



Mental Illness Claim Management Guidelines

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Contents

| | |
|--------------------------------------|----|
| Introduction | 03 |
| Acknowledgements | 04 |
| Purpose | 05 |
| Mental Illness – An Overview | 06 |
| Suicide and Self Inflicted Harm | 11 |
| Mental Illness Awareness - Education | 16 |
| Stakeholder Responsibilities | 21 |
| Claim Practice Model | 24 |
| Mutual Benefits | 30 |
| Appendix I | 32 |

Introduction

These guidelines have been developed by the participating Insurers of SuperFriend - Industry Funds Forum Mental Health Foundation ('SuperFriend'). This paper outlines a case management model that stakeholders may choose to implement when considering proactive assessment methodologies for mental illness claims.

Acknowledging that industry superannuation funds offer default levels of insurance cover to members, stakeholders of SuperFriend expressed desire to improve the current systems and processes available for managing mental illness claims.

Mental health professionals have reported that people with mental illness may have negative experiences with service providers during the management of their illness. This can stem from a range of processes, including initial diagnosis, the health care system, employment and insurance. Unsurprisingly, these experiences may impact on how a member relates to and engages with the claims process.

This strengthens SuperFriend's recommendation for a case management model, where the quality of the engagement and the member experience of the process is a priority.

These guidelines draw on expert advice from participating organisations belonging to the insurance, industry fund and mental health sectors. The guidelines apply to the management of Income Protection Claims where Mental Illness is the primary disabling condition. Strategies that may be applicable for Total and Permanent Disability (TPD) claims are outlined at Appendix 1.

Each claim is different and the claims management model suggested herein may not be relevant in all circumstances. Stakeholders should consider the appropriateness of these guidelines on a case by case basis.

This paper also illustrates the benefits of rehabilitation. It is acknowledged that insured members are not bound by the policy to undergo rehabilitation and should seek pre-approval from their treating doctor or allied health professionals.

Industry Members are bound to comply with all applicable law including the Trade Practices Act (Cth). These guidelines are not intended to contravene any such law or to create an obligation that they be followed.

Acknowledgements

SuperFriend would like to thank the organisations and individuals who have contributed significantly to the development of these Claims Management guidelines.

This commitment demonstrates a drive to deliver improvements to the management of mental illness claims, as well as broader process improvements to enhance the member experience.

“SuperFriend and the sector deserve to be patted on the back for having the courage to bring the complex issue of mental illness and its consequences into the open.

This work recognises the importance education and awareness plays as a preventative and constructive approach to a still often misunderstood subject.

New understanding of mental health vulnerabilities will go a long way to help improve the sector's working processes and practices and is a huge step forward in destigmatisation and discrimination.”
- Ingrid Ozols, Managing Director mh@work®, Workplace Mental Health educator and advocate.

SuperFriend wishes to thank the following organisations for their contribution:

- AIA Australia
- Asteron
- *beyondblue*: the national depression initiative
- *beyondblue* blueVoices Consumer Group
- Commlnsure
- ConNetica Consulting
- Hannover Life Re
- IFSA
- IFS Insurance Broking
- Industry Funds Forum
- Mental Health @ Work
- Mental Illness Fellowship Australia (MIFA)
- MLC
- REST
- SANE Australia
- Suncorp
- Superannuation Complaints Tribunal
- Superpartners
- Tower Australia

Purpose

Industry Superannuation Funds are concerned about the incidence of insurance claims arising from mental illness and the suicide of members, especially those in known high risk categories. The cost of mental illness and suicide in personal, social and economic terms is significant. In collaboration with the public and not-for-profit sectors, the industry must play a role in reducing this burden on the Australian community.

A need was identified to create a document similar to that developed by Investment and Financial Services Association Limited (IFSA) - Mental Health Claims Guidelines - and expand further on the issues that affect the management of Industry Super claims, namely Income Protection, Death and Total and Permanent Disability claims.

This document will discuss some of the options available to insurers and present some new case management concepts that challenge the traditional assessment method that exists between the fund, administrator and insurer. In addition, these guidelines aim to play an educative role in the industry superannuation and insurance industries, with a view to challenging and alleviating common misconceptions about mental illness, suicide and insurance.

This document reflects contemporary understanding and evidence in relation to the prevention, early intervention, treatment and recovery of people with a mental illness.

It emphasises the need for early action and assertive case management by insurance case managers with all relevant parties including the member/representative, medical practitioner and employer.

The quality of the engagement by the case manager is a key factor in achieving positive outcomes for all parties. The document also challenges some of the myths, misconceptions and stigma that impact on a client's willingness to disclose mental health conditions.

