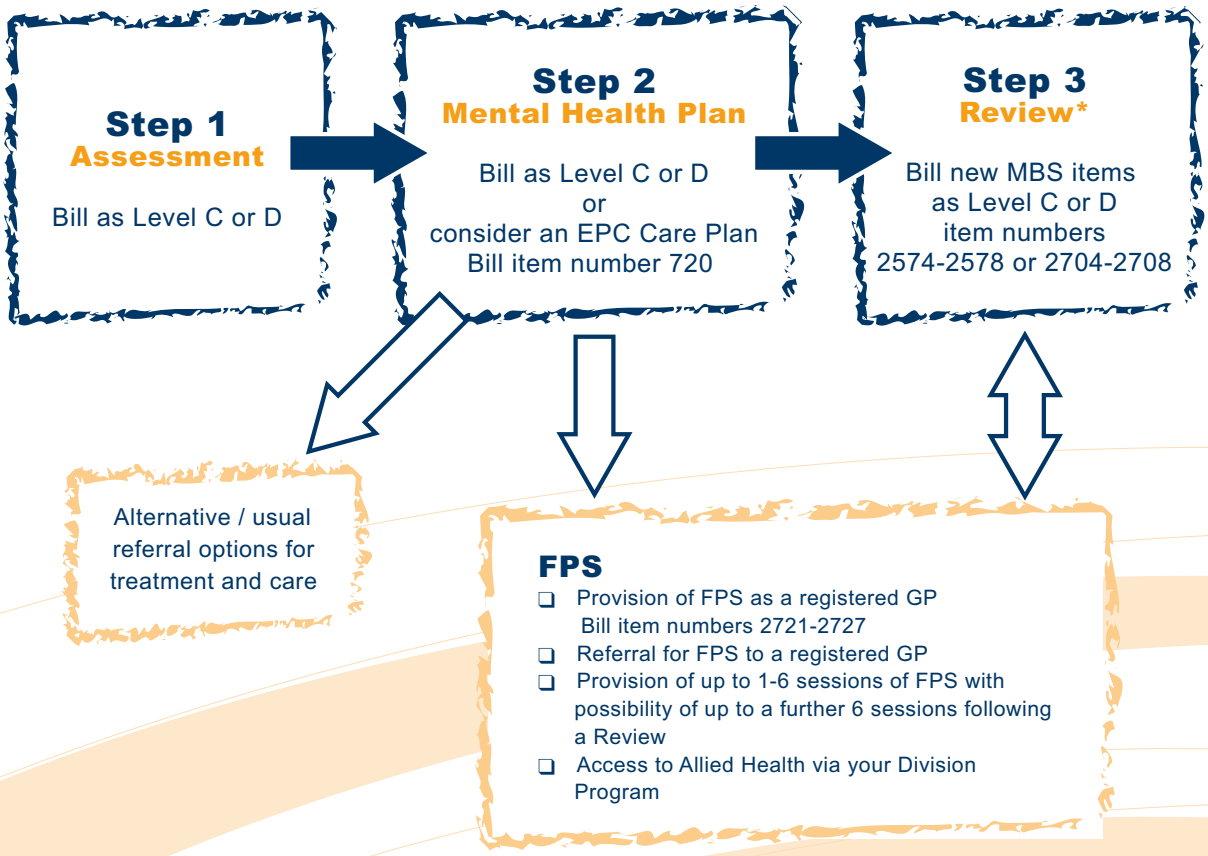
A checklist highlighting the requirements for conducting the 3 Step Mental Health Process has been developed as a guide for GPs completing the 3 Step Mental Health Process.

Proformas have also been developed for GPs to use as part of the clinical notes when conducting an assessment, mental health plan and a review. These proformas are examples only and GPs are free to modify these to suit their own needs. The proformas have been provided to software companies for incorporation into medical software programs.

Copies of the checklist and the proformas are included at Appendix C and D of this manual. Electronic copies can be downloaded from the ADGP website. Refer to page 50 for information on accessing the ADGP website.

The checklist and the proformas are based on the requirements detailed under the MBS item descriptors for the 3 Step Mental Health Process. A copy of the descriptors is provided in Appendix G.

Figure 1. The 3 Step Mental Health Process



Review to occur between 4 weeks & 6 months

* When the Review item is claimed, a SIP payment of $150 is triggered. This SIP is paid once per patient, per year.

Incentive Payments and Billing

What incentive payments does the 3 Step Mental Health Process attract?

There are two incentive payments:

- a sign on payment of $150 when GPs register with the HIC for the initiative; and,
- a Service Incentive Payment (SIP) of $150 per 3 Step Mental Health Process per patient per year on completion of the review step.

What is the sign on payment?

When a GP has successfully met the pre-requisite criteria and is registered with the HIC for Level 1 (3 Step Mental Health Process), the GP will receive a one off payment of $150.

What is the Service Incentive Payment (SIP)?

A SIP of $150 per 3 Step Mental Health Process per patient per year, will be available to eligible GPs on completion of the review step. The Service Incentive Payment is a payment made directly to the GP, not the practice, unless the practice has established other arrangements.

Why is there a maximum annual SIP per GP?

The maximum annual SIP for this initiative per GP per financial year is $10,000. An upper limit has been imposed on the number of 3 Step Mental Health Process SIPs paid per year to ensure there is a wide spread up-take of the initiative amongst GPs within the allocated funding.

Why one SIP payment per patient per year?

Benefits are payable for one 3 Step Mental Health Process per patient in any 12 month period unless another is indicated. The 3 Step Mental Health Process encourages ongoing management of a patient's mental health condition, with revision to the mental health plan over the year, rather than repeating the complete 3 Step Mental Health Process.

What if the patient's condition changes?

If the patient has received a 3 Step Mental Health Process in the last 12 months but there has been a significant change in the patient's condition requiring a new 3 Step Mental Health Process (eg. diagnosis of a new condition) the GP may decide another 3 Step Mental Health Process is clinically indicated. In such cases, the patient's invoice or Medicare voucher should be annotated to indicate that the 3 Step Mental Health Process was required to be provided within 12 months of another 3 Step Mental Health Process.

How do I bill for the 3 Step Mental Health Process?

The assessment and mental health plan should be billed under the normal Attendance items (ie. for a Level C or D). At the review, the only consultation at which the SIP payment is triggered, bill the MBS item numbers for the 3 Step Mental Health Process.

Billing the MBS item numbers for the 3 Step Mental Health Process triggers the SIP payment of $150 and attracts the usual Medicare rebate for the patient for a normal Level C or D.

How will the SIPs be made?

SIPs will be made by the HIC to eligible GPs' nominated bank accounts, in conjunction with each quarterly PIP payment. This will also apply to GPs practising in accredited practices that are not participating in the PIP.

These payments are generally made in February, May, August and November by Electronic Funds Transfer (EFT).

Do I need to provide my bank details?

GPs currently working from a PIP practice and registered in any of the Asthma, Diabetes or Cervical Screening SIPs do not need to provide their bank account details. GPs not currently registered in the other SIPs, or practising from accredited practices not participating in the PIP, will need to provide additional practice information, such as bank account details for payment of the incentives. The HIC will seek this information from GPs when they register for the initiative.

Which doctors are eligible to claim the SIP?

The doctors eligible to participate in the Better Outcomes in Mental Health Care Initiative are medical practitioners including GPs, but excluding specialists and consultant physicians, that have completed the relevant training requirements, are registered with the HIC and practising from an accredited practice. This includes registrars and overseas trained doctors who have an unrestricted provider number and are claiming Medicare items in the normal way.

Do I need to be practising from a PIP or accredited practice?

