APMHA HEALTHCARE LIMITED
Service Delivery and Orientation Manual

Psychological Therapy Services

For Western Victoria Primary Health Network

Version 2: 29/06/2019

Table of contents.

Introduction to APMHA HealthCare Limited 3
Introduction to Western Victoria PHN 4
Stepped Care approach to Mental Health Services 5
Code of Conduct 6
Recovery-oriented, client-centred approach 8
National Mental Health Standards 9
Working with families and carers 10
Psychological Therapy Services programme – Western Victoria PHN 11
PTS - Eligibility 12
Interventional approaches in scope for PTS 13
Clinical Governance and Service Quality 13
Service Requirements 14
Western Victoria PHN Referral Point 15
Eligibility criteria for Mental Health Professionals to deliver PTS 16
Overview of service requirements 17
General inormation about consultation sessions 0
Contractor's Responsibility and Reporting Requirements 1
APMHA HealthCare Ltd MHPs Requirements 4
Psychological Outcome Measures 6
People Who Self-Harm or Who Are at Risk of Suicide 7
Minimum Data Set (MDS) 7
Interpretor Services 8
Treatment Completion 8
Better Access and PSS 10
Clinical Monitoring and Audit 10
APMHA HealthCare LTD program management and support 11
KEY CONTACTS 13

Introduction to APMHA HealthCare Limited

APMHA HealthCare Ltd is a national not-for-profit company specialising in primary mental health care service delivery. It was established in 2015 as the then Victorian Primary Mental Health Alliance Pty Ltd, trading as the Australian Primary Mental Health Alliance. The Company was developed in direct response to reflect national mental health reform and the stepped mental health care service model. The CEO and General Managers spent 3 years refining the business model and now the transition to a Not For Profit entity which better reflects our benevolent nature and focus.

APMHA HealthCare is created upon the strategic alliances and partnerships of our primary mental health clinicians and partner organisations across Australia. We offer employed, secondment and sub-contract arrangements for a clinical and non-clinical workforce that provides a national footprint of highly qualified mental health professionals across Australia. Our large network of clinicians works virtually as a collaborative team, bringing together clinicians to enhance program reach and depth to those clients who need support the most.

APMHA HealthCare's corporate office is in Flemington, Victoria and it supports local services in various locations across Australia, primarily Victoria and NSW.

Our funders and partners are Primary Health Networks, State and Federal Government, private companies and other Not For Profits. We currently hold service delivery contracts in Western Victoria, Rural North East Vic, Goulburn Valley, South Western Sydney and Central and Eastern Sydney regions.

Our executive team collectively have over 150 years of experience working across all areas of mental health and within various sectors such as public and community mental health, and also in the last 20 years, working in primary mental health alongside general practice.

We work closely with Alaya Partners Australia to deliver quality education and training and consultancy to the mental health, primary care and drug and alcohol sectors.

APMHA HealthCare offers its subcontractors and employees a collaborative partnership, which assists clinicians to work outside of isolated practice and be involved in a robust and pioneering workforce which strives to improve the quality of life for consumers and carers living in the community.

APMH HealthCare offers

- Workforce support in the delivery of funded primary mental health services
- Network access to highly qualified and skilled mental health professionals
- Access to strong clinical and organisational governance processes
- Access to communities of practice, supervision and mentorship
- Provision of locum services and workforce support
- Access to CPD - Education and training
- Opportunities to work within new and innovative programme areas and designs
- Access to newly funded programs as they become available.

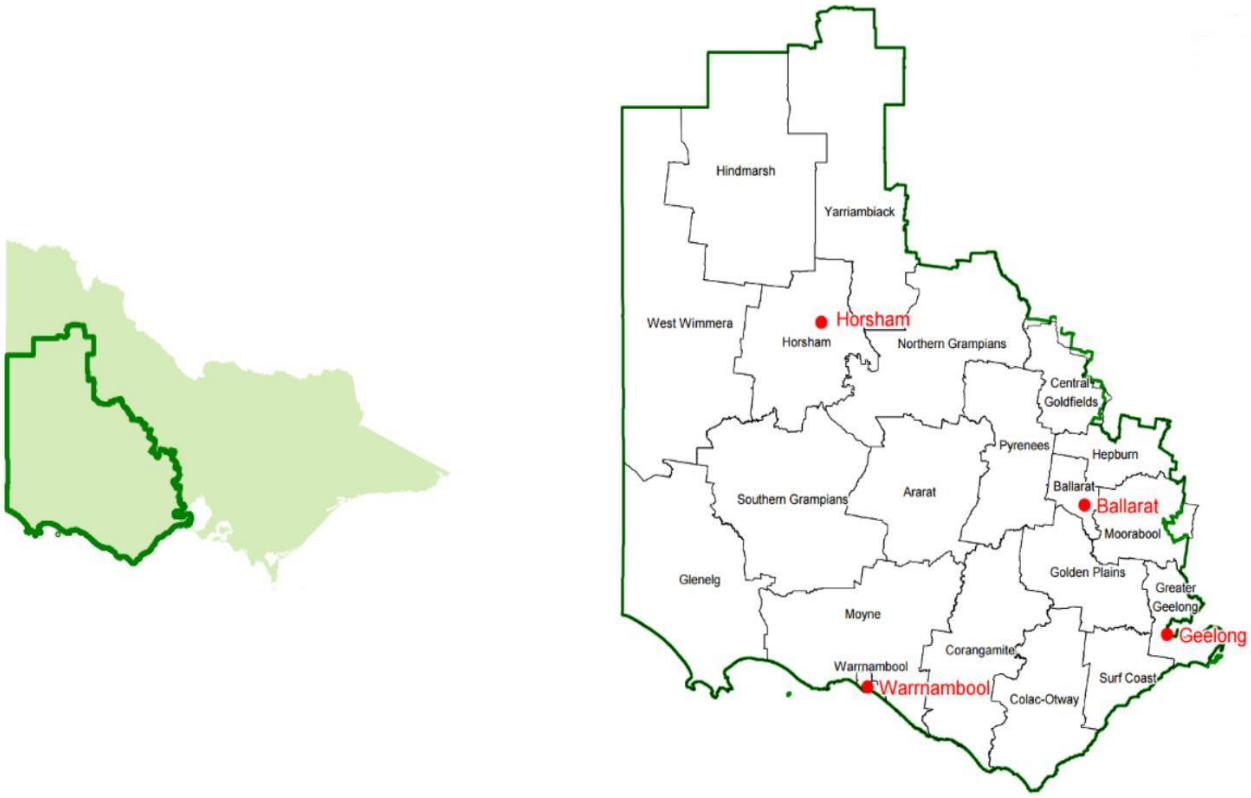
Introduction to Western Victoria PHN

Western Victoria Primary Health Network (PHN), established on 1 July 2015, is a not-for-profit organisation, responsible for delivering the following two objectives set by the Federal Government:

- Increase the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes; and
- Improve coordination of care to ensure patients receive the right care, in the right place, at the right time.