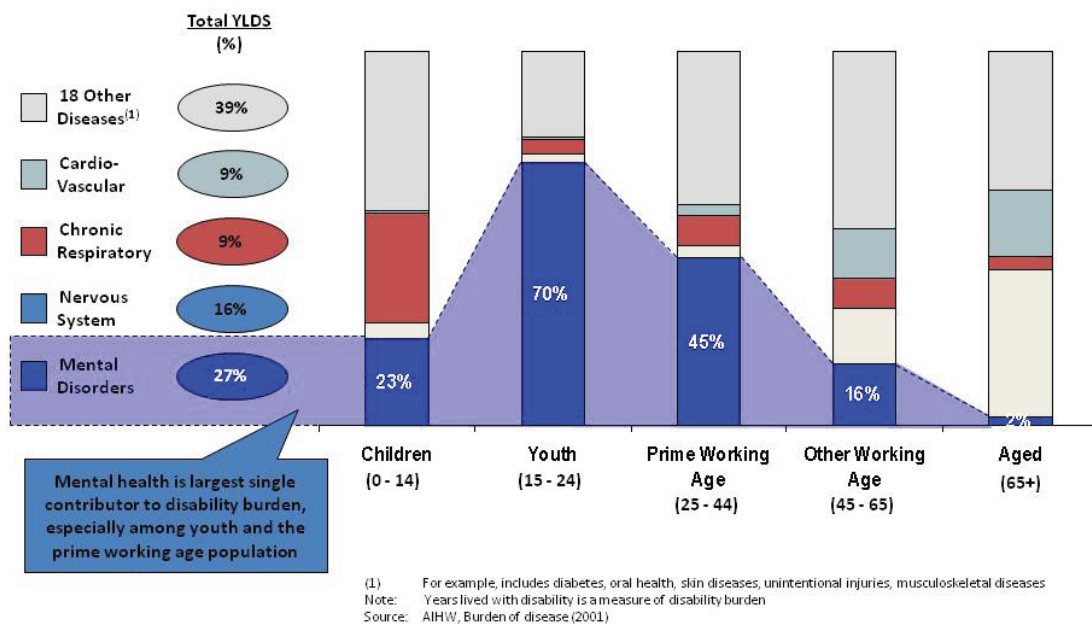
Mental Illness - An Overview

Mental health conditions are among the most common health conditions. 'Mental illnesses' or 'mental health conditions' are both umbrella terms that cover a wide spectrum of illnesses.

The most recent Australian survey (ABS, 2007) shows that nearly half of all people aged over 16 will develop a mental health condition at some point in their lives. In any one year, one in five Australians experience a mental health problem, and one in four of these people (or 5% of the adult population), will experience more than one mental disorder.

These are high rates of prevalence for any health condition. As a consequence, mental health conditions contribute more than any other health condition to the level of disability in the Australian community (see Figure 1).

Figure 1 – Mental Health and Disability



Results from the 2007 ABS survey show that in a 12 month period:

- One in seven or 14.4% of adult Australians had an anxiety disorder
- More than one in twenty or 6.2% had an affective disorder (e.g. depression)
- One in twenty or 5.1% had a substance use disorder
- There are important differences between males and females. These are shown in Table 1
- The incidence of mental illness decreases with age - with the highest percentage of mental illness reported for those aged 16-24 years (26.4%) and 25-34 years (24.8%) as compared with 5.9% for those 75-85 years
- Women are more likely than men to experience anxiety disorders (17.9% compared with 10.8%) while men and more likely than women to experience substance use disorders (7.0% compared to 3.3%)
- Suicide remains relatively uncommon, but the ABS survey found 3.3% of the adult population have attempted suicide at some point in their lives.

The ABS Survey also showed that a number of social factors were highly associated with having a mental disorder in the past 12 months – unemployment, prior homelessness and previous time in prison.

Table 1 - Prevalence of mental health disorders by sex in the previous 12 months

| Mental Disorder | Males | | Females | | Females | |
|----------------------------|------------------|----------------|------------------|----------------|------------------|----------------|
| | % Pop'n estimate | Pop'n estimate | % Pop'n estimate | Pop'n estimate | % Pop'n estimate | Pop'n estimate |
| Any affective disorder | 5.3 | 420,100 | 7.1 | 573,800 | 6.2 | 995,900 |
| Any anxiety disorder | 10.8 | 860,700 | 17.9 | 1,442,300 | 14.4 | 2,303,000 |
| Any substance use disorder | 7.0 | 556,400 | 3.3 | 263,500 | 5.1 | 819,800 |
| Any mental disorder | 17.6 | 1,400,100 | 22.3 | 1,797,700 | 20.0 | 3,197,800 |

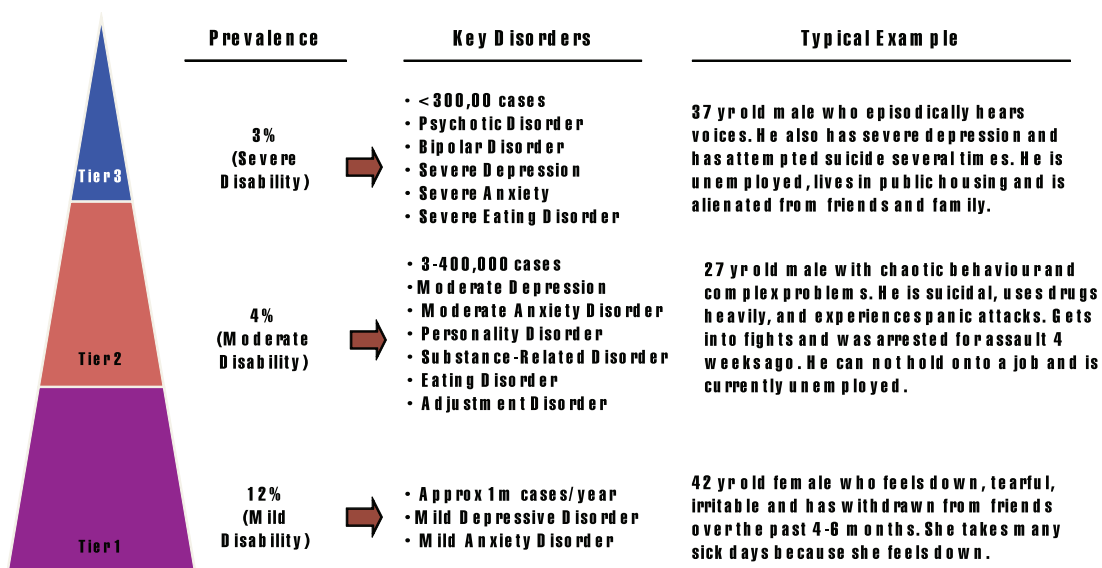
Source: ABS, National Survey of Mental health and Wellbeing: Summary of Results, 2007