To claim the 3 Step Mental Health Process MBS item numbers, GPs are required to conduct their consultations from a practice that is either participating in the PIP or accredited by either AGPAL or GP Accreditation Plus. For GPs practising from accredited practices that are not participating in the PIP, evidence of practice accreditation will be required.

Figure 2. Better Outcomes in Mental Health Care Initiative MBS Item Numbers

3 Step Mental Health Process

	Vocationally Registered	Non Vocationally Registered*
Assessment	usual Level C or D	equivalent Level C or D
Plan	usual Level C or D	equivalent Level C or D
Review - Level C (in Surgery)	2574	2704
Review - Level C (out of Surgery)	2575	2707
Review - Level D (in Surgery)	2577	2705
Review - Level D (out of Surgery)	2578	2708

*For non-vocationally registered GPs the reference to Cs and Ds in the Familiarisation Training materials is intended as a guide only with the equivalent of a Level C being a long consultation and a Level D, a prolonged consultation.

Focussed Psychological Strategies

	Vocationally Registered	Non Vocationally Registered*
FPS (in Surgery, 30-40 min)	2721	2721
FPS (out of Surgery, 30-40 min)	2723	2723
FPS - extended attendance (in Surgery, > 40 min)	2725	2725
FPS - extended attendance (out of Surgery, > 40 min)	2727	2727

*Same numbers for VR and non VR GPs.

Medical Practitioner Case Conference

Conference Time	GP Organises	GP Participates
15-30 minutes	740	759
30-45 minutes	742	762
more than 45 minutes	744	765

*Same numbers for VR and non VR GPs. Case conferencing items where GP and psychiatrist are paid.

Education and Training for GPs

What training do I need to complete?

To participate in the Better Outcomes in Mental Health Care Initiative GPs need to meet specified training requirements. The training requirements are:

- Familiarisation Training;
- Mental Health Skills Training (Level 1 – essential);
- Mental Health Skills Training (Level 2 – optional);
- Ongoing learning in mental health.

Completion of the Familiarisation Training and Mental Health Skills Training is required for GPs to register with the Health Insurance Commission (HIC) for the initiative.

What is the Familiarisation Training and where do I access it?

Familiarisation Training is available through your Division of General Practice and provides information on the components of the Better Outcomes in Mental Health Care Initiative and how they can be accessed.

The Familiarisation Training has been approved by the RACGP QA&CPD program (allocated 2 points per hour) and the ACRRM Professional Development Program (allocated 1 point per hour). Total RACGP CDP points: 4 (group 2 – mental health). Total ACRRM Professional Development: 2 points.

What is Mental Health Skills training?

Two levels of mental health skills training have been established under the initiative. GPs must complete training courses that have been accredited by the General Practice Mental Health Standards Collaboration to register for the initiative. Level 1 training is an essential requirement (coupled with Familiarisation Training) for registration. Level 2 training is optional and is aimed at GPs wanting to deliver focussed psychological strategies to patients requiring this level of treatment.

Level 1

Level 1 accredited courses focus on mental health skills training in relation to conducting mental health assessments, mental health planning and review. Level 1 training courses are conducted over a minimum of six hours.

Completion of Level 1 training, coupled with the Familiarisation Training enables GPs to apply to the GPMHSC for educational adjudication and have their application referred to the HIC for registration to access the 3 Step Mental Health Process incentive payments.

Level 2

Level 2 accredited courses focus on mental health skills training for the delivery of Focussed Psychological Strategies (FPS). While Level 2 training programs are conducted within a minimum of 20 hours, in practice, they are often longer than this.

Completion of Level 2 training, coupled with registration at Level 1, enables GPs to register with the HIC to access the new MBS items for FPS.

Better Outcomes in Mental Health Care: Training Requirements

What ongoing learning is required?

To maintain an ongoing level of knowledge and skills in mental health and registration with the Better Outcomes in Mental Health Care Initiative, GPs are required to obtain 30 mental health education points per triennium.

The number of mental health points GPs have obtained is listed on RACGP credit point statements for GPs who are members of the RACGP QA&CPD program.

Are there exceptions for this triennium for ongoing learning?

In this triennium only (Jan 2002 - December 2004), the points accrued in undertaking Level 1 skills training (not RPL) can count towards the 30 point requirement for ongoing learning. GPs registered for Level 1 who undertake training in Focussed Psychological Strategies to register for Level 2, will automatically meet their requirements for ongoing learning. Points gained through completion of Familiarisation Training do not contribute to the 30 point requirement.

Who sets the Standards for training?

The General Practice Mental Health Standards Collaboration (GPMHSC) has been established under the Better Outcomes in Mental Health Care Initiative to be the adjudicating body responsible for establishing standards for the accreditation of mental health education activities and/or training.

The GPMHSC is auspiced by the RACGP but is a joint collaboration of the following groups:

- Australian College of Rural and Remote Medicine;
- Royal Australian College of General Practitioners;
- The Mental Health Council of Australia;
- The Australian Psychological Society; and,
- The Royal Australian and New Zealand College of Psychiatrists

The GPMHSC can be contacted by email, gpmhsc@racgp.org.au or by phone on 03 8699 0554. Website: www.racgp.org.au/mentalhealth

How do I access an education activity accredited by the GPMHSC?

Education activities that have been accredited by the GPMHSC for Level 1, Level 2 and ongoing learning can be accessed from the following websites:

- www.racgp.org.au/mentalhealth;
- www.rrmeo.com; and,
- www.adgp.com.au (provides links to the above sites).

For information on locally based education and training activities, check with your Division of General Practice.

What records do I need to keep?

GPs will be required to maintain records of their current training status, whether this is through personal storage of documents or through records maintained at the RACGP, ACRRM or other organisations.

The number of mental health points that GPs have obtained will be listed on the RACCGP credit point statements for GPs who are members of the RACGP QA&CPD program.

How should registrars and members of ACRRM keep their records?

Registrars are very welcome to undertake the mental health skills training and apply for registration for the initiative. Registrars who do not currently participate in the RACGP QA Program, will need to verify their attendance at training. Therefore Registrars must attach supporting documentation to their registration form (ie. certificates of attendance at Familiarisation Training and approved skills training) and keep their own, verifiable and complete records for ongoing learning for adjudication at the end of each triennium.

ACRRM's Professional Development Program is now recognised for the purposes of maintaining vocational registration. Members can search for accredited activities on www.rrmeo.com and claim credit for events which have not been prospectively accredited by keeping a record of participation or by contacting ACRRM with details.

What is Recognition of Prior Learning (RPL) and how can I apply?

GPs who have a strong skill base in mental health may be eligible to apply to the GPMHSC for recognition of their skills instead of undertaking the accredited Level 1 and Level 2 training mentioned above.

There are two different types of RPL:

1. For a GP who has already completed a course that has been pre-approved for RPL by the GPMHSC (see website for up to date lists www.racgp.org.au/mentalhealth); and,
2. For a GP who has specific mental health skills training and competencies, often obtained by attending a relevant course that has not been submitted to the GPMHSC for adjudication. In these cases a GP submits an individual application for RPL and provides supporting documentation. These applications are adjudicated by the GPMHSC on a case by case basis.

Individual applicants should obtain an individual application form from the GPMHSC via the website – www.racgp.org.au/mentalhealth or by phoning the GPMHSC staff on 03 8699 0554.

What are the options for RPL for Level 1?