Western Victoria PHN has four regional centres located in Horsham, Ballarat, Geelong and Warrnambool.

Western Victoria PHN region



Stepped Care approach to Mental Health Services

Western Victoria PHN Western Victoria PHN is required to implement a stepped care approach to mental health to comprise a full continuum of services, from low intensity, early intervention 'stepping up' to intensive high levels of care, including coordinated care for people with severe and complex mental illness. It is the expectation of the Federal Government that Western Victoria PHN will commission the delivery of clinical services using fair and transparent competitive procurement processes.

Stepped care model in primary mental health care clinical service delivery

• A stepped care approach to mental health promotes person centred care which targets the needs of the individual. It recognises that the individual needs change and allows for flexibility for people to move across services levels to support their recovery.

• In a stepped care approach, a person presenting to the mental health system is matched to the intervention level that most suits their current need. An individual does not generally have to start at the lowest, least intensive level of intervention in order to progress to the next 'step'. Rather, they enter the system and have their service level aligned to their needs.

• It is recognised that underserviced groups also need access to other levels of service within a stepped care model, including low intensity services, youth friendly services and more intensive services targeted at people with severe mental illness.

• Not all clients would receive the same type and the same number of services. The type and number of services to be provided is expected to be determined by the health professional in consultation with the client and the client's GP and based on individual client needs, the severity of their illness and the evidence based treatment and meet the session allocation guidelines relating to the delivery of the programme.

Code of Conduct

APMH HealthCare Code of Conduct sets out standards of behaviour expected from people providing clinical services on behalf of APMHA HealthCare Ltd. It applies to contractors and employees of APMHA HealthCare.

The Australian Government has set **National Practice Standards for Mental Health Workforce** and mental health professionals have their own Codes of Ethics that establish specific behaviours that are relevant to that particular profession.

This Code of Conduct should be read in conjunction with the National workforce standards and any relevant professional codes of ethics.

Professional Codes set out a range of matters relating to the profession including dealing with breaches of that Code. A breach of such a Code may affect your capacity to continue to act as a representative of that profession and consequently may also affect your ability to provide services on behalf of APMHA HealthCare.

Code of Conduct

A contracted or employed clinical service provider of APMHA HealthCare will:

1. Deliver all services in accordance with relevant national and jurisdictional legislation and standards including:
   - Australian Government program and funding guidelines and relevant PHN program guidelines
   - Australian State and Territory Mental Health Acts
   - Privacy Act 1988
   - Human rights legislation including Disability Discrimination Act 1992 Age Discrimination Act 2004, Racial Discrimination Act 1975. Sex Discrimination Act 1984
   - National standards for mental health services 2010
   - A National framework for recovery-oriented mental health services
   - ISO 9001:2016 – quality management systems
2. Recognise that their primary responsibility is to help individuals understand recovery and achieve their own recovery needs, wants, and goals. They will be guided by the National Recovery Oriented Principles (see below) and conduct themselves in a manner that fosters recovery.
3. At all times, respect the rights, dignity, privacy and confidentiality of those they support and will let people know, when first discussing confidentiality:
   a. the degree to which information will be shared with others
   b. that probable or actual harm to self or others cannot be kept confidential
   c. that APMHA HealthCare will be notified immediately about any person's possible harm to self or others or abuse from caregivers
   d. that if family and carers are to be involved in their care, that they will be given sufficient information to support their caring role.

4. Never intimidate, threaten, harass, use undue influence, physical force or verbal abuse, or make unwarranted promises of benefits to people they support. They will recognise they work with a vulnerable population and will protect the welfare of all individuals they support by ensuring that their conduct will not constitute physical or psychological abuse, neglect, or exploitation.
5. Never engage in any sexual activities with individuals they support, nor enter into a relationship or commitment which conflicts with the support needs of individuals they support.
6. Not practice, condone, facilitate or collaborate in any form of discrimination on the basis of ethnicity, race, sex, sexual orientation, age, religion, national origin, marital status, political belief, or disability.
7. Not accept gifts of significant value from individuals they support. They will not loan, give, or receive money or payment for any services to, or from, individuals they support and nor will they encourage people they support to make gifts or loans to any other people or organisations.
8. Not discuss their employment situation in a negative manner with any individual the support.
9. Advocate for individuals so that they, or an authorised substitute decision-maker, may make decisions in all matters relating to their care.
10. Create opportunities for improvement in physical health, exercise, recreation, nutrition, expression of spirituality, creative outlets and stress management (see factsheet for strategies)
11. Work with people, families and carers to understand what might trigger periods of illness, and what helps to prevent or resolve these periods
12. Provide appropriate, culturally relevant mental health literacy resources and education and support materials to people, families and carers
13. Implement assessment and intervention strategies for health-compromising behaviours, particularly as they relate to mental health outcomes
14. Develop effective partnerships with key stakeholders to help people achieve and maintain the best possible mental health of the people they support.
15. Keep current with emerging knowledge relevant to recovery, and openly share this knowledge with co-workers and individuals they support. They will refrain from providing advice outside their scope of expertise.
16. Participate in recovery-oriented, and other forms of, supervision and abide by the standards for supervision established by APMHA HealthCare.
17. Only provide service and support for individuals on behalf of APMHA HealthCare within the hours, days and locations that are authorised by APMHA HealthCare.

Breach of this Code

A substantive breach of this Code may result in action being taken by APMHA HealthCare. Action may include temporary suspension of association and further discussion to resolve the issue; or in serious cases, termination of your involvement with APMHA HealthCare; in the most serious cases where actions may be in breach of Victorian or Australian Government law, referral of the matter to appropriate authorities will occur.

Recovery-oriented, client-centred approach

As stated in the above Code of Conduct, service delivery aligns with the six recovery oriented principles:

1. Uniqueness of the individual

Recovery oriented mental health practice:

- recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community
- accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life
- empowers individuals so they recognise that they are at the centre of the care they receive.

2. Real choices

Recovery oriented mental health practice:

- supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored
- supports individuals to build on their strengths and take as much responsibility for their lives as they can
- ensures that there is a balance between duty of care and support for individuals to take positive risks and make the most of new opportunities.

3. Attitudes and rights

Recovery oriented mental health practice:

- involves listening to, learning from and acting upon communications from the individual and their carers about what is important to the individual
- promotes and protects an individual's legal, citizenship and human rights
- supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to them
- instils hope in an individual about their future and ability to live a meaningful life.