In addition to the three most common mental health disorders shown in the ABS Survey (known as high prevalence disorders), about 3-4 in every 100 people in the Australian population experience low prevalence disorders such as bi-polar affective disorder, schizophrenia, drug psychosis, other psychoses and personality disorders at some time during their lifespan.

It is important to understand that the severity of disability from mental illness varies from mild to severe, as shown in Figure 2. Schizophrenia for example, whilst relatively uncommon with a prevalence of less than 1 in 100, usually results in severe disability for people who develop the condition.

On the other hand, people who experience anxiety disorders and most affective disorders respond quickly to treatment and experience only mild disability. In practical terms, they are able to resume work, education and other forms of participation in the community. mental illness in the previous 12 months sought support services.

Figure 2 – The Three Tiers of Mental Illness



Adapted from: *Improving Mental Health Outcomes for Victorians*, Boston Consulting Group, 2006

Treatment and Recovery

Research over the past 20 years has helped to better understand the causes of a number of mental illnesses and most importantly, develop more effective treatments. Combinations of talk therapy, Cognitive Behavior Therapy (CBT) and new medications have improved recovery from a mental illness.

Exercise has also been shown to be highly effective in the treatment of depression, anxiety disorders and bi-polar affective disorder. A significant number of studies (almost 30) have shown jogging, weightlifting, walking, stationary bicycling and resistance training have all been found to be effective. In older people, exercise has been found to be as helpful as antidepressant medication or social contact.

Employment and social engagement have also been shown to be highly effective in minimising the impact of mental illness, and as a therapeutic intervention. Research has also shown that web-based therapies, or virtual therapies, are just as effective in treating many mental illnesses as therapies provided face-to-face by a professional in a consulting room.

The evidence is clear that with early treatment, most people recover from a mental illness and are able to fully participate in the social and economic life of the community. However, the stigma associated with mental illness inhibits help-seeking action by too many Australians. This is supported by the ABS Survey which showed that just over a third of those with a mental illness in the previous 12 months sought support services.

Importantly, the range of mental health services has developed remarkably since the days of the psychiatric hospital. Table 2 lists the types of services now available across Australia which can offer more flexible, evidence based care for people with a mental illness. As with any health condition, early diagnosis and treatment of a mental illness reduces the impact of the condition, the likelihood of complications and promotes recovery.

Table 2 – Typology of Mental Health Services

| Service type | Examples |
|----------------------------------|--|
| In-patient services | Public psychiatric hospitals Public acute hospitals with psychiatric services Private psychiatric hospitals |
| Community residential services | Step up / step down programs Supported accommodation Residential rehabilitation Respite care |
| Day treatment community services | Hospital-based outpatient clinics GP clinics Psychologist and Psychiatry consultations Psychosocial rehabilitation day programs |
| Community support services | Home-based outreach Employment support and education Peer support and consumer advocacy Mental Health Promotion |

In recent years, the concept of 'recovery' has developed in mental health services. Research has shown that the overwhelming majority of people who experience a mental illness recover and fully participate in community life. Even for those people with the most severe and persistent mental illnesses, it has been clearly shown that they can live well in the community, sometimes with little or no on-going support.

A number of high profile Australians have disclosed their mental illness and have retained high profile roles in public offices, the media and business. This has encouraged help seeking actions by others, reduced community stigma, and demonstrated that a mental illness is not for most a life-long debilitating condition. Some of the principles that underpin the recovery model of mental health care are listed in Table 3.

Table 3 - Some Relevant Principles of Rehabilitation

| |
|--|
| 1. All people have an under-utilised capacity which should be developed |
| 2. All people can be equipped with skills (social, vocational, educational, interpersonal, et al) |
| 3. People have the right and responsibility for self-determination |
| 4. Services should be provided in as normalised environment as possible |
| 5. Assessment of needs and care is different for each individual |
| 6. Care is provided in an intimate environment without professional, authoritative shields and barriers |
| 7. Crisis intervention strategies are in place |
| 8. Environmental agencies and structures are available to provide support |
| 9. Changing the environment (educating community and restructuring the environment to care for people with mental illness) |
| 10. No limits on participation |
| 11. Work centred process |
| 12. There is an emphasis on a social rather than a medical model of care |
| 13. Emphasis is on the client's strengths rather than on pathologies |
| 14. Emphasis is on the here and now rather than on problems from the past |

Source: King et al (2007) *Handbook of Psychosocial Rehabilitation*. Blackwell, Carlton, Victoria pp 4-16

However, there is still a way to go before mental illness is viewed and accepted as other health conditions.