Depending on the mental health skills and experience of the GP, RPL can be sought through one of four options:

1. Completion of a relevant university qualification in mental health (eg. Masters or Post-Graduate Diploma); or,
2. Completion of a formal training program during the past 6 years (ie. since 1996) which has been adjudicated by the GPMHSC against the Standards (eg. SPHERE, or the Monash University Short Course in GP Psychiatry) and completion of an intention statement; or,
3. Participation in a previously approved 3pph mental health learning event (of a minimum of 6 hours and within the RACGP QA&CPD program) that meets quality criteria against the GPMHSC Standards for the 3 Step Mental Health Process and completion of an intention statement; or,
4. Individual application for RPL. This is awarded in RARE cases. GP's should contact the GPMHSC to discuss their application.

All RPL applicants must complete the Familiarisation Training.

What are the options for RPL for Level 2?

Applicants for Level 2 RPL must:

- have completed a relevant, coherent skills training program in Focussed Psychological Strategies of at least 15 hours duration. The course must have been completed within a reasonable timeframe (ie. since 1995);
- top up their FPS training to the 20 hour minimum requirement;
- clearly demonstrate capacity to deliver a minimum of four HIC recognised Focussed Psychological Strategies; and,
- be able to provide documentary evidence of training.

Focussed Psychological Strategies

An element of the Better Outcomes in Mental Health Care Initiative is the introduction of MBS rebates for Focussed Psychological Strategies (FPS) that can be provided by GPs who satisfy the relevant education requirements set by the GPMHSC.

What are Focussed Psychological Strategies (FPS)?

FPS are specific mental health care treatment strategies, derived from evidence based psychological therapies. They have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise.

What is the remuneration for provision of FPS?

In recognition of the enhanced mental health care skills and expertise required for GPs to provide FPS, MBS rebate levels have been set at approximately 20% above the current Level C or D Attendance items and include two time bands:

- 30 to 40 minutes; and,
- longer than 40 minutes.

What strategies can be provided by GPs under the MBS item numbers for FPS?

The strategies and treatments that have been approved for use by GPs under the Better Outcomes in Mental Health Care Initiative are limited to:

1. **Psycho-education**
2. **Cognitive-behavioural therapy including:**
    - Behavioural interventions
        - Behaviour modification (especially for children, including behaviour 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
    - Skills training
        - Problem-solving skills training
        - Anger management
        - Stress management
        - Communication training
        - Social skills training
        - Parent management training
        - Motivational interviewing
3. **Interpersonal therapy (especially for depression)**

Hypnosis and family therapy have not been approved for use under the FPS item numbers. The major FPS that are shown to be evidence based for a number of psychological disorders are provided in Appendix I.

What do I need to know about FPS?

The FPS are time limited, being deliverable, in up to six planned sessions and in some instances following a review by the referring GP, up to another six sessions in any year to an individual patient.

A session should last for a minimum of 30 minutes and include two time bands:

- 30 to 40 minutes; and,
- longer than 40 minutes.

How do I bill for the MBS rebates for FPS?

Bill using the item numbers for FPS. They include item numbers 2721 – 2727. Refer to the table on page 17 of this manual.

When should I refer my patient for FPS?

The decision to refer a patient for FPS must be made in the context of the 3 Step Mental Health Process. In the process of developing the mental health plan, or even at the review stage, it may be determined that FPS is the preferred treatment. The 3 Step Mental Health Process does not have to be completed prior to claiming for FPS.

Who completes the 3 Step Mental Health Process Review if referring GP to GP?

If GPs are not registered for FPS (Level 2), they can refer their patients to other registered GPs for the provision of FPS. The referring GP remains as the manager or coordinator of care and will need to complete the 3 Step Mental Health Process by conducting the review following the provision of FPS. The referring GP will need to indicate this to the GP providing the FPS.

What if there are multiple consultations on the same day?

Where a patient is seen for FPS in addition to another condition on one occasion or on the same day, the GP may, at their clinical discretion, consider the two conditions separately and charge for two consultations.

The rationale for separating the two conditions is to ensure that the FPS session is not compromised by the other condition and that the rebate level is higher for the FPS session.

The patient's account is to be annotated to this effect before presentation to the HIC. The FPS item descriptor will reflect this requirement.

What are the requirements for access to the MBS items for FPS?

GPs are required to complete a course accredited by the GPMHSC that covers a minimum of four focussed psychological strategies. The course completed must be a minimum of 20 hours duration. GPs can apply for recognition of prior learning for this training. Refer to page 21 - 22 of this manual for details.

In addition to meeting the above education requirements, GPs must register with the HIC for Level 1 (3 Step Mental Health Process) and Level 2 and provide services from either PIP participating and/or accredited practices.

Access to Allied Health Services

This component of the Better Outcomes in Mental Health Care Initiative is designed to provide GPs with support from allied health professionals in treating people with a mental health disorder. The Access to Allied Health Services program is administered through Divisions of General Practice to support a more integrated primary care system adapted to local needs.

What services can the Access to Allied Health Services program provide?

The services that can be provided by allied health professionals under the initiative are the same focussed psychological strategies that can be provided by GPs through the FPS MBS items. In addition, some programs have provisions for referral for diagnostic assessment and group therapy. Refer to page 23 of the GP and Practice Manual for the list of focussed psychological strategies that can be provided.

Generally, these services are deliverable:

- in up to six time-limited sessions (minimum requirement of 30 minutes per session);
- with an option for up to a further six sessions following a mental health review by the referring GP.

What allied health professional disciplines can provide these services?

For the purposes of this initiative, the allied health professional disciplines that can provide services include:

- psychologists;
- social workers;
- mental health nurses;
- occupational therapists; and,
- Aboriginal and Torres Strait Islander health workers.

When will I have an Access to Allied Health Services program in my Division?

The Access to Allied Health Services program is being rolled out in a staged approach. Initially, pilot sites were established across 20 Divisions of General Practice. Ongoing funding is now available to Divisions and implementation is intended to occur as follows:

- more than 60 per cent of Divisions to have allied health programs by 2003/04;
- all Divisions who wish to participate will have an allied health program by 2004/05.

How might the Access to Allied Health Services programs differ?

Each program has been tailored to adapt and respond to local needs and programs will vary from Division to Division in the following areas:

- the allied health professionals available;
- the patient target group that can be referred for services;
- the location for the provision of services;
- the communication system between the GP and allied health professional; and,
- whether a small co-payment is charged to increase the spread of services.

Who is eligible to access the Allied Health Services program?

Only GPs who are registered with the HIC for the Better Outcomes in Mental Health Care Initiative have access to the Access to Allied Health Services program.

How can consumers and carers access this program?

Consumers will require a referral from their GP to participate in this program.

When should I refer my patient for FPS?

A referral should be conducted in the context of the 3 Step Mental Health Process. In the process of developing the mental health plan or even at the review stage, it may be determined that referral to an allied health professional for FPS would be appropriate.

Talk to your Division of General Practice to obtain the specifics of the services available through your Division's program and how to refer.

Where can I find more information about the allied health programs currently operating?

A description of the Access to Allied Health Services programs is provided on the PARC website accessed via http://som.flinders.edu.au/FUSA/PARC/. Alternatively, follow links to the PARC website through the ADGP website www.adgp.com.au.

Access to Psychiatrist Support

The access to psychiatrist support component of the Better Outcomes in Mental Health Care Initiative is designed to better enable psychiatrists and GPs to participate in case conferencing and for psychiatrists to be available to provide patient management advice to GPs.

What are the arrangements for psychiatrist advice for patient management?

Patient management advice will be available through the Access to Advice from Psychiatrists in an Emergency Situation initiative. This program will be introduced over a three-year period and in the first year will develop and test possible approaches for supporting GPs including:

- provision of psychiatrist advice via phone, fax or email;
- provision of psychiatrist advice within 24 hours, where case conferencing or other referral mechanisms cannot be scheduled and crisis assessment is not required;
- complementing and building on existing infrastructure and support services available through State/Territory health for the treatment of people with a mental health problem or disorder.