4. Dignity and respect

Recovery oriented mental health practice:

- involves being courteous, respectful and honest in all interactions
- involves sensitivity and respect for each individual, especially for their values, beliefs and culture
- challenges discrimination wherever it exists within our own services or the broader community.

5. Partnership and communication

Recovery oriented mental health practice:

- acknowledges that each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them
- values the importance of sharing relevant information and the need to communicate clearly

- involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations.

6. Evaluating recovery

Recovery oriented mental health practice ensures and enables continuous evaluation at several levels:

- Individuals and their carers can track their own progress.
- Services demonstrate that they use the individual's experiences of care to inform quality improvement activities.
- The mental health system reports on key outcomes that indicate recovery, including housing, employment, education, social and family relationships, health and well being

National Mental Health Standards

As stated in the Code of Conduct, APMHA Healthcare and Western Victoria PHN uphold the National Mental Health Standards for consumers in their approach to providing mental health programs:

Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery:

- Consumers have the right to be treated with respect and dignity at all times. This includes respect for their culture, age, gender, religious / spiritual beliefs, sexual orientation, disability, experiences, values and beliefs.
- Consumers have the right to receive service free from abuse, exploitation, discrimination, coercion, harassment and neglect.
- Consumers have the right to receive a written statement, together with a verbal explanation, of their rights and responsibilities in a way that is understandable to them as soon as possible after entering the program or service.
- Informed consent is actively sought from consumers prior to any service or intervention provided or any changes in care delivery are planned, where it is established that the consumer has capacity to give informed consent.
- Consumers are continually educated about their rights and responsibilities.
- A mental health professional responsible for coordinating clinical care is identified and made known to consumers.
- Consumers are partners in managing all aspects of their treatment, care and recovery planning.
- Consumers are provided with current and accurate information on the care being delivered.
- Consumers have the right to choose from the available range of treatment and support programs appropriate to their needs.
- The right of consumers to involve or not to involve carers and others is recognised and respected.
- Consumers have an individual exit plan with information on how to re-enter the service if needed.
- Consumers are actively involved in follow-up arrangements to maintain continuity of care.
- The right of consumers to have access to their own health records is recognised in accordance with relevant Commonwealth and state / territory legislation / guidelines.
- Information about consumers is protected and only accessed by authorised persons.

Working with families and carers

Recovery-oriented practice and service delivery recognises the unique role of personal and family relationships in promoting wellbeing, providing care, and fostering recovery across the life span, and recognises the needs of families and carers.

APMHA Healthcare and Western Victoria PHN uphold the National Mental Health Standards for families and carers in their approach to providing mental health programs, as stated in the APMHA HealthCare Client Charter:

With consent from the consumer, families and carers have a right to:

- Be recognised, respected and supported as partners in providing care to the consumer
- Be involved in providing essential information to the clinician in the assessment phase, and in the ongoing treatment and care of the consumer
- Receive timely and easily understood information about the mental illness, its likely causes, treatment options and outcomes
- Have rights explained and a copy provided
- Be provided with support in their caring role

A practical guide for working with carers of people with a mental illness recommends that clinicians:

- recognise who carers are and acknowledge the importance of their role
- always welcome carers and inquire about their reason for visiting or contacting the service
- request information from carers to assist with the care and support of the consumer
- provide information about our service, including its purpose and how it can be contacted
- provide information about carer rights and responsibilities
- ask if carers have any questions and do our best to answer them
- explain what can, and cannot, be discussed
- refer carers to separate carer information and support services
- ensure carers are fully engaged in all stages of care

Support services for carers

Carers Australia 1800 242 636

Carers Australia is the national peak body representing Australia's carers for all health conditions. It advocates on behalf of carers to influence policies and services at a national level. Services are provided by a network of State and Territory Carers Associations, including counselling, advice, and information.

Carers online support

An online eight-session course from Carers Australia, providing mental health foundations for carers new to their role.

Mental Illness Fellowship of Australia (MIFA) Carers Forum

The Carers Forum is a safe, anonymous community for the friends, family and carers of people living with mental illness, moderated 24/7 by mental health professionals.

Dependent children

Many people with a mental illness will be caring for dependent children. Parents with a mental illness face the same challenges that all parents face, but will be simultaneously managing the symptoms of their illness. Almost all parents with a mental illness are able to care for their children, but some, at different times, need support from family, friends and health professionals. *The Principles and actions for services and people working with children of parents with a mental illness* provides clinicians with good practice strategies.

Psychological Therapy Services programme – Western Victoria PHN

Mild to moderate primary mental health services within the Western Victoria PHN, called Psychological Therapy Services (PTS), targets people with mild to moderate mental illness who experience barriers to accessing mainstream treatment options.

This may include population groups which have particular difficulty in accessing mental health treatment such as:

- People who are not able to access Medicare funded mental health services;
- People less able to pay fees;
- People in rural and remote locations;
- Aboriginal and Torres Strait Islander people;
- People with Culturally and Linguistically Diverse (CALD) backgrounds; and
- People who experience or at risk of homelessness.
- Children under the age of 12
- Young people
- Women experiencing post-natal depression
- People at risk of suicide
- Residents of Aged Care Facilities experiencing mental illness

PTS has been established to ensure that groups who have traditionally had difficulty accessing services are provided high quality mental health care. These services aim to reach those with mild to moderate mental illness within a stepped care model of primary mental health services. The following checked categories are considered "in scope" for PTS and will be delivered as part of Western Victoria PHN contract. Providers with associated qualifications and credentials are able to deliver services under one or more of these categories.

☒ **Category A: General**

Evidence-based, short-term psychological interventions to individuals (12 years +) with a diagnosable mild to moderate, mental illness.

☒ **Category B: Children**

Evidence-based, short-term psychological interventions to children (up to 12 years of age) at risk of developing a mental illness.

☒ **Category C: Suicide Prevention**

The Suicide Prevention category aims to reduce current risk of suicide / self-harm by resilience building, increasing self-awareness and solution focussed work. Evidence-based, short-term psychological interventions to people who have attempted, or who are at risk of suicide or self-harm. No formal diagnosis is required. An initial formal intervention is defined as a meaningful clinical contact that is appropriate to determine level of risk and immediate clinical management.

☒ **Category D: RACFs**

Evidence-based, short-term psychological interventions to individuals / residents of Residential Aged Care Facilities who have a diagnosable mild to moderate, mental illness.