In comparison with other developed or OECD nations, Australia has poor levels of employment participation for people with mental illness. Overall, only 29% of all those with a mental illness participate in open employment, compared to over 60% in the Netherlands and 53% within the OECD.

In Australia, only 9% of those experiencing schizophrenia participate in the workforce - in the Netherlands, it is over 30%. The reasons for this are essentially structural and attitudinal. That is, community and workplace attitudes, structural barriers within the welfare systems, and to a lesser extent, insurance industry practices and product design are the key factors contributing to our comparatively low rate of workforce participation for people with a mental illness.

Economic analysis shows that employees with depressive symptoms who are not receiving treatment are absent from work for 5.5% of total working time which is 4.3% more than their non-depressed counterparts. This equates to an annual wage loss of at least \$1.5 billion due to absenteeism in Australia. Moreover, employees with depressive symptoms have a reduction in the ability to function at their usual level of capacity while at work.

Initiatives by all Australian governments in recent years, including action by the Council of Australian Governments (COAG), are resulting in improvements in the access to services, the quality of care, workforce participation and community attitudes.

It is here that participating insurers and funds of SuperFriend, and the broader insurance and superannuation industry, can make a valuable contribution to improving the social and health outcomes for people who experience a mental illness.

Suicide and Self-Inflicted Harm

Australian Bureau of Statistics data shows that approximately annual number of deaths due to suicide over the past decade has been between 2500 and 1800 per annum. Suicide represents the 15th highest cause of death. Suicide is now the leading cause of death among young people under the age of 30. Men are 4 times more likely to die as a result of suicide than women.

The number of people who are affected by a suicide is substantially greater, and the number of people who attempt suicide has been estimated to be between 10 and 20 times greater – many need hospitalization to recover from the resultant injuries. In total, some 40,000 Australians are admitted to hospitals each year as a result of self-inflicted harm.

It is generally accepted that the ABS suicide numbers are some 30% below the actual number of suicides. The reasons for this are complex but include:

- Stigma
- Religious beliefs and practices
- The burden of proof for coroners
- A lack of expert investigations and different reporting protocols across states and territories.
- Family and relatives also often fear that reporting a death as suicide will jeopardise life insurance or other forms of financial compensation.

Suicide is an event with multiple interacting, often complex, contributing factors. One of the most common and significant contributing factors is mental illness. The results of the ABS National Survey of Mental Health and Wellbeing shows that people with a mental illness are much more likely to have serious suicidal thoughts than other people (8.3% as compared to less than 1%). Other Australian research indicates that about 65% of those who die by suicide have symptoms consistent with major depression at the time of death.

However, it is important to understand that the relationship between mental illness and suicide is not casual. The vast majority of people who experience a mental illness do not experience or show signs of suicidal thoughts or behaviours and a person does not have to have a mental illness to have a suicide risk.

While mental health conditions are believed to be present in the majority of suicides, a significant number, estimated to be around 80%, are untreated at the time of death. This again underscores the need to encourage people to seek professional services for a mental health condition.

Because each individual is unique, there is no single reason as to why a person completes suicide. However, there are several factors that may contribute to a person engaging in suicidal behaviour. These include, but are not limited to:

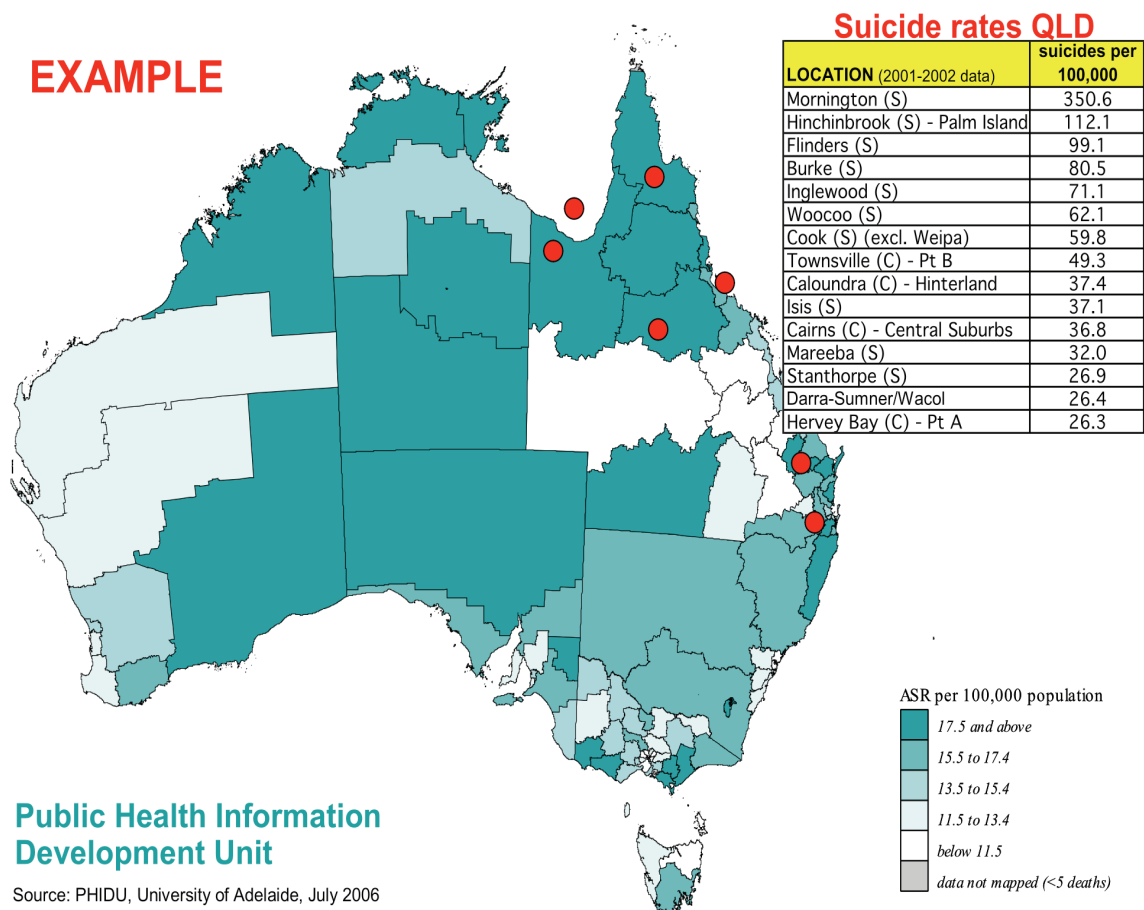
- A personal crisis often associated with a major life transition, such as loss of a loved one, breaking up of a significant relationship, losing a job, etc.