Further information can be obtained from the Department of Health and Ageing and ADGP websites, www.mentalhealth.gov.au and www.adgp.com.au.

What are the consultant physician / medical practitioner case conferencing items?

These items refer to where a minimum of three formal health care providers participate in a case conference, where the consultant physician and the GP are paid. In a case conference, participants can discuss a patient's history and identify multidisciplinary needs, identify outcomes and tasks that need to be achieved by the team members and assess previously identified outcomes.

How do I bill for the medical practitioner case conferencing items?

GPs and psychiatrists bill for the case conference using different item numbers. The item numbers GPs can use are referred to in a table on page 17 of this manual.

There are different item numbers for different time bands and for organising or participating in a case conference. The three time bands are:

- at least 15 minutes but less than 30 minutes;
- at least 30 minutes but less than 45 minutes; and
- at least 45 minutes.

Enhanced Primary Care

Can EPC replace the mental health plan?

Where patients meet the eligibility requirements for both an EPC care plan (including that they have complex needs requiring care from a multidisciplinary team), and a 3 Step Mental Health Process, developing an EPC care plan can meet the requirements for and replace a mental health plan consultation.

While an EPC care plan may be done as the middle step of the 3 Step Mental Health Process, there is no requirement that it be done at that point.

Can the EPC and the 3 Step Mental Health Process items both be claimed?

It is quite open to a GP to do an EPC care plan at any time they recognise that the patient has a chronic condition and complex needs requiring ongoing multidisciplinary care.

Both items can be claimed, but the EPC care plan would need to be conducted on a separate occasion in addition to the 3 Step Mental Health Process.

Registering for the Initiative

How do I register with the HIC for Level 1?

GPs interested in registering for Level 1 (3 Step Mental Health Process) will need to meet the education and training requirements referred to on pages 18 - 22 of the manual, complete the registration form for Level 1 and forward it to the General Practice Mental Health Standards Collaboration (GPMHSC). A copy of the registration form has been inserted into this manual. Further copies are available from the ADGP website, www.adgp.com.au and GPMHSC website, www.racgp.org.au/mentalhealth.

The GPMHSC assess the GP's mental health skill status listed on the registration form and then notifies the HIC and the individual GP of the GP's eligibility to register for the initiative.

The HIC will advise GPs when they have successfully registered. GPs should note that claims for the 3 Step Mental Health Process MBS item before the HIC advises that you are registered for the incentive payments, may result in patient rebate claims being rejected.

How do I register with the HIC for Level 2?

Similarly, GPs interested in registering for Level 2 (Focussed Psychological Strategies) will need to meet the education and training requirements referred to on pages 18 - 22 of the manual, complete the registration form for Level 2 and forward it to the General Practice Mental Health Standards Collaboration (GPMHSC) for assessment and referral to the HIC. Registration forms are available from the ADGP website, www.adgp.com.au and GPMHSC website, www.racgp.org.au/mentalhealth.

Appendices

Index of Appendices

Appendix A

Standards for Mental Health Skills Training

The Mental Health Assessment

1. Skills in detecting common, disabling and treatable mental health disorders in general practice (eg. identifying mental health disorders in patients with chronic medical problems).
2. Understanding of the need for systematic assessment including interview skills, history taking, mental status assessment, risk assessment and co-morbidity.
3. Understanding of the epidemiology and aetiology of mental health conditions and the complexities of co-morbidity.
4. Understanding of contextual issues - time limitations, competing demands and undifferentiated clinical presentations in recognition and treatment of mental health disorders.
5. Appropriate use of psychometric instruments (eg. screening and severity rating scales) to aid assessment and identify a baseline of severity of the disorder against which improvement or deterioration can be assessed.
6. Capacity to reassess people with a known mental health disorder in their care.
7. Ability to transfer generic knowledge and skills across the range of patients and disorders.

The Mental Health Plan

8. Ability to negotiate a shared understanding of a mental health problem with consumers that culminates in an agreed mental health plan.
9. Knowledge of the appropriate use of effective pharmacological and psychological therapies for treatment of common mental health disorders.
10. Understanding and knowledge of the importance of consumer and carer education; use of accurate and consumer friendly education materials about common mental health problems.
11. Awareness and knowledge of local specialist mental health care providers and allied health professionals from the public, private and non government sectors; commitment to working with these providers.
12. Ability to introduce self-help strategies into ongoing management.
13. Ability to transfer generic knowledge and skills across the range of patients and disorders.

The Mental Health Review

14. Understanding of the need for systematic follow-up of consumers and ongoing monitoring of mental health plan outcomes.
15. Knowledge of how to assist people with mental health disorders with self-monitoring strategies to increase proactive steps in response to early warning signs.
16. Knowledge of how to assist people with a mental health disorder to develop a personal relapse prevention plan.
17. Ability to transfer generic knowledge and skills across the range of patients and disorders.

Appendix B
Outcome Tool (K10)

K10

For all questions, please fill in the appropriate response circle.

The maximum score is 50 indicating severe distress.
The minimum score is 10 indicating no distress.

In the past 4 weeks:	1 None of the time	2 A little of the time	3 Some of the time	4 Most of the time	5 All of the time
1. About how often did you feel tired out for no good reason?	○	○	○	○	○
2. About how often did you feel nervous?	○	○	○	○	○
3. About how often did you feel so nervous that nothing could calm you down?	○	○	○	○	○
4. About how often did you feel hopeless?	○	○	○	○	○
5. About how often did you feel restless or fidgety?	○	○	○	○	○
6. About how often did you feel so restless you could not sit still?	○	○	○	○	○
7. About how often did you feel depressed?	○	○	○	○	○
8. About how often did you feel that everything is an effort?	○	○	○	○	○
9. About how often did you feel so sad that nothing could cheer you up?	○	○	○	○	○
10. About how often did you feel worthless?	○	○	○	○	○

Today's date ☐☐/☐☐/☐☐☐☐
Day Month Year

The 3 Step Mental Health Process Checklist

Step 1: Assessment (Bill as Level C or D)

Make sure the assessment includes:

- ❑ The presenting complaint
- ❑ A detailed biological, psychological and social history
- ❑ A mental state examination
- ❑ A risk assessment
- ❑ A diagnosis and/or formulation
- ❑ The administration of an outcome tool (except where clinically inappropriate)

The Assessment may take more than one consultation. A minimum of one consultation as a Level C or D is required.

Step 2: Mental Health Plan (Bill as Level C or D)

Make sure the plan:

- ❑ Is prepared in consultation with the patient and/or carer
- ❑ Has the approval of the patient
- ❑ Is provided to the patient and/or carer (as appropriate)
- ❑ Is kept as part of the patient s medical records

And includes:

- ❑ A discussion of the diagnosis and/or formulation
- ❑ A discussion of the treatment options
- ❑ A written plan for treatment of the assessed mental health disorder and crisis intervention
- ❑ The provision of psycho-education
- ❑ A plan for relapse prevention, if appropriate at this stage

The Mental Health Plan may take more than one consultation. A minimum of one consultation as a Level C or D is required.