PTS - Eligibility

To be eligible for PTS, an individual must live, work or go to school in the Western Victoria PHN region and be diagnosed as having a mental illness by a General Practitioner (GP) or an equivalent medical practitioner and have a current and valid Mental Health Treatment Plan (MHTP) prepared by the GP. The GP continues to play a central role in the provision and coordination of care within a primary care setting to PTS clients. PTS is particularly suitable for providing short term psychological services to underserviced or hard to reach groups presenting with:

1. **Low need Mild presentations** - (high prevalent disorders): requiring brief psychological interventions up to 5 sessions. These can be provided via face to face, phone or Skype, delivered by mental health nurses, psychologists, social workers and occupational therapists.
2. **Moderate need Moderate presentations** - (high prevalent disorders) requiring medium term psychological interventions up to ten sessions. These can be provided via face to face, phone or Skype.

In some cases, people with severe mental illness (who are receiving services through moderate to severe mental health programmes) may benefit from short term, focused psychological intervention as part of their overall care.

Note: PTS is for clients experiencing mild to moderate mental illness who are not clinically suited to lower intensity levels of intervention, including self-help, digital mental health services and low intensity mental health services and who are underserviced through other arrangements, particularly the Medicare Benefits Schedule (MBS).

Programme Exclusions:

PTS is not a:

- crisis service
- drug and alcohol service
- sexual assault service
- domestic violence service
- couples or family counselling service

- homelessness support service.

Dementia, delirium, tobacco use disorder and intellectual disability are not regarded as mental disorders for the purposes of this program scope.

Interventional approaches in scope for PTS

Treatments are limited to evidence based Focused Psychological Strategies (FPS) indicated by the Department of Health, under the "Better Outcomes in Mental Health Care Initiative". These are:

- Cognitive behaviour therapy (CBT)
- Interpersonal psychotherapy (IPT)
- Narrative therapy
- Family therapy and family-based interventions
- Mindfulness-based cognitive therapy (MBCT)
- Acceptance and commitment therapy (ACT)
- Solution-focused brief therapy (SFBT)
- Dialectical behaviour therapy (DBT)
- Schema-focused therapy
- Psychodynamic psychotherapy
- Emotion-focused therapy
- Hypnotherapy
- Self help
- Psychoeducation

Clinical Governance and Service Quality

APMHA Healthcare maintains robust clinical governance and quality assurance processes to ensure delivery of high quality clinical services. These processes include:

- Availability of clinical governance framework, policy and procedures for staff and contractor reference and guidance (Available via apmhahealthcare.com.au)
- maintaining our provider database of PTS MHPs, their qualifications, specialties, training, availability, service location/s, professional body registration, current insurances and criminal clearances;
- ensuring appropriate clinical supervision arrangements are in place;
- ensuring clinical oversight of client care arrangements, timely service delivery and follow up;
- ensuring treatment and recovery plans are in place, prepared in consultation with the client and any family, carers or significant others as requested by the client, identifying goals for treatment and recovery;

- ensuring transition pathways are in place that allow clients to seamlessly move to an appropriate alternate service, or up and down “steps” should their circumstance / need change;
- ensure relapse prevention is included in exit / discharge processes
- ensure consistency with standards articulated in the new National Standards for Mental Health Services 2017 and all other relevant standards and legislative/regulatory requirements;
- promotion of recovery from mental illness, in line with the National Standards for Mental Health Services 2017, the National Practice Standards for the Mental Health Workforce 2013 and the National Framework for Recovery Oriented Mental Health Services 2013 all found on apmhahealthcare.com.au
- Ensure compliance with consent, confidentiality, privacy, medical records maintenance and secure transfer of client information.

Service Requirements

The service requirements of each party are as follows:

Promotion and branding

(a) Western Victoria PHN and APMHA HealthCare will coordinate the promotion of PTS and referral pathways

(b) Any promotional material must be developed in line with APMHA HealthCare and Western Victoria PHN guidelines and approved by prior to release.

Client Information Management System – Bridge CRM

(a) APMHA HealthCare MHPs must agree to use the client management system known as Bridge CRM and agree to attend training in the use of this system.

(b) Bridge CRM is used to support central intake and allocation, record keeping, session data entry and financial management of PTS. Bridge CRM also supports Minimum Data Set (MDS) reporting to the PHN and the Department of Health and its use is a mandatory requirement for MHPs delivering PTS.

(c) Access to, and training in the Bridge CRM will be provided to APMHA HealthCare staff and MHPs by the Western Victoria PHN and is accompanied by a user guide which is located on both APMHA HealthCare website.

(d) No clinical documents or notes are to be held on Bridge CRM. APMHA HealthCare MHPs are expected to keep their own records for auditing purposes.

Western Victoria PHN Referral Point

Western Victoria PHN will be responsible for the intake and allocation of PTS referrals across the region.

Referral Point will:

- provide a vital interface between Western Victoria PHN, General Practice, and providers and mental health services;
- enable the management of referrals for psychological therapy services, ensuring referrals meet the criteria for the services and direct referrals to an appropriate treatment service; and
- assess referrals in order to identify the appropriate referral end point. The most suitable provider in a region will receive the referral based on the referral information and known availability of service providers and skill mix.

The determination of the appropriateness of referrals against the eligibility criteria and appropriate provider of treatment services will be made. If clarification of any aspect of a referral is required, this will be identified and acted on via Referral Point and more information sought, or where there are concerns about the appropriateness of the referral, this will be addressed with the referring health professional.

Eligibility criteria for Mental Health Professionals to deliver PTS

To ensure a high-quality standard of service delivery APMHA HealthCare must engage appropriately trained and qualified mental health professionals who have extensive experience and training in working with clients.

All sessions must be delivered by credentialed mental health professionals who hold registration with their relevant professional body, including AHPRA, and adhere to the professional ethics of their professional associations.

Eligible providers include:

- Credentialed mental health nurses;
- Mental health occupational therapists;
- Social workers (mental health);
- Psychologists (Registered and Clinical);
- Aboriginal and Torres Strait Islander Health Practitioner (AHPRA registered).

Other mental health professionals who do not meet the above criteria and who are engaged to deliver Services must be:

- qualified and experienced in the delivery of focused psychological therapies directly under the supervision of a credentialed Mental Health professional;
- where clinical governance for the intervention is held by a credentialed Mental Health professional; and
- Clinical Governance frameworks are clearly documented and with clinical risk managed by a credentialed Mental Health professional.

All professionals must have a valid Working with Children's Check and Police Check.

Services must be delivered in accordance with the program guidelines and practice consistent with standards articulated in the National Standards for Mental Health Services 2010 and all other relevant standards and legislative/ regulatory requirements.

Appropriately qualified, experienced and supervised workers from other disciplines may provide services where the above qualified workforce shortages necessitate. They must be supervised by an appropriately credentialed professional above listed categories. Western Victoria Primary Health Network and APMHA Healthcare must approve use of these groups in writing, prior to them commencing service delivery.