- A major life change may leave individuals feeling overwhelmed, unsupported, alienated and not be aware of alternative coping options
- Psychological disorder often amplifies and distorts the distress
- Alcohol and substance abuse can cause a person to lose self control and engage in impulsive suicidal behaviours
- Distorted thoughts associated with depression, including feelings of helplessness, loneliness and worthlessness.

There are also significant differences across Australia in suicide rates as illustrated in Figure 3 below.

Figure 3 - Suicide and self-inflicted injuries

Suicide and self-inflicted injuries (0 to 74 years), Health Regions, Australia, 1997-01

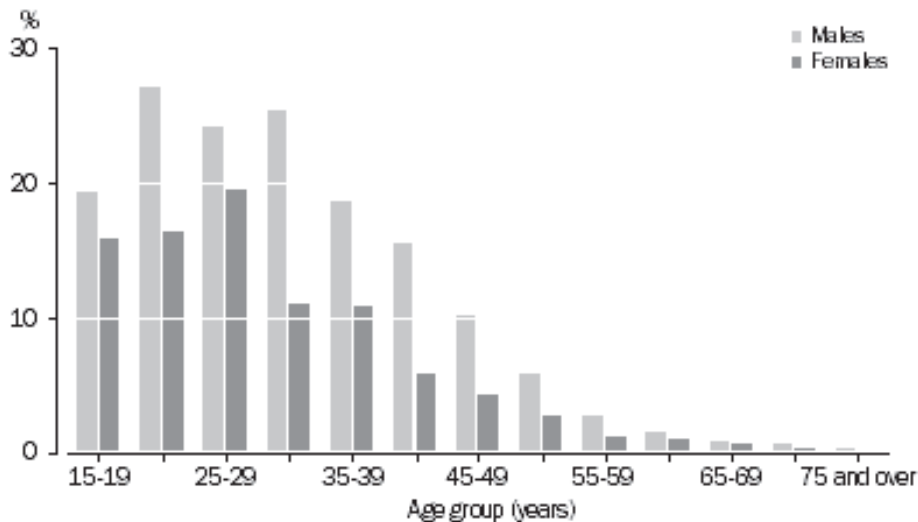


More men than women take their own lives, and the rate for single people is twice that of married people. Certain occupational groups and industries also have higher rates of suicide including mining, farming, building and construction. The rate of suicide across the indigenous population is four times that for non-indigenous Australians and in some areas significantly higher - for example in the Kimberley the rate is seven times the rate for non-indigenous Australians.

Suicide as Proportion of Total Deaths

While suicide accounts for only a small proportion (1.6%) of deaths of persons of all ages, it accounts for a greater proportion of deaths from all causes in specific age groups (see Figure 4). For example, suicide deaths make up more than 20% of deaths from all causes, in each five year age group for males between 20 to 34 years. Similarly for females, suicide deaths comprise a much higher proportion of total deaths in younger age groups compared with older age groups.

Figure 4 - Suicide as proportion of total deaths 2005



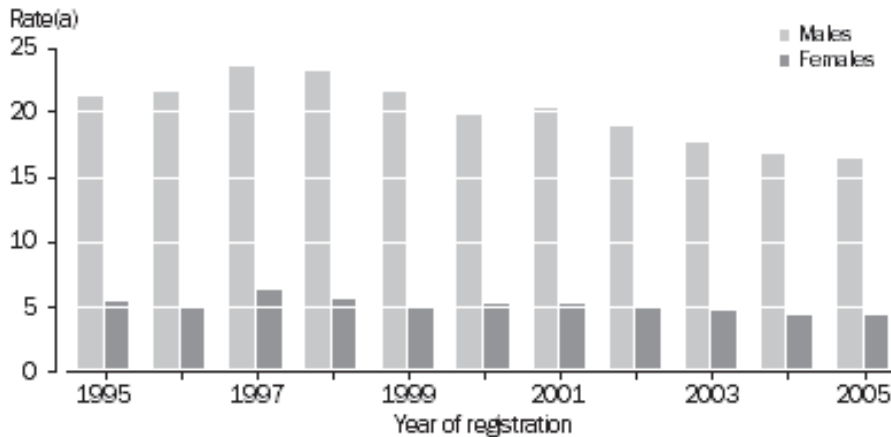
Age-Standardised Rates

The age-structure of the Australian population has changed over time. Age standardisation allows comparison of rates between populations with different age structures. The age-standardised suicide rate (for persons) in 2005 was 1% lower than the corresponding rate for the previous year and 30% lower than in 1997.