Step 3: Review (Bill for 3 Step Mental Health Process)

Make sure the review:

- ❑ **Is conducted between 1-6 months from when the mental health plan was prepared**
- ❑ Checks progress against the goals of the mental health plan
- ❑ Has modifications of the mental health plan (if necessary)
- ❑ Has education re-inforced and expanded
- ❑ Has a plan for relapse prevention if not previously provided
- ❑ Re-administers the same outcome tool used in the assessment (Step 1)

GPs (VR) — bill item number 2574 for Level C and 2577 for Level D, Non VR - bill item number 2704 for Level C and 2705 for Level D (in surgery consultations). Refer to Group A18 (VR) for items 2574 -2578 and Group A19 (Non VR) for item numbers 2704 — 2708 of the Medicare Benefits Schedule.

Funded by the Commonwealth Department of Health and Ageing
national mental health strategy

Appendix D
Proformas for the 3 Step Mental Health Process

MENTAL HEALTH ASSESSMENT

Patient name				**Date of Birth**	
Address					
Post Code		**Phone**		**Gender**	
Aboriginal or Torres Strait Islander origin	No ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Unknown ☐				
GP				**Practice postcode**	
Date of Assessment		**Outcome Tool**		**Result**	

Problem	**Diagnosis**
1.	
2.	
3.	

Mental Health History / Treatment

Allied Health Referral Data	**Has the person ever received specialist mental health care:** Yes ☐ No ☐ Unknown ☐ **Language spoken at home:** English ☐ Italian ☐ Greek ☐ Cantonese ☐ Mandarin ☐ Arabic ☐ Vietnamese ☐ Other ☐ Please specify:..... **How well does the person speak English:** Very well ☐ Well ☐ Not well ☐ Not at all ☐

Medications	**Allergies**

Family History of Mental Illness

Medical Conditions

Social History

Allied Health Referral Data	**Does the person live alone:** Yes ☐ No ☐ Unknown ☐ **Is the person a low income earner** (A judgment by GP) Yes ☐ No ☐

Abuse history – substance / sexual / physical

Alcohol use: **Tobacco:** **BMI:**

Personal History (eg childhood, education, relationship history, coping with previous stressors)

Allied Health Referral Data	**Highest education level completed:** Primary or below ☐ Secondary Year 10 or equivalent ☐ Secondary Year 11 or equivalent ☐ Secondary Year 12 or equivalent ☐ Tertiary ☐

Relevant Physical and Mental Examination	**Investigations**

Mental Status Examination	
Appearance and General Behaviour	**Mood** (Depressed / Labile)
Thinking (Content / Rate / Disturbances)	**Affect** (Flat / Blunted)
Perception (Hallucinations etc)	**Sleep** (Initial Insomnia / Early Morning Wakening)
Cognition (Level of Consciousness / Delirium / Intelligence)	**Appetite** (Disturbed Eating Patterns)
Attention / Concentration	**Motivation / Energy**
Memory (Short & Long term)	**Judgement** (Ability to make rational decisions)
Insight	**Anxiety Symptoms** (Physical & Emotional)
Orientation (Time / Place / Person)	**Speech** (Volume / Rate / Content)

Risk Assessment			
Suicidal ideation		Suicidal intent	
Current plan		Risk to Others	
Key Family/ Support Contact			

FORMULATION - Main problem / diagnosis	**ICD - 10 Provisional Diagnosis**
(risk / protective factors)	F1 Alcohol & Drug Use disorder ☐
	F2 Psychotic Disorder ☐
	F3 Depression ☐
	F4 Anxiety Disorder ☐
	F5 Unexplained Somatic Disorder ☐
	Other / Unknown:
Patient Education **Yes** ☐ **No** ☐	**Date for Mental Health Plan**
Eligibility for the Better Outcomes in Mental Health Care initiative **Yes** ☐ **No** ☐	

Notes

MENTAL HEALTH PLAN & REVIEW

Patient Name		**Date of Birth**	
		GP Name	
Date of Mental Health Plan		**Actual Date of Mental Health Review**	

Outcome Tool		**Result at assessment**		**Result at review**	

	GOAL	**ACTION / TASK**
Problem / Issue	(eg. Reduce symptoms, improve functioning)	(eg. Referral for Allied Health, or pharmacological treatment, or engagement of family/other supports)
1.		
2.		

Allied Health Referral Data

Intervention Requested		**Cognitive Behavioural Therapy (CBT):**	
Diagnostic assessment	Yes ☐ No ☐	Behavioural interventions	Yes ☐ No ☐
Psycho-education	Yes ☐ No ☐	Cognitive interventions	Yes ☐ No ☐
Interpersonal Therapy	Yes ☐ No ☐	Relaxation strategies	Yes ☐ No ☐
Other (specify)		Skills training	Yes ☐ No ☐
		Other CBT interventions	Yes ☐ No ☐
		Consent form signed by patient (to share clinical notes)	Yes ☐ No ☐

Follow Up / Relapse Prevention Plan (if appropriate)

Emergency Care

Notes

Patient Education given	Yes ☐ No ☐	**Copy of MH plan given to patient**	Yes ☐ No ☐

I understand the above Mental Health Plan and agree to the outlined goals / actions

Patient Signature	**GP Signature**

Proposed date for Mental Health Review (between 4 weeks & 6 months)	

Review (Progress on actions and tasks)

MENTAL HEALTH ASSESSMENT

Patient name	Tessa Speed			**Date of Birth**	02 · 11 · 43
Address	1101 Attfield Street, Fremantle				
Post Code	6160	**Phone**	9336 1123	**Gender**	F
Aboriginal or Torres Strait Islander origin	No ☑ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Unknown ☐				
GP	DR. M. FIELD			**Practice postcode**	
Date of Assessment	01 · 03 · 03	**Outcome Tool**	K10	**Result**	40

Problem	Diagnosis
1. No energy	Lassitude ? Depression
2. Very lonely. Recent move to area	Social Isolation
3.	

Mental Health History / Treatment

Mild depression with 1st child

Allied Health Referral Data

Has the person ever received specialist mental health care: Yes ☐ No ☑ Unknown ☐
Language spoken at home: English ☑ Italian ☐ Greek ☐ Cantonese ☐ Mandarin ☐ Arabic ☐
Vietnamese ☐ Other ☐ Please specify:.....
How well does the person speak English: Very well ☐ Well ☐ Not well ☐ Not at all ☐

Medications	Allergies
Nil	Nil

Family History of Mental Illness

Nil

Medical Conditions

On HRT for menopausal symptoms (flushing)
Nil else significant

Social History

Separated from husband 5 years ago
2 adult children living interstate
Moved for new start

Allied Health Referral Data

Does the person live alone: Yes ☑ No ☐ Unknown ☐
Is the person a low income earner (A judgment by GP) Yes ☑ No ☐

Abuse history – substance / sexual / physical

Alcohol use: 1-2 glasses wine/night
Tobacco: Nil
BMI: 26

Personal History (eg childhood, education, relationship history, coping with previous stressors)

Happy childhood . Usual life crises

Allied Health Referral Data

Highest education level completed: Primary or below ☐ Secondary Year 10 or equivalent ☐ Secondary Year 11 or equivalent ☐ Secondary Year 12 or equivalent ☐ Tertiary ☑

Relevant Physical and Mental Examination	**Investigations**
BP 140/90 Slightly overweight Euthyroid	CBC BS U+E's LFTs

Mental Status Examination

Appearance and General Behaviour Normal	**Mood** (Depressed / Labile)
Thinking (Content / Rate / Disturbances) Normal	**Affect** (Flat / Blunted) Flat
Perception (Hallucinations etc) Normal	**Sleep** (Initial Insomnia / Early Morning Wakening) Erratic
Cognition (Level of Consciousness / Delirium / Intelligence) Normal	**Appetite** (Disturbed Eating Patterns) Little interest
Attention / Concentration Difficulty concentrating	**Motivation / Energy** Low
Memory (Short & Long term) Bit forgetful	**Judgement** (Ability to make rational decisions) Feels overloaded
Insight Good	**Anxiety Symptoms** (Physical & Emotional) Tense / headaches
Orientation (Time / Place / Person) OK	**Speech** (Volume / Rate / Content) Normal