Overview of service requirements

	Category A: General (includes RACFs)	Category B: Children	Category C: Suicide prevention
Service	Provide evidence based, short term psychological intervention to adults (12+) with a diagnosable mild, moderate or in some cases severe mental illness Evidenced Based Treatments	Provide evidence based, short term psychological intervention to children (up to 12) at risk of developing a mental illness.	Provide evidence based, short term psychological intervention to people who have attempted, or who are at risk of suicide or self-harm.
Referral Source	General Practitioners Aboriginal and Torres Strait Islander Health Practitioners	General Practitioners Paediatricians Aboriginal and Torres Strait Islander Health Practitioners	General Practitioners Aboriginal and Torres Strait Islander Health Practitioners
Referral acceptance	Within 5 business days of referral		Within 24 hours (1 business day) of referral Face to Face contact within 72 hours (3 business days) of referral.
Intervention	Within four (4) weeks of acceptance of the referral		Within 24 hours of acceptance of referral for 100% of clients
Delivery method	Face to Face Web Conferencing Telephone – (if outlined as a part of care plan)	Face to Face Face to Face with Parents Web Conferencing	Face to Face Telephone – (if outlined as a part of care plan)
Sessions	Up to 10 sessions to be utilised within the current financial year. Sessions must be a minimum of 45 mins		Up to 10 sessions within 2 months of referral Sessions must be a minimum of 45 mins
Types of Evidenced Interventions	Cognitive Behavioural Therapy - Behavioural Interventions Cognitive - Interventions - Relaxation Strategies - Skills Training Psycho-Education Interpersonal Therapy Narrative Therapy (ATSI only)	Cognitive Behavioural Therapy - Behavioural Interventions Cognitive - Interventions - Relaxation Strategies - Skills Training Psycho-Education Interpersonal Therapy Narrative Therapy (ATSI only) Parent Training in Behaviour Management Family-based interventions Attachment intervention Parent-Child Interaction Therapy	Cognitive Behavioural Therapy - Behavioural Interventions Cognitive - Interventions - Relaxation Strategies - Skills Training
Outcome Reports	Outcome reports to be provided within 2 weeks of completion of sessions 7 and 10 or at completion of treatment.		
Outcome Measures	K10 or K5 Work and Social Adjustment Scale	Strengths and Difficulties Questionnaire (SDQ)	Modified Scale for Suicidal Ideation (MSSI) K10 or K5

General inormation about consultation sessions

Individual sessions – PTS:

Treatment under Psychological Therapy Services (PTS) is as follows:

- Up to 10 treatment sessions can be delivered by the MHP to each client;
- Clients will initially be allocated 4 sessions;
- An additional 3 sessions (sessions 5-7) will be made available on completion and submission of an outcome measure report to BridgeCRM and where on-going treatment is clinically indicated;
- A further 3 sessions are also available (8-10) following a Session Request for a GP review and completion of an outcome measure review;
- All 10 sessions must be completed within 12 months of the GP referral and MHTP being completed;
- Each session shall be provided on the basis of at least 45 minutes sessions;
- MHPs must ensure that each service provided under PTS includes psychological treatment, recording of required data in the MDS and preparation of feedback to GP;
- MHPs must record all relevant information, outcome scores and MDS data for individual and group sessions; and upload all correspondence including GP reports and letters in the Bridge CRM within 5 working days of delivering the session with a client;
- A 'no show' is defined as a client not showing up for an appointment on the day it was booked;
- MHPs must ensure that each Session is conducted on a separate date;
- Sessions cannot continue until the Mental Health Treatment Plans are loaded into Bridge CRM OR sent by the GP to Referral Point and approved and allocated.
- The MHP must:
    (i) verbally explain the APMHA HealthCare client consent and client charter at first appointment and provide the consumer with a copy.
    (ii) administer the required clinical and client rated outcome tool (K10+, K5, Social Adjustment Scale, SDQ and Modified Scale for Suicidal Ideation (MSSI)) at required intervals for each client referral. These are to be uploaded into Bridge CRM:
    (iii) implement a client experience of service measure as determined by APMHA HealthCare;
    (iv) provide timely and comprehensive written feedback to the General Practitioner within 5 working days and uploaded into Bridge CRM, for each client referred after;
        - Initial consultation

- the completion of an allocated block of sessions
- at the point of discharge.

(v) Participate in review and evaluation of PTS as directed by Western Victoria PHN.

- Services must be delivered within the Western Victoria PHN catchment area and from locations that are easily accessible to clients, including those with a disability. APMHA HealthCare and the MHP warrants that the location complies with relevant WHS policies and appropriate insurance coverage is in place.
- MHPs must ensure that no co-payment, gap fee or cancellation fee is to be charged to the client.
- Western Victoria PHN and APMHA HealthCare will NOT reimburse for 'no shows' or any travel costs.
- APMHA HealthCare and the MHPs will maintain adequate and legible records of all services provided as part of the PTS. Such records by law must be kept for 7 years following completion of treatment or in the case of minors until they reach age 25.

Suicide Prevention

The focus of the intervention is to reduce current risk of suicide / self-harm by resilience building, increasing self-awareness and solution focused work. Clients can be moved from the Suicide Prevention category General category when the crisis abates according to the longer-term needs of the client. No diagnosis is required for Suicide Prevention.

A client that has completed up to 10 sessions of treatment, may be eligible for referral to Category A (General) or B (Child). Access to Category A or B requires a referral from an appropriate referral source.

Children

For the purposes of managing funding and reporting requirements Category B (Child) will be defined as Under 12 years. Clinically however, child and youth expertise will be recognised as being specifically relevant up to the age of 18 years. Next of Kin details remain a requirement for 12-16-year olds.

Contractor's Responsibility and Reporting Requirements

Outcome Reports

Contractors must provide an initial confirmation of engagement of treatment with clients to the referring GP after session one (1).

Outcome Reports must be provided to the referring GP at session one (1), five (5) and ten (10) or discharge.

Outcome reports must be completed on the template provided by Western Victoria PHN (or APMHA HealthCare in the absence of a template provided by Western Victoria PHN).

Outcome reports must be provided to the GP and uploaded on the Bridge CRM reporting system within 5 days of the relevant session.

Program evaluation reports must be provided upon request.

Performance Measures

The following mandatory performance measures apply:

- For suicide prevention the provider must have a formal intervention with the client within 48 hours from receipt of referral. Face to face, intervention is preferred, but not necessarily required within the initial response time.
- For all other clients the provider must have formal intervention with the client within four (4) weeks from receipt of referral.
- Reports must be submitted within two (2) weeks of the relevant appointment.

