

***Access to Allied Psychological Services Program  
Information on Better Access Changes***

**CIRCULAR No. 2  
November 2011**

This circular provides information on the changes to the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative. It also provides information on the Access to Allied Psychological Services (ATAPS) program.

The circular covers the following frequently asked questions:

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## **BUDGET CHANGES**

### **1. What changes have been made to the Better Access initiative?**

From 1 November 2011, new time-tiered Medicare items for the preparation of a GP Mental Health Treatment Plan and changes to Medicare rebates have come into effect. Changes to a patient's calendar year entitlement to allied mental health services under the Better Access initiative have also come into effect. Details of these changes are outlined at [Attachment A](#).

### **2. What happens to people who require focussed psychological strategies services after 1 November 2011?**

The normal arrangements apply ie people who have a diagnosed common mental disorder, such as anxiety and depression, particularly of mild to moderate severity, should see their GP to have a GP Mental Health Treatment Plan developed and to be referred to an appropriate allied mental health service.

Depending on the patient's clinical needs, location and capacity to pay, the GP can refer a patient for a course of up to six focussed psychological strategies services either under the Better Access initiative or the Access to Allied Psychological Services (ATAPS) program.

Generally, people who access treatment through Better Access do not receive services under ATAPS within the same calendar year unless: their location changes and they are no longer able to access Better Access services due to workforce constraints, or their financial circumstances change and they are no longer able to meet the co-payments associated with Better Access services.

### **3. Can existing Better Access clients who have completed ten individual services in 2011 calendar year access ATAPS services?**

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

We know from the Better Access evaluation that the most vulnerable Australians with mental illness continue to miss out on these Medicare subsidised services and that is why the Government is doubling the capacity of ATAPS to reach the hardest to reach. As is the case now the treating clinician needs to decide - based on a range of factors, such as workforce availability and the patient's ability to contribute to the cost - whether to refer a patient to Better Access or to ATAPS.

ATAPS targets people from low socioeconomic areas: individuals at risk of suicide or self harm; individuals who are homeless or at risk of homelessness; and people in rural and remote areas. ATAPS also focuses on Indigenous people, children and women with perinatal depression.

People who have already completed ten sessions or more of individual services under Better Access before 1 November 2011 should not be referred to ATAPS to access additional services during the remainder of the 2011 calendar year. However, from 1 January 2012 these people can access a further ten individual or ten group services under Better Access in the 2012 calendar year.

Alternatively, if their circumstances have changed, and it would be more appropriate to be referred to ATAPS these people can access ATAPS services in 2012. Changed circumstances include: changes in location where the person is no longer able to access Better Access services due to workforce constraints; or their financial circumstances change and they are no longer able to meet the co-payments associated with Better Access services. In deciding if ATAPS is more appropriate GPs should consider the focus and target of the ATAPS program.

The Better Access Evaluation showed that the average number of sessions used was five, and 87% of people used ten sessions or less. This means that the vast majority of people will be unaffected by these changes. Therefore, it is not envisaged that there would be a significant increase in demand for ATAPS services from people who would normally be referred to Better Access.

## **ATAPS**

### **4. Who does ATAPS target?**

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

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

The program also has dedicated funding to provide innovative services to people who have self harmed or attempted suicide or are at risk of suicide, Indigenous people, children and their families and women with perinatal depression. This is often referred to as Tier 2 ATAPS.

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

### **5. How many allied mental health services are available under ATAPS?**

ATAPS targets hard to reach and particularly vulnerable and disadvantaged groups who continue to miss out on Medicare subsidised services such as people from low socioeconomic areas, individuals at risk of suicide or self harm, individuals who are homeless or at risk of homelessness, and people in rural and remote areas. It also focuses on Indigenous people, children and women with perinatal depression. The number of mental health services available under ATAPS remains unchanged – up to 12 individual and/or 12 group therapy

services in a calendar year. In exceptional circumstances an individual can access up to a total of 18 individual services in a calendar year (see question 6 for details).