Risk Assessment

Suicidal ideation	Minor. All seems hopeless	Suicidal intent	No
Current plan	None at present	Risk to Others	Nil
Key Family/ Support Contact	None at present		

FORMULATION – Main problem / diagnosis (risk / protective factors)	**ICD – 10 Provisional Diagnosis**
① Depression assoc. with social isolation & readjustment after move ② check bloods – exclude other causes for tiredness	F1 Alcohol & Drug Use disorder ☐ F2 Psychotic Disorder ☐ F3 Depression ☑ F4 Anxiety Disorder ☐ F5 Unexplained Somatic Disorder ☐ Other / Unknown:
Patient Education Yes ☑ No ☐	**Date for Mental Health Plan**
Eligibility for the Better Outcomes in Mental Health Care initiative Yes ☑ No ☐	07·03·03

Notes

MENTAL HEALTH PLAN & REVIEW

Patient Name	Tessa Speed	**Date of Birth**	02 · 11 · 43
		GP Name	DR. M. FIELD
Date of Mental Health Plan	07 · 03 · 03	**Actual Date of Mental Health Review**	

Outcome Tool	K10	**Result at assessment**	40	**Result at review**	

Problem / Issue	**GOAL** (eg. Reduce symptoms, improve functioning)	**ACTION / TASK** (eg. Referral for Allied Health, or pharmacological treatment, or engagement of family/other supports)
1. Lassitude	Get motivated by developing interests & goals	Refer to counsellor
2. Lonliness	Get involved with other adults	Join local group (radio club)

Allied Health Referral Data

Intervention Requested		**Cognitive Behavioural Therapy (CBT):**	
Diagnostic assessment	Yes ☐ No ☑	Behavioural interventions	Yes ☐ No ☐
Psycho-education	Yes ☑ No ☐	Cognitive interventions	Yes ☐ No ☐
Interpersonal Therapy	Yes ☑ No ☐	Relaxation strategies	Yes ☐ No ☐
Other (specify)		Skills training	Yes ☐ No ☐
		Other CBT interventions	Yes ☐ No ☐
		Consent form signed by patient (to share clinical notes)	Yes ☑ No ☐

as indicated

Follow Up / Relapse Prevention Plan (if appropriate)

See following counselling or earlier if needed

Emergency Care

Contact GP. Emergency phone number given

Notes

Patient Education given	Yes ☐ No ☐	**Copy of MH plan given to patient**	Yes ☐ No ☐

I understand the above Mental Health Plan and agree to the outlined goals / actions

Patient Signature	**GP Signature**
Tessa Speed	M. Field

Proposed date for Mental Health Review (between 4 weeks – 6 months) 3/12

Review (Progress on actions and tasks)

Appendix F

Privacy and Discrimination

Patient Privacy and potential for discrimination through insurance claims

"I think initially, I was quite hesitant about using the 3 Step Process and the mental health items because of concerns about privacy from a patient perspective. I was concerned that labelling a patient with a mental illness may lead to discrimination in the future for the patient, particularly around aspects of application for insurance, personal income protection and life insurance. Fortunately, I have been involved in some of the discussions that the mental health stakeholders have been holding over the last year or more with the peak insurance body IFSA and now that we have signed a MoU with IFSA, I am feeling a lot more confident that the benefits of the whole process can be seen for the patients."

Dr Marli Watt, GP Queensland

"The potential that patients be discriminated against when applying for life insurance is a problem that has been happening for a long time, but is actually nothing to do with the new mental health item numbers. The insurance companies rely almost entirely on GP reports and not on accessing HIC records. We have been working with the insurance companies to make sure patients are not discriminated against and that underwriting and claims management of insurance is evidence based."

Dr Tori Wade, ADGP GP Representative

"No, I don't have a problem with getting a Medicare bill that says 3 Step Process. I'm just glad that my problem is being taken seriously, that I've had treatment and now I'm getting better."

Lucy, Consumer

Is my patient's information secure using the MBS items for mental health?

All information collected by the HIC is confidential and its staff must abide by the secrecy provisions of legislation including the Privacy Act 1998 and the Health Insurance Act 1973. The HIC has implemented strict policies and procedures to ensure it complies with its legal obligation in dealing with personal information.

What does the MoU mean for my patients?

Mental health conditions will now be treated in the same way as other high prevalence, treatable medical conditions with underwriting and claims management of income protection and life insurance to be evidence based. Revised underwriting and claims forms will be launched before the end of the 2003/04 financial year.

Representatives from this consortium group including beyondblue, the Mental Health Council of Australia, ADGP and the AMA now sit on the Investment and Financial Services Association working groups. The MoU commits all parties to cooperate on this issue until at least December 2003. This world first Australian MoU blueprint is now being sought by other countries including the USA, UK and NZ.

Appendix G

3 Step Mental Health Process MBS Item Descriptors (Review consultation)
General Practitioner Attendances (VR)

INCENTIVE ITEMS	GENERAL PRACTITIONER
	GROUP A18 - GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS
	SUBGROUP 4 - COMPLETION OF THE 3 STEP MENTAL HEALTH PROCESS
	Note: Benefits included in Subgroup 4, A18 or A19, are payable for one 3 Step Mental Health Process per patient only in a 12-month period, unless a further 3 Step Mental Health Process is clinically indicated. At a minimum the 3 Step Mental Health Process must include: - at least 3 consultations of more than twenty minutes each for a patient with an assessed mental health disorder; - at least two of the consultations to have been planned visits; - an assessment and formulation or diagnosis of the mental health disorder/s; - provision of a written mental health plan and appropriate education to the patient and/or the carer (with the patient's agreement); - a review of the patient's progress against the goals included in the mental health plan. This review to have been conducted a minimum of 4 weeks and a maximum of 6 months from the consultation in which the mental health plan was prepared; and - utilising an outcome tool in the assessment and review stages except where considered clinically inappropriate. The 3 Step Mental Health Process can only be provided by a general practitioner, who practices in general practice and has been notified to the HIC as having the required credentials (See Note A30.2). **LEVEL C** Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies; AND which completes the requirements of the 3 Step Mental Health Process. **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.30 of explanatory notes to this Category)* 2574 **Fee:** $55.95 **Benefit:** 75% = $42.00 85% = $47.60
	OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) *(See para A.30 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2574, plus $20.60 divided by the number of patients seen, up to a maximum of six patients. 2575 For seven or more patients - the fee for item 2574 plus $1.45 per patient.
	LEVEL D Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan; AND which completes the requirements of the 3 Step Mental Health Process. **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.30 of explanatory notes to this Category)* 2577 **Fee:** $82.40 **Benefit:** 75% = $61.80 85% = $70.05
	OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) *(See para A.30 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2577, plus $20.60 divided by the number of patients seen, up to a maximum of six patients. 2578 For seven or more patients - the fee for item 2577 plus $1.45 per patient.