Discharge Requirements

Sessions must be completed within the specified timeframes. Where possible discharge should be planned and any recommendations for follow-up should be clearly communicated. GP's should be informed in writing at discharge as well as at other points in the intervention. All MDS data must be completed.

Referral Point

- Referral is the process for all GP referrals, service supplier allocation and data collection for reporting requirements.
- All Contractors must have internet service that enables access to the Client Management System - Bridge CRM.
- Contractors are required to maintain their interface with the Western Victoria PHN Client Management System - Bridge CRM to ensure that information is current.
- APMHA HealthCare may inform Referral Point of Contractors with specific expertise related to mild to moderate mental illness.
- *NOTE: The Western Victoria PHN data system is not designed to store clinical records pertaining to client progress during treatment and intervention. It is expected that all Contractors will make appropriate arrangements on how to securely store clinical information related to client clinical progress/presentation.*

Referrals

- All Psychological Therapy Services are initiated through a GP referral to Referral Point.
- All referrals must be managed through Referral Point.
- All eligible referrals will be allocated at the discretion of Referral Point.
- All referrals received through Referral Point will generate a notification to the referring GP to inform that their client has been accepted by a Provider along with the Provider's details.

- GPs may nominates a preferred Provider, however APMHA HealthCare as the Supplier, has the authority to reallocate to an alternative APMHA HealthCare Provider where clinically appropriate.
- Referral Point will notify the Supplier when a new client is allocated.
- When a referral is allocated to a Supplier, the Supplier must notify Referral Point to confirm acceptance or rejection of the referral within five (5) business days for Category A and B, and one (1) business day for Category C.
- Where the referral is rejected by a Supplier or Provider a reason is to be given.

Acceptance/Rejection of Referral

- Category A (General) and Category B (Children) – The Contractor must notify APMHA HealthCare within five (5) business days of outcome of referral.
- Category C (Suicide) – The Supplier must notify APMHA HealthCare within one (1) business day of outcome of referral.

Delivery and Treatment Methods for Category A General and Category B Children

- Evidence based short term psychological interventions must be provided to individuals with a diagnosed mild to moderate mental illness.
- Face to face interventions must be provided unless other technology hosted modes of delivery are detailed in the GP Mental Health Treatment Plan or approved by Western Victoria PHN or APMHA HealthCare.
- Professional interpreter services must be provided when the need is identified by the GP for culturally and linguistically diverse or hearing impaired clients.
- Minimum session duration is forty-five (45) minutes.
- Formal intervention by the provider must be within four (4) weeks of acceptance of the referral.
- The GP's decision for further treatment must be processed through Referral Point.
- Up to a maximum of ten (10) sessions must be completed by the provider within twelve (12) months of receiving the GP referral.
- The formal summary and progress report must be provided to the GP within two (2) weeks of completion of sessions one (1), five (5) and ten (10) or at discharge.
- Acceptance or rejection of all referrals made to the supplier will be confirmed within one (1) business day of the referral being processed by Referral Point.
- All session data must be entered into the Client Management System - Bridge CRM.

Delivery and Treatment Methods for Category C Suicide Prevention

- The Suicide Prevention category aims to reduce current risk of suicide / self-harm by resilience building, increasing self-awareness and solution focused work.
- Acceptance or rejection of all referrals made to the supplier are to be confirmed within one (1) business day of the referral being processed by Referral Point.
- Face to face interventions must be provided unless telephone treatment is outlined in the GP Mental Health Treatment Plan.

- Professional interpreter services must be provided when the need is identified by the GP for culturally and linguistically diverse or hearing impaired clients.
- Minimum session duration is forty-five minutes (45) minutes.
- A formal intervention must be provided within twenty-four (24) hours of acceptance of referral for 100% of clients. Face to face, intervention is preferred, but not necessarily required within the initial response time.
- Up to a maximum of ten (10) sessions must be completed by the provider within two (2) months of receiving the GP referral.
- The GP's decision for further treatment must be processed through Referral Point. Transfer from the suicide prevention program to the General Category A or Children Category B may occur when the relevant criteria are met.
- The formal summary and progress report must be provided to the GP within two (2) weeks of completion of sessions one (1), five (5) and ten (10) or at discharge.
- All session data must be entered into the Bridge CRM.

APMHA HealthCare Ltd MHPs Requirements

Arrangement of Appointments

The MHP will not unreasonably refuse a client referred, and where a client is refused, contact APMHA HealthCare to discuss.

Service Delivery

On acceptance of the referral, the MHP agrees to provide the requested services in a timeframe that is acceptable to the client, the referrer and the programme's guidelines.

The MHP agrees to:

- Provide the premises and all costs associated with the operation, maintenance and safety of such premises where consultations are provided in the MHP's consulting rooms;
- Be responsible for the provision of all resources, stationery and equipment, maintenance of records, on-going professional development and maintenance of professional standards; and
- Not charge the referred client any gap fee or other payment for the consultation(s).
- The services are to be delivered in accordance with the program guidelines.
- At the completion of the final session the MHP will ask the client to complete a "Client feedback Questionnaire" with an APMHA HealthCare addressed pre-paid envelope or online at the APMHA HealthCare website: www.apmhahealthcare.com.au Completion of this survey is voluntary and anonymous and will not affect further services provided to the client. All responses are confidential and will be used for evaluation purposes only.
- The MHP must provide all the information required for the Minimum Data Set on BridgeCRM system within 5 days of a session.

- The MHP must provide the referring GP with the relevant interim, progress and final reports at nominated session times

Cancelled Appointments

APMHA HealthCare will not pay the MHP a fee in respect of a client cancellation.

It is the MHP's responsibility to advise the client of their cancellation policy at the time of making the appointment and again prior to commencing treatment,

In the event that the client contacts the GP and/or Western Victoria PHN to advise that they do not wish to continue with the service, the MHP will be notified. The client reserves the right to terminate treatment at any time. In this event, APMHA HealthCare will not be liable for payment of any remaining sessions.

Minimum Record Keeping Responsibilities

A minimum standard of record keeping and reporting is required by all MHPs contracted with APMHA HealthCare. This includes:

(a) Every contact with client dated (whether face to face or otherwise);

(b) Written record of any advice given; and

(c) More detailed record taken regarding any unsafe or risky situation; and

(d) At least a paragraph to be written on each face-to-face contact; and

(e) Written record of attempts to contact any client who has failed to attend.

Reporting Obligations

The MHP must provide a formal summary and progress report as set out by APMHA HealthCare and/or Western Victoria PHN. This should include a summary of progress, any ongoing issues and management needs. Recommendation of alternative services for the enhanced benefit of the referred client, is recommended for discussion with the referrer (on a case by case basis) prior to engaging these services, e.g. if a referral to a Psychiatrist or community/group programme is required.