The age-standardised suicide rate in 2005 for males was 16.4 per 100,000 while the corresponding rate for females was 4.3 per 100,000 (see Figure 5).

Throughout the period 1995 to 2005, the male age-standardised suicide death rate was approximately four times higher than the corresponding female rate, as can be seen in the following graph.

Figure 5 - Age-standardised death rates for suicide



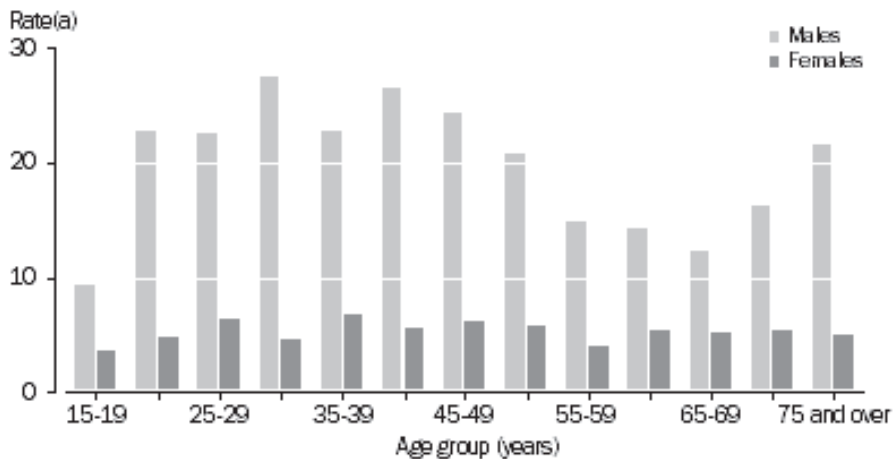
(a) Age-standardised rate per 100,000. Standardised using direct method and the Australian estimated resident population (persons) at 30 June 2001 as standard population.

Age

The median age at death for suicide in 2005 was 41.4 years for males and 44.1 years for females (see Figure 6). In comparison, the median age for deaths from all causes in 2005 was 76.8 for males and 82.9 years for females.

The pattern of age-specific rates in 2005 for suicide in males and females is shown in the graph below.

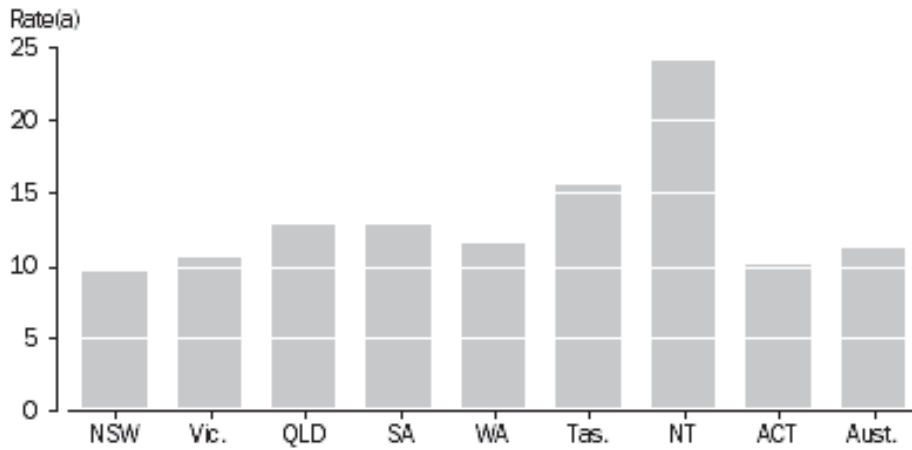
Figure 6 - Age-specific suicide rates 2005



(a) Rate per 100,000 estimated resident population

The highest age-specific suicide death rate for males in 2005 was observed in the 30-34 years age group (27.5 per 100,000) and the lowest was in the 15-19 years age group (9.5 per 100,000). For females the highest age-specific suicide death rate in 2005 was observed in the 35-39 years age group (6.9 per 100,000) and the lowest in the 15-19 years age group (3.6 per 100,000) (see Table 6).

Figure 7 - Suicide by State and Territory 2001-2005, age-standardised rates



(a) Age-standardised rate per 100,000. Standardised using direct method and estimated resident population for Australia (persons) at 30 June 2001 as standard population

Mental Illness Awareness - Education Member Information Brochure

Despite increased social awareness and access to information, mental health conditions remain misunderstood by the general community. For many, the experience of a mental illness can be isolating and difficult. Stigma and fear remain important issues, coupled with common community misconceptions about mental illness.

For this reason, it is recommended that industry funds and other relevant stakeholders seek to improve member's mental health literacy through the provision of educational materials.