INCENTIVE ITEMS	OTHER NON-REFERRED
	GROUP A19 - OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES
	SUBGROUP 4 - COMPLETION OF THE 3 STEP MENTAL HEALTH PROCESS
	Note: Benefits included in Subgroup 4, A18 or A19, are payable for one service per patient only in a 12-month period, unless a further 3 Step Mental Health Process is clinically indicated. At a minimum the 3 Step Mental Health Process must include: - at least 3 consultations of more than twenty minutes each for a patient with an assessed mental health disorder; - at least two of the consultations to have been planned visits; - an assessment and formulation or diagnosis of the mental health disorder/s; - provision of a written mental health plan and appropriate education to the patient and/or the carer (with the patient's agreement); - a review of the patient's progress against the goals included in the mental health plan. This review to have been conducted a minimum of 4 weeks and a maximum of 6 months from the consultation in which the mental health plan was prepared; and - utilising an outcome tool in the assessment and review stages except where considered clinically inappropriate. The 3 Step Mental Health Process can only be provided by a medical practitioner (not including a general practitioner, a specialist or consultant physician), who practices in general practice and has been notified to the HIC as having the required credentials (See Note A30.2). **SURGERY CONSULTATIONS** (Professional attendance at consulting rooms) **LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration. AND which completes the requirements of the 3 Step Mental Health Process. *(See para A.30 of explanatory notes to this Category)* 2704 **Fee:** $38.00 **Benefit:** 75% = $28.50 85% = $32.30
	PROLONGED CONSULTATION of more than 45 minutes duration and which completes the requirements of the 3 Step Mental Health Process. *(See para A.30 of explanatory notes to this Category)* 2705 **Fee:** $61.00 **Benefit:** 75% = $45.75 85% = $51.85
	OUT-OF-SURGERY CONSULTATIONS (Professional attendance at a place other than the consulting rooms) **LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND which completes the requirements of the 3 Step Mental Health Process. *(See para A.30 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. 2707 For seven or more patients - an amount equal to $35.50 plus $0.70 per patient.
	PROLONGED CONSULTATION of more than 45 minutes duration and which completes the requirements of the 3 Step Mental Health Process. *(See para A.30 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. 2708 For seven or more patients - an amount equal to $57.50 plus $0.70 per patient.

Appendix H
FPS MBS Item Descriptors
General Practitioner Attendances (VR GPs/ NON VR GPs/ OMPs)

MEDICAL PRACTITIONER	MEDICAL PRACTITIONER

GROUP A20 - FOCUSSED PSYCHOLOGICAL STRATEGIES

MEDICAL PRACTITIONER ATTENDANCE (INCLUDING A GENERAL PRACTITIONER, BUT NOT INCLUDING A SPECIALIST OR CONSULTANT PHYSICIAN) ASSOCIATED WITH PROVISION OF FOCUSSED PSYCHOLOGICAL STRATEGIES

Note: These services may only be provided by a medical practitioner who is registered with the HIC as meeting the requirements to participate in the Better Outcomes in Mental Health Care Initiative. The medical practitioner must provide the service in a general practice participating in the PIP or which is accredited.

Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies, that have been shown to integrate the best external evidence of clinical effectiveness with general practice clinical expertise. These strategies are required to be provided to patients by a credentialled medical practitioner and are time limited; being deliverable, in general, in up to 6 planned sessions. In some instances, following review by the practitioner managing the 3 Step Mental Health Process, up to a further 6 sessions may be approved in any 12 month period to an individual patient. Medical practitioners must be notified to the HIC by the General Practice Mental Health Standards Collaboration that they have met the required standards for higher level mental health skills.
A session should last for a minimum of 30 minutes.

FPS ATTENDANCE

Professional attendance for the purpose of providing focussed psychological strategies (from the list included in the Explanatory Notes) for assessed mental health disorders by a medical practitioner registered with the Health Insurance Commission as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes to less than 40 minutes.

	SURGERY CONSULTATION (Professional attendance at consulting rooms) *(See para A.31 of explanatory notes to this Category)*		
2721	**Fee:** $70.50	**Benefit:** 75% = $52.90	85% = $59.90
	OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) *(See para A.31 of explanatory notes to this Category)*		
2723	**Derived Fee:** The fee for item 2721, plus $20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2721 plus $1.45 per patient.		

FPS EXTENDED ATTENDANCE

Professional attendance for the purpose of providing focussed psychological strategies (from the list included in the Explanatory Notes) for assessed mental health disorders, by a medical practitioner registered with the Health Insurance Commission as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes.

	SURGERY CONSULTATION (Professional attendance at consulting rooms) *(See para A.31 of explanatory notes to this Category)*		
2725	**Fee:** $100.95	**Benefit:** 75% = $75.75	85% = $85.85
	OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) *(See para A.31 of explanatory notes to this Category)*		
2727	**Derived Fee:** The fee for item 2725, plus $20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2725 plus $1.45 per patient.		

Appendix I

Description of the Focussed Psychological Strategies

1. Psycho-education

Psycho-education usually involves giving the patient information about the disorder covering: prevalence, symptoms, related problems, aetiology, prognosis and recommended treatments.

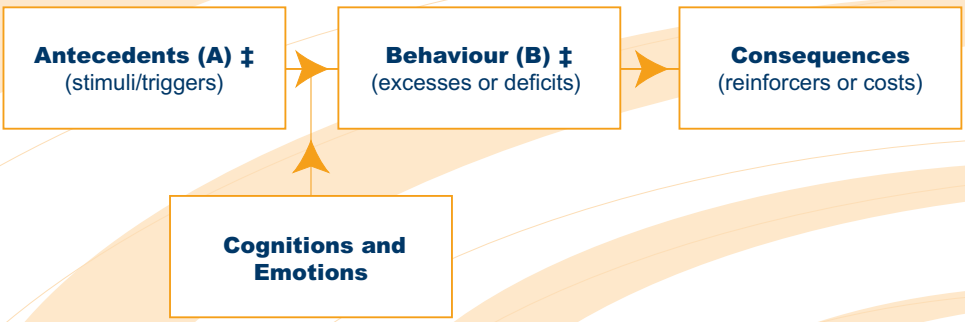
2. Cognitive-behavioural therapy (CBT)

Within the theoretical framework of learning theory, mental disorders are conceptualised in terms of emotional and behavioural problems that have been learned.

Behaviour therapy is based on the theory that behaviour is learned and maintained (through observation, pairing of antecedents and behaviour, and conditional reinforcement) and hence can be altered (through modeling and rehearsal, stimulus control and contingency management).

Cognitive therapy is based on the theory that distressing emotions and maladaptive behaviours are the result of faulty or irrational patterns of thinking. Dysfunctional beliefs, expectations, perceptions, attributions, interpretations and appraisals are identified and modified or replaced with rational, adaptive cognitions which alleviate the problematic feelings and behaviour.

In a simplified form, CBT is based on the following model of the development and maintenance of mental disorders:



Antecedents or stimuli trigger the problematic cognitions and/or feelings. The individual then responds with problematic behaviour, which may be followed by consequences which reinforce the inappropriate behaviour.

CBT involves altering the antecedents, behaviour, consequences and the associated intervening cognitions.

Behavioural interventions

Behaviour modification

Behaviour modification (especially for children) is used to decrease problematic or dysfunctional behaviour (usually excesses) or to increase or learn desirable or functional behaviour. It is particularly effective for the treatment of externalising disorders and for developing prosocial and basic living skills.

Behaviour modification starts with a thorough behavioural analysis, which involves specifying and measuring the behaviours to be altered and identifying the variables 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. They include graded exposure to the feared object or situation, and sometimes, systematic desensitisation. 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 them in terms of increasing fear. 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 but not overwhelming. By remaining in this situation until the fear subsides, the person learns that it is groundless. Systematic desensitisation is similar in that it involves exposure to a hierarchy of feared objects or situations (often in imagination) while using slow breathing and/or other relaxation techniques and cognitive coping self-statements to cope with the anxiety experienced. On exposure, the person is assisted to implement the learned relaxation techniques and use the coping self-statements until the fear subsides.