A referring medical practitioner can refer an individual to an initial course of up to six ATAPS services. On completion of the initial course of services, the allied health professional is to provide a written report to the referring medical practitioner. The written report is to include information on the assessments carried out, treatment provided, the individual's outcomes and recommendations on future management of individual's mental disorder. Following receipt of the written report, the referring medical practitioner will consider the need for further treatment and issue a new referral for an additional up to six ATAPS services. Further allied mental health services should not be provided without a referral for additional services.

#### **6. What are exceptional circumstances and how can an individual access the 13-18 services under ATAPS in a calendar year?**

In exceptional circumstances people can access an additional six services. However, as is the case now, people are not automatically eligible to access up to 18 services in a calendar year.

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

Unless the individual under treatment is being provided with a new referral for a new course of treatment for a **different** mental condition, this is considered to be a continuation of the original course of treatment and is not to be recorded as a new course of treatment or as a new individual.

#### **7. Is ATAPS intended to support people with severe mental illness?**

To be eligible for allied mental health services under the ATAPS program, individuals need to have a clinical diagnosis of mental illness. The short term, goal oriented focussed psychological strategies services that ATAPS provides are of most therapeutic value to individuals with common disorders of mild to moderate severity.

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

## **8. How can allied health professionals become ATAPS providers?**

The Department of Health and Ageing funds Divisions of General Practice to deliver psychological services to people with a mental disorder of mild to moderate severity under ATAPS. Medicare Locals will take over the fund holding role for ATAPS by 2012-13, as they are established and demonstrate capacity to provide ATAPS services. Continuation of ATAPS service delivery to new and existing clients is a key priority and Medicare Locals must demonstrate capacity to provide ATAPS services before the funding is transitioned.

The way Divisions/Medicare Locals deliver psychological services under ATAPS varies across the country. Some Divisions employ allied health providers to deliver such services, while others engage private providers to deliver ATAPS services on a fee-for-service or sessional basis.

Under ATAPS Divisions/Medicare Locals can engage a range of allied health providers to deliver services including psychologists, mental health nurses and appropriately trained social workers and occupational therapists as well as Aboriginal and Torres Strait Islander health workers who meet the standards outlined in the ATAPS Operational Guidelines. The Department would encourage Divisions/Medicare Locals to consider this range of skilled and experienced professionals available in the area across these four professions.

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

Appropriately qualified allied health professionals who are interested in providing ATAPS services should contact their local Division or a Medicare Local, if already operational, to discuss service delivery arrangements and opportunities to become an ATAPS provider.

## **BETTER ACCESS CHANGES**

### **9. How many allied mental health services can be accessed under Better Access from 1 January 2012?**

Medicare rebates are available for up to ten individual allied mental health services in a calendar year. A calendar year is defined as the period of time between 1 January and 31 December. The services may consist of: GP focussed psychological strategies services (items 2721 to 2727); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165).

In addition to individual services, patients may also be eligible for referral for up to ten separate group therapy services within a calendar year.

## **FLEXIBLE CARE PACKAGES**

### **10. What is happening with the Flexible Care Packages measure?**

The 2011-12 Budget provided \$549.8 million over five years for a significant new reform measure to provide coordinated care and flexible funding for people with severe, persistent mental illness and complex care needs (what we are now calling the ‘Partners in Recovery’ measure) under the *Delivering National Mental health Reform* package. To ensure a consolidated approach and support the implementation of the new measure, from 2012-13, the Flexible Care Packages funding has been completely redirected to support the new ‘Partners in Recovery’ initiative.

This means that funding under the Flexible Care Packages measure is only available for clinical services and only in 2011-12. Funding available in 2011-12 will be provided to all Divisions and established Medicare Locals to increase their capacity to provide additional ATAPS services to target hard to reach groups, including people with severe mental illness whose condition is one that will benefit from short term psychological treatment (as part of the overall treatment plan).

The new ‘Partners in Recovery’ initiative was never intended to be part of ATAPS and will not be automatically rolled out through Medicare Locals. Funding under this measure will be rolled out through a competitive tender process and Medicare Locals are expected to participate in that process. It is anticipated that tender processes for service delivery will commence in early 2012 with service delivery to commence in the 2012-13 financial year.

The Government is working closely with service providers, experts, consumers and carers to ensure that the planning and design of the Partnerships in Recovery: Coordination Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Care Needs initiative is successfully implemented.