Communication

It is the MHP's responsibility to ensure that effective, prompt communication is provided back to the referrer around delivery of client care. If there are any disputes or grievances identified between the MHP and a referrer, the MHP must:

- Contact the referrer directly to attempt to resolve the issue;
- Notify APMHA HealthCare General Manager, Clinical, of the issue and the action taken to resolve the matter.

If a referrer contacts APMHA HealthCare with a dispute or a grievance regarding a MHP, APMHA HealthCare must:

- Contact the MHP to discuss the matter;
- Provide feedback to the referrer; and

- Log the issue and any actions taken to resolve the matter.

Co-Payments

Under no circumstances must the MHP ask for or accept a co-payment from a client referred for services under this programme.

Payment for Services

Payments will be made as per the terms set out in the MHP individual Service Agreement.

- APMHA HealthCare will be responsible for payment of sessions delivered by the MHP. However, payment will not be made if the MHP's paperwork is incorrect or incomplete or the MHP has not complied with reporting requirements and data input via the CMS.
- APMHA HealthCare will not make payment for sessions where incorrect or incomplete information is entered onto CMS.
- All payment enquiries will need to made in writing and directed to the APMHA HealthCare Finance Department – **finance@apmhahealthcare.com.au**

Psychological Outcome Measures

Outcome Measures are available in Bridge CRM.

Frequency of Measures:

- Kessler 10 (K10), Kessler 5 (K5), Modified Scale for Suicidal Ideation (MSSI) outcome measure reports to be completed at sessions 4, 7 and 10 / last session and entered onto Bridge CRM.
- Work and Social Adjustment Scale to be completed at sessions 1, 4, 7 and 10/last session for General and Suicide Prevention Program clients and entered onto Bridge CRM.
- SDQ outcome measure reports to be completed at sessions 1 and 10 / last session for Child Program and entered onto Bridge CRM.
- Outcome measure report can be completed by the clinician in the client's absence. Should this occur, it should be clearly indicated.

In addition, Contractors may use any outcome measures they are experienced in using, including:

- Edinburgh Post-natal Depression Scale EPNDS
- Kessler Psychological Distress Scale K10 +
- Kessler Psychological Distress Scale K5 (For ATSI clients)
- Modified Scale for Suicide Ideation MSSI
- Strengths and Difficulties Questionnaire – Parent of 4 -10 year olds SDQPC
- Strengths and Difficulties Questionnaire – Parent of 11 – 17 year olds SDQPY

- Strengths and Difficulties Questionnaire – Self-completion by 11 - 17 SDQYR

People Who Self-Harm or Who Are at Risk of Suicide

(Including Those Who Have Had a Suicide Attempt)

- Evidence suggests that cognitive behavioural therapy (CBT) and problem-solving therapy (PST) have a significant effect on reducing attempts and re-attempts. For suicide prevention providers must have a formal intervention with the client within 24 hours from receipt of referral (this must be met for 100% of clients).
- Services under suicide prevention are not intended to replace the services provided by Local Health Districts, nor is it expected to replace emergency responses.

Minimum Data Set (MDS)

The MDS was developed to gather common, basic information and therefore acts as an important evaluation tool. The MDS will be entered on Western Victoria PHN Bridge CRM database

The MDS is designed to capture de-identified, consumer-level information. The MDS is invaluable in collecting information that provides a picture of the level of uptake of the projects (by GPs and other referrers, Allied Health Professionals and consumers), a description of the socio-demographic and clinical characteristics of consumers, and an overview of the services they are receiving.

Contractors are responsible in ensuring that all session data is entered on the Western Victoria PHN Client Management System - Bridge CRM - within 5 business days of the delivery of session as prescribed (including but not limited to):

- Session Data
- Type of Interventions
- Clinical measures.

The MDS collected may include (but is not limited to):

- Date of Birth
- Gender
- Language
- Diagnosis
- Type of Focussed Psychological Strategies being provided
- Psychotropic Medication
- Patient's name

Information required to satisfy the MDS may vary depending on the contractual obligations set out and will be determined by the contracted services APMHA HealthCare is funded to provide. If the Contractor agrees to provide services under said contract, they agree to provide the necessary data attributed to the contract.

Interpretor Services

People with Culturally and Linguistically Diverse (CALD) backgrounds are a specifically identified cohort that experience difficulty accessing services. When language or hearing impairment are identified as challenges to delivering Psychological Therapy Services, professional interpreter services may be required.

This should be identified by the referrer and included in the referral information.

The use of interpreter services requires approval by Referral Point. These costs will be applied in addition to the session fees. Approved Interpreter service costs need to be invoiced separately and submitted to Referral Point.

Referral Point will pre - approve funding of appropriately qualified and credentialed interpreter services accessed from an external source from the Supplier organisation.

If a Supplier receives a referral and interpreter services are not identified but the provider believes an interpreter is required, the Provider should inform Referral Point by email and have interpreter services approved by Referral Point.

Treatment Completion

Treatment must be completed within specified timeframes as per the Services Agreement. Where possible session completion should be planned and any recommendations for follow-up should be clearly communicated to the GP.

Treatment completion is considered to be:

- at the end session 4, session 7 or session 10;
- if the Provider/client believes the clients has met treatment goals; or
- if the client has attended at least one appointment but does not attend more than one follow up appointment.

It is expected that Providers follow up clients that do not attend sessions and discuss any decision to no longer follow up a client with Referral Point.

All session data, including clinical measures, must be completed in the CRM and a Clinical Outcome Report must be sent to the GP within two (2) weeks of the last session (in no less than 80% of

instances). Verification that this has occurred should be noted in the Referral Conclusion page and the referral closed.

Closure where treatment is not complete

Where a client ceases to attend, refuses further contact, fails to attend two appointments or has no contact for sixty days, ***the case should be closed***, a clinical outcome report sent to the GP and an outcome measure entered on Bridge CRM.

Closure definitions are as follows:

1. Episode closed - treatment concluded
2. Episode closed administratively - client could not be contacted
3. Episode closed administratively - client declined further contact
4. Episode closed administratively - client moved out of area
5. Episode closed administratively - client referred elsewhere
6. Episode closed administratively - other reason

Notes: In order to use code 1 (Episode closed - treatment concluded) the client must have at least one service contact. All other codes may be applicable even when the client has no service contacts.

1 - Episode closed - treatment concluded - No further service contacts are planned as the client no longer requires treatment.

2 - Episode closed administratively - client could not be contacted - Further service contacts were planned but the client could no longer be contacted

3 - Episode closed administratively - client declined further contact - Further service contacts were planned but the client declined further treatment.