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 in 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 distract patients 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 interventions

Cognitive analysis, challenging and restructuring

Cognitive analysis involves identifying the dysfunctional thoughts which lead to unwanted emotions and problematic behaviour. This process firstly requires patients to become aware of the thoughts which produce distressing feelings and behaviour and to uncover the beliefs which underlie these 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 (eg. anxiety, panic disorder, phobias, OCD and depression). Often people with these disorders have cognitive schema which are faulty and they engage in distorted cognitive processing, ie., they have unrealistic, negative, overgeneralised and sometimes catastrophic beliefs about themselves, others and the world. Their dysfunctional thought patterns, including expectations, perceptions, attributions and appraisals need to be challenged and replaced by more functional thoughts to enable them to stop worrying, experience positive emotions, cope with life and feel successful. In cognitive therapy, patients are made aware of their irrational thoughts and evidence is gathered through behavioural experiments. Therapist feedback to dispute or counter the cognitive distortions underlying various disorders. Ultimately, the aim is to assist the person to restructure their dysfunctional cognitive schema underlying their maladaptive thinking and to develop appropriate beliefs and rational processing.

In externalising disorders, there may be deficient cognitive processing (eg. absence of processing as in ADHD), or both deficient and distorted processing, (eg. in conduct disorder). In these disorders, functional cognitive structures and processes need to be developed.

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 patient 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. The use of positive self-statements, related to self-evaluation and reinforcement are also learned.

Attention regulation

Patients 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 patients to attend to positive aspects of themselves, others and situations and to process events in a realistic way. They then feel more able to cope and more positive about themselves.

Relaxation strategies

Guided imagery, deep muscle 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 and what situations produce it, followed by learning through a series of exercises to progressively tense then relax the tense muscles throughout the body, can overcome this problem. This procedure needs to be taught by a skilled practitioner and practised for a period of time before it can be effectively implemented in anxiety-provoking situations. 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.

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-judgmental. 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. If it was not successful, another course of action is selected, implemented and the outcome again evaluated. Successful outcomes are celebrated.

Anger management

Anger management involves the addition of specific techniques to the basic steps of problem-solving, to identify when anger is building and ways of dealing with it. The additional steps include: establishing likely anger arousing situations; learning to identify body sensations (physiological reactions) and thoughts that lead to feelings of anger and aggressive behaviour; then developing alternative strategies (for thinking and behaving) that reduce the angry feelings or sensations, 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 (eg. anxiety, depression, post-traumatic stress or psychosomatic symptoms). Cognitions may have to be challenged and coping self-statements learned, as well as alternative behaviour (eg. engaging in pleasant activities or relaxation) 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. In addition, social support is often required.

Communication training

Communication involves both verbal and non-verbal skills. Effective communication requires: attention, active listening, accurately understanding, then summarising and reflecting back, empathy and responding with clear messages to the original speaker. 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 practise in the person's social settings, feedback and reinforcement is an essential part of any social skills program.

Parent management training

Parent management training involves teaching parents appropriate skills to raise 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 the parents learn to monitor their children's behaviour and identify the antecedents and consequences which control it. They are then taught how to modify these variables in order to develop adaptive prosocial behaviour. They learn to set appropriate rules and limits, along with logical consequences for breaking these rules, which must be consistently implemented. The rules and consequences must be clearly communicated to their children. The parents are also encouraged to reward prosocial behaviour, spend quality time with their children and to work together and support each other in parenting their family.

Motivational interviewing

Motivational interviewing is a useful technique to use with people who are initially ambivalent or reluctant to engage in CBT, particularly when needing to change a behaviour which provides rewards for them (eg. drinking excessively). Discussions of the costs and benefits of change and even planned exercises are sometimes needed to convince the person that in the longer (and sometimes shorter) term, the benefits of change outweigh the costs of not changing. Often concerns about what might happen, or their perception of their inability to cope, impedes progress and these must be uncovered and dealt with, along with discussing what might the future might look like if they changed and the impact of the change on their satisfaction with life.

3. Interpersonal Therapy (especially for depression)

Interpersonal therapy is based on the theory that interpersonal relationships play a significant role in both causing and maintaining depression. Interpersonal therapy aims to identify and resolve interpersonal difficulties that are thought to be related to the depression. These difficulties may include: conflict with others, role disputes or role transitions, social isolation and prolonged grief following loss. Interpersonal therapy builds skills – mainly in the communication and interpersonal domains.

Importance of the context

In treating a patient's mental health problems, it is most important to attend to the context in which the problems exist, ie. the patient's family, social support and economic situation. Issues considered should include family conflict and breakdown, abuse or violence, social isolation, unemployment, lack of finance and housing, as well as stressful life events and psychopathology in the family. It is often necessary to deal with the context in addition to treating the individual.

Where can I obtain further relevant clinical information?

Further information for GPs is available on the web based clinical information site,

CLIMATE Help www.crufad.org

This site contains useful information for GPs and allied health providers about the evidence base for the focussed psychological strategies available under the Better Outcomes in Mental Health Care Initiative. This database, designed for use by GPs and mental health allied health providers, will contain diagnostic categories and information on how to recognise and classify mental health disorders.

Appendix J

List of Abbreviations

ACRRM- Australian College of Rural and Remote Medicine

ADGP - Australian Divisions of General Practice

AMA - Australian Medical Association

AGPAL - Australian General Practice Accreditation Limited

CPD - Continuing Professional Development

EPC - Enhanced Primary Care

FPS - Focussed Psychological Strategies

GP - General Practitioner

GPMHSC - General Practice Mental Health Standards Collaboration

HIC - Health Insurance Commission

IFSA - Investment and Financial Services Association

MBS - Medicare Benefits Schedule

MoU - Memorandum of Understanding

OMPs - Other Medical Practitioners

PIP - Practice Incentive Payment

RACGP - Royal Australian College of General Practitioners

RPL - Recognition of Prior Learning

SIP - Service Incentive Payment

VR - Vocationally Registered

Appendix K

Useful Contact Numbers and Websites

For further information on The Better Outcomes in Mental Health Initiative

Contact your local Division, your State Based Organisation or the Australian Divisions of General Practice.

Enquiries to the Australian Divisions of General Practice

Email: mentalhealth@adgp.com.au
Phone: 02 6228 0800
Facsimile: 02 6228 0899
Post: PO Box 4308
Manuka ACT 2603

Enquiries to the GPMHSC

Email: gpmhsc@racgp.org.au
Phone: 03 8699 0554
Facsimile: 03 8699 0570
Post: National Mental Health Education Development Officer
GPMHSC
1 Palmerston Crescent
South Melbourne VIC 3205

HIC/PIP Hotline

Service Incentive Payments/Registration with the HIC

HIC Hotline: 1800 222 032

Accessing the ADGP Familiarisation Training Webpage

The ADGP Familiarisation Training web page is your one stop shop to seeking the information you require on Familiarisation Training and the Better Outcomes in Mental Health Initiative.

Through the provision of up to date information and links to important sites such as the GPMHSC webpage, the Familiarisation Training web page provides access to information on outcome tools, accredited education and training programs and focussed psychological strategies. Copies of registration forms, the K10 outcome tool, proformas for the 3 Step Mental Health Process and this manual can be obtained from the site.

Access to the Familiarisation Training Website can be achieved by following these steps:

1. Refer to www.adgp.com.au
2. Select National Programs
3. Click on the Familiarisation Training banner (as shown below)

funded
by the
Commonwealth
Department
of Health and Ageing

adgp

Australian Divisions of **General Practice**

national mental health strategy