Industry funds and insurers have a great opportunity to provide sustained education and awareness by providing members with information about mental health issues at:

1. Policy Inception
2. Statement/Renewal time,
3. Increases to existing cover and 'life stage' events, and
4. Submission of a mental illness claim.

The development of member information brochures will help members identify the warning signs and also guide them on how and where to seek support should they experience an event or any symptoms impacting their mental health. These brochures may be sent as part of a claims pack, or sent as a standalone resource.

"I feel this would be beneficial. This way individuals can pick up on warning signs...I would be comfortable with this coming from my super fund."

- beyondblue blueVoices consumer

Whether the employer or fund wants to specifically mention issues where the workplace environment may potentially contribute to concerns of mental health is something for discussion. This may tie in with existing OH&S and Human Resources activities and policy, where issues such as workplace bullying and work stress may need to be addressed. These can be co-contributors to mental health conditions and may be addressed specifically within the business.

This information is readily available through SuperFriend and its mental health content partners. New resources are periodically developed as part of the SuperFriend education program. The following websites are also useful resources for information and services:

www.superfriend.com.au

www.beyondblue.org.au

www.blackdoginstitute.org.au

www.bluepages.anu.edu.au

www.itsallright.org

www.lifeline.org.au

www.menslineaus.org.au

www.mentalhelp.net

www.mhca.org.au

www.mifa.org.au

www.moodgym.anu.edu.au

www.psychcentral.com

www.reachout.com.au

www.sane.org.au

Emergency Help

Emergency help is available in Australia 24/7 at:
Phone: Emergency 000
Lifeline: 13 11 14



State services

All state health and in some states, other agencies such as Department of Communities, provide helplines, mental health services and alcohol and drug information services. For example: In the **ACT** Mental Health Triage Service: 24 hr/toll free Ph: 1 800 629 354.

In **New South Wales**; the nearest hospital can arrange a crisis team to come or can advise where to get help in your area.

Central Coast; Central Intake/CRISIS 24 hours, 7 days Ph: 02 4320 3500

Or

Salvo Suicide Helpline, Ph: 02 9331 2000

Information Brochure

A short form brochure (DL size) is recommended to be included in general correspondence provided to members at specific policy and communication times.

The brochure should contain:

- Information about mental health conditions
- Symptom checklist of various conditions (sourced from reputable mental health organisations)
- Information about co-morbidity ie. the link between physical injury/illness and mental health conditions (primary and secondary cause of claim)
- Details of service providers
- Explanation of the services available under the Mental Health Care Plan through GPs
- Prevention - how depression and anxiety may be prevented
- Where to go for help - various free counseling services and help online
- What kinds of treatments are available
- Testimonials of people who have sought treatment, and
- Recovery from mental illness - facts sheet outlining the type of services available.

For members that would like more information, we consider the development of an information pack with several other resources may be prudent.

Information Pack

It is recommended that specific information packs are provided to the member. Information packs can compliment the brochures, and should expand on the information provided. Specifically, the information packs should be designed to step the member through the claims process and illustrate how it will be handled. This will greatly assist in reducing the anxiety, frustration and confusion of the member, and significantly improve the member experience when communicated effectively.

Claims Pack

Upon notification it is recommended the member is provided with additional documentation outlining:

- A service commitment from the fund administrator / insurer which would explain how each party performs their role and how this will benefit the claims experience for the member
- The initial claims process, timeframes, communication etc - general overview of the steps taken by the claims consultant and the general time taken to complete assessment. Explanation of potential delays that may be experienced if fully complete forms, information and disclosures are not made at the onset
- Confirmation of any further information required of the member or third parties i.e. generally setting the expectation that additional information could be requested depending on the individual circumstances of a claim and the information already made available
- Explanation of the case management process, providing some clarification of each party's involvement e.g. implementation of a personalised claim management plan in conjunction with the member's treatment provider and our medical officer to manage recovery and response to treatment
- Ongoing claims management including the use of claim forms, treating medical reports, and independent medical examinations.

Frequently Asked Questions (FAQ)

A Frequently Asked Questions (FAQ) document is recommended to be included in the claims pack and claims correspondence to help alleviate unnecessary confusion and distress during the claims process. An FAQ style document could address members' most commonly asked questions and give further comfort to members around the expectations and requirements of the claims process.

The recommended FAQ document should include:

1. Claim Processes; initial assessment requirements
 - Why am I required to complete claim forms?
 - When should claims forms be returned?
 - Initial Claim Form
 - Certification by a recognised Medical Professional: In what instances will I be required to participate in a medical examination?
 - What are the benefits of attending an independent medical examination and can this assist my doctor with formulating a treatment plan?
 - Medical History report
2. Claim Processes; ongoing assessment requirements
 - Who do I contact if I have enquiries?
 - What information needs to be provided for an ongoing claim?
 - What are my responsibilities while I am receiving benefits?
3. Access to rebates under Medicare's GP Mental Health Care Plan
4. Role of a Counsellor
5. Role of General Practitioner
6. Role of a Psychiatrist
7. Role of a Psychologist
8. Role of an Employer
9. Role of a Rehabilitation provider
10. The benefits of specialist consultation
 - Medication review: A Psychiatrist, in consultation with your General Practitioner, is able to provide advice on the effectiveness of your current medication

11. Access to community care, websites and information
12. What is a: Independent Medical Assessment (IME), Neuropsychological Assessment, Functional Evaluation Assessment, Vocational Assessment, Rehabilitation
13. My responsibilities whilst on claim (ie. telling the Insurer if engaged in employment, significant change in treatments, etc)
14. If I have a complaint who do I contact and what is the process?
15. Are there appeal processes?