4 - Episode closed administratively - client moved out of area - Further service contacts were planned but the client moved out of the area without a referral elsewhere. Where a client was referred somewhere else Episode Completion Status should be recorded as code 5 (Episode closed administratively - client referred elsewhere).

5 - Episode closed administratively - client referred elsewhere - Where a client still requires treatment, but a different service has been deemed appropriate or a client has moved out of the area so has moved to a different provider.

6 - Episode closed administratively - other reason - Where a client is no longer being given treatment but the reason for conclusion is not covered above.

Where a client has been accepted and contact attempted but not made the provider remains responsible for closing the client on Bridge CRM and providing the clinical outcome report to the referrer.

Referral Point reserves the right to close clients where no activity has taken place for sixty-plus days without reason. The provider remains responsible for informing the referrer of the clinical outcome.

Referral Point may close a client when a review is pending if there has been no activity for sixty- plus days.

The referral will be reopened on receipt of review and the provider informed.

Better Access and PSS

In the instance where an individual has received the ten psychological therapy services available under Better Access through the Medicare Benefits Schedule initiative and is considered to clinically benefit from additional services, the individual may be eligible for PHN funded Psychological Therapies if they meet the relevant eligibility criteria. Further information from the MBS is available here (Item number 2712, Associated Notes, Referral):
http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=2712#assocNotes

Clinical Monitoring and Audit

Regular auditing is randomly conducted by an APMHA HealthCare appointed auditor to ensure compliance with administrative and communication processes for the programme.

MHPs undergoing an audit will be advised 2 weeks prior to the agreed date and informed which consumer records will be audited.

A review of an agreed number of clinical records and client feedback forms will be conducted to assess in the following areas:

- client perceptions of the intervention, and satisfaction levels,
- the quality of information in case notes,
- the outcomes of care such as changes in psychological outcome assessments, observed changes in behaviour, physical changes, improved relationships, or other determinants of health (e.g. improved parent/ child attachment for CMHS providers),
- compliance with clinical/ programme guidelines for service provision,
- compliance with legal requirements,
- compliance with professional guidelines, and
- compliance with ethical guidelines of professional bodies.

To obtain this data, two or more methods will be used:

- an audit of a random sample of client records, sufficient to adequately review the clinical records of each discipline and individual professional. The number of client records audited should be no less than 10% of the overall clinician's programme caseload, and
- analysis of client feedback forms.

Findings will be documented using the APMHA HealthCares Clinical Record Report and Audit Summary Form.

Audit findings will be reported in writing to all MHPs affected by the audit and a process of implementing necessary improvements engaged including but not limited to:

- team meetings
- training sessions, and
- peer supervision.

All services rendered must be within the guidelines and provision of service delivery outlined in the contract and the PHN programme guidelines.

APMHA HealthCare LTD program management and support

Contract Management

Contract and HR management is provided by APMHA HealthCare's General Manager - Operations.

Communication

All MHPs will receive regular e-news and updates about program delivery. When required, MHP will be invited to participated in a 'go to meeting' (Webinar) to trouble shoot, discuss and update on program delivery.

Quality Documents For Contractors And Employees

Relevant policies, procedures, frameworks and supporting documents have been developed to guide service delivery for contractors and staff. Please note all documents will be available on the APMHA HealthCare's website: www.apmhealthcare.com.au/resources. If you do not have access to these documents, please notify APMHA HealthCare.

Quality documents which are relevant for MHPs includes (but is not limited to):

- Clinical Governance Framework
- Clinical Governance Procedure
- Policy for clinical pathways for PHN Psychological Services Programmes
- Clinical Audit Procedure
- Service Delivery Policy
- APMHA HealthCare Service Delivery and Orientation Manual (this document)
- Recovery Oriented Practice Guidelines
- Psychological Services Program Intake and Allocation Procedure
- Psychological Services Program - Allocations procedure when program is at capacity
- GP mental health treatment plan and referral forms - MD / BP & Zed Med versions
- Psychological Services – GP notification templates (First Appointment, Initial, Progress & Final report
- Client Management System (BrdgeCRM) Userguide

- APMHA HealthCare Relapse Prevention Toolkit
- Consumer Consent Form & Rights / Responsibility Charter
- Transition of Care Consent Form
- Privacy Policy
- Consumer Health Records Policy
- RACGP Patient Privacy Pamphlet
- Stakeholder engagement strategy
- Feedback and compliments and complaints procedure
- Open Disclosure Policy
- Credentialing & induction procedure
- Provider credentialing Audit Form
- Supervision Record template
- Clinical Supervision Guidelines
- Guidelines for reflective practice
- Group and individual supervision agreement templates
- Clinical Incident Procedure
- Clinical Incident Notification Form
- Contractor induction checklist
- Infection prevention and control in clinical settings policy
- Home visiting procedure
- Clinical Settings Guideline and Checklist

REFERENCE DOCUMENTS FOR CONTRACTORS AND EMPLOYEES (located on APMHA's website)

- Australian Charter of Health Care Rights
- National Mental Health Standards 2017
- Victorian Charter of Human Rights.
- Recovery Star User Guide
- Recovery Star Organisation Guide
- APMHA Relapse Prevention Toolkit
- Evidence-based Mental Health Promotion Resource
- A practical guide for working with carers of people with a mental illness
- Principles and actions for services and people working with children of parents with a mental illness
- Physical health and care for people with mental health conditions
- Working Safely in Community Services
- PHN CMS user guide
- Primary Mental Health Program Guidelines
- National Mental Health Commission's *Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services.*
- The Commonwealth Government response to *Contributing Lives, Thriving Communities*.

KEY CONTACTS

APMHA HealthCare Ltd key contacts:

Corporate office 7 Norwood Place, Flemington. Vic 3031 P.O. Box 391, Flemington. Vic. 3031 **Hours of operation** 8:30am – 5pm Mon – Friday Closed on National Public Holidays Closed 24th Dec – 1st Jan inclusive	Phone: 1300 514 811 Fax: 03 9376 0317
Website:	www.apmhahealthcare.com.au
General enquiries and support:	1300 514 811 admin@apmhahealthcare.com.au
Central intake, triage and allocations	1300 514 811 allocations@apmhahealthcare.com.au
Finance administration:	1300 514 811 finance@apmhahealthcare.com.au
Renee Hayden Chief Executive Officer	1300 514 811 renee@apmhahealthcare.com.au
Donal McGoldrick General Manager – Operations (Deputy CEO)	1300 514 811 donal@apmhahealthcare.com.au
Jennifer Craggs General Manager - Clinical	1300 514 811 jennifer@apmhahealthcare.com.au
Tung Le General Manager - Service Delivery	1300 514 811 tung@apmhahealthcare.com.au