The Mental Health Council of Australia and the Australian General Practice Network have both held workshops, funded by the Government, to gain input from the non-government sector and primary care sector on the implementation of this measure, and the Department is currently establishing an expert reference committee to oversee implementation.

## **PEOPLE WITH COMPLEX NEEDS**

### **11. What happens to people who need more than ten allied mental health services in a calendar year?**

The Better Access initiative was introduced to address low treatment rates for high prevalence mental disorders such as depression and anxiety – particularly presentations of mild to moderate severity where short-term evidence-based interventions are most likely to be useful.

While some people with more complex or intensive care needs may benefit from psychological interventions under Better Access, the initiative was not designed to provide intensive, ongoing therapy for people with severe, ongoing illness.

It is important that people get the right care for their needs. People who currently receive more than ten allied mental health services under Better Access are likely to be patients with more complex needs and would be better suited for referral to more appropriate mental health services. GPs can continue to refer those people with more severe ongoing mental disorders to Medicare subsidised consultant psychiatrist services or state/territory specialised mental health services.

To help make psychiatry services available in more areas, from 1 July 2011 the Government is providing new Medicare rebates for video psychiatrist consultations for patients living in regional, remote and outer metropolitan areas. GPs, specialists and other health professionals will be provided with financial incentives to help deliver these online services and funding will also be provided to support training and supervision for health professionals.

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For further information on the ATAPS services, Divisions and Medicare Locals can contact:

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For further information in relation to Better Access changes generally, Divisions and Medicare Locals can contact:

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**Mental Health Services Branch  
Mental Health and Drug Treatment Division  
Australian Government Department of Health and Ageing**

## **DETAILS OF BETTER ACCESS CHANGES**

### ***Changes to GP Mental Health Treatment Plan items***

The 2011-12 Budget included the introduction of new time-tiered Medicare items for the preparation of a GP Mental Health Treatment Plan and changes to Medicare rebates.

From 1 November 2011, Medicare items 2702 and 2710 for the preparation of a GP Mental Health Treatment Plan will be removed from the Medicare Benefits Schedule (MBS) and replaced with four new time-tiered items – 2700, 2701, 2715 and 2717.

GPs who have completed Mental Health Skills training accredited by the General Practice Mental Health Standards Collaboration (GPMHSC) and who previously claimed item 2710 will now claim item 2715 (for a consultation of between 20 and 39 minutes) or item 2717 (for a consultation of 40 minutes or more). The schedule fee for item 2715 is \$87.60 and item 2717 is \$129.00.

GPs who have not completed accredited Mental Health Skills training and who previously claimed item 2702 will now claim item 2700 (for a consultation of between 20 and 39 minutes) or item 2701 (for a consultation of 40 minutes or more). The schedule fee for item 2700 is \$69.00 and item 2701 is \$101.55.

There will also be changes to the MBS fee structure for the GP Mental Health Review item 2712 and the GP Mental Health Consultation item 2713. From 1 November 2011, the rebate for both items 2712 and 2713 is \$69.00.

### ***Changes to allied mental health items***

The 2011-12 Budget also included changes to a patient's calendar year entitlement to allied mental health services under the Better Access initiative.

Under the Better Access initiative MBS items provide Medicare benefits for allied mental health services including psychological therapy services (items 80000 to 80020) provided by eligible clinical psychologists and focussed psychological strategies services (items 80100 to 80170) provided by eligible psychologists, occupational therapists and social workers.

Prior to 1 November 2011, patients receiving services under Better Access were able to access up to 12 individual services and/or up to 12 group services. In exceptional circumstances patients were able to access an additional six individual services prior to 1 November 2011. In accordance with the Medicare Benefits Schedule, exceptional circumstances are defined as a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the number of services. It is up to the referring practitioner to determine that the patient meets the requirements for exceptional circumstances.

From 1 November 2011, Medicare rebates for eligible people with a diagnosed mental disorder under the Better Access initiative will be capped at ten individual allied mental health services per calendar year, from 12. Individuals may also be referred for up to ten group services per calendar year in addition to their individual allied mental health services.

Individuals who have already accessed ten or more individual and/or ten or more group services by 1 November 2011 will not be eligible for additional services until 1 January 2012.