Stakeholder responsibilities

Employer and Employee

Employers need to promote awareness, early detection, support and management of mental illness in their workplace. In some cases, where the employer can take a proactive approach to address mental health issues (training, education, detaction, awareness sessions, internal process improvements), some claims may be prevented.

Promoting the use of treatment and rehabilitation services for employees through their Employee Assistance Program (EAP) should also be undertaken. In addition, it is recommended that where possible, a greater emphasis on work flexibility and accommodation for employees who experience mental illnesses should be considered. In the same way workplaces have provided physical modifications of the workplace and roles for employees with physical health conditions, employers can 'modify' the workplace and role to better accommodate employees who may experience an episodic mental illness.

Employees should acquire the skills and knowledge to recognise the signs and symptoms of mental illness for themselves and others; and obtain a diagnosis which enables the commencement of a treatment regime.

Fund

Where possible, reporting structures should be implemented to ensure the fund is notified as soon as it is apparent a mental illness claim may be submitted (i.e. extended sick leave, workers compensation claim, etc). This should be extended to include where a mental illness is a secondary/underlying condition to the initial claim cause.

Administrator &/or Insurer

The responsibilities of both parties require careful consideration. These responsibilities are dependent on a number of factors, including existing service and contract arrangements, operational structure and operational strategy. Nonetheless, where a decision has been made to transition to a more proactive Case Management model, responsibilities to consider include:

- Who is responsible for undertaking the notification interview?
- Who will be the person/Case Manager forming an ongoing relationship with the member, their doctor and employer?
- Who has the appropriate skills and resources to manage mental illness claims?
- In many instances the insurer is unable to contact the member directly. Do current practices prevent implementation of the early intervention process?

Medical Practitioner

Where appropriate, the medical practitioner should encourage the member to seek appropriate care and treatment.

Administrators and insurers can help influence this process by raising the medical practitioner's awareness of rehabilitation and the Mental Health Care Plan.

Better Access Mental Health Care Plan

From 1 November 2006, additional GP Mental Health Care items were made available on the Medicare Benefits Schedule (MBS). The items were designed to improve access to mental health services provided by GPs and have been developed in consultation with GP organisations.

Rebates are available for consultations with psychiatrists, clinical psychologists, psychologists, social workers, occupational therapists and mental health nurses.

To qualify for rebates under the Better Access program, a person with depression, anxiety or other mental disorder needs to obtain a referral from a General Practitioner (GP), psychiatrist or paediatrician.

The items provide a structured framework for GPs to undertake early intervention, assessment and management of patients with mental disorders, and provide new referral pathways to clinical psychologists and other allied mental health service providers.

There are three GP Mental Health Care items:

(1) GP Mental Health Care Plan (item 2710)

- Involves the assessment of a patient and preparation of a GP Mental Health Care Plan.
- Enables referral of patients to psychiatrists, and for psychological therapy by clinical psychologists or focused psychological strategies (FPS) services by qualified GPs or allied mental health professionals.
- Those eligible for rebates can receive up to 12 individual consultations and up to 12 group therapy sessions with a mental health professional under Medicare.

(2) Review of a GP Mental Health Care Plan (item 2712)

- Enables a review of the patient's progress against the goals in the GP Mental Health Care Plan.
- Recommended frequency is an initial review between four weeks and six months after the completion of the GP Mental Health Care Plan and, if required, a further review at least three months after the first review.

(3) GP Mental Health Care Consultation (item 2713)

- An extended consultation (at least 20 minutes) with a patient where the primary treating problem is related to a mental disorder.
- May be used for continuing management of a patient with a mental disorder, including for a patient being managed under a GP Mental Health Care Plan.

It is important to note that conditions of the Mental Health Care Plan are subject to change. To obtain the most accurate, up to date information, visit:

- Department of Health and Ageing,
<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba>
- *beyondblue* Fact sheet 24: **Help for depression, anxiety and related disorders under Medicare**,
<http://www.beyondblue.org.au>

Claims Practice model

Under the current claims management model the notification of an Income Protection (IP) or Total and Permanent Disability (TPD) claim is typically completed by the fund administrator. Insurers rarely have direct contact with the member as the claims assessment requirements are normally sent via the administrators.

The following stages outline the proposed Claims Practice Model, which includes:

- The Notification Interview.
- Completion of Claim Form with Member, Employer and Treating Doctor.
- Assessment of IP Claims; and
- Assessment of TPD Claims.

I. The Notification Interview

To establish a true case management model, where ongoing support is provided to members with mental illnesses, the insurer will need to be involved in the end to end assessment process. Of paramount importance is the conduction of a Notification Interview as soon as a member notifies the employer or fund of their intention to submit a claim for mental illness.

The Notification Interview is an early intervention assessment process where the Case Manager* completes a questionnaire with the member over the phone. Through this model, emphasis is placed on the quality of the engagement and service delivery, significantly enhancing the member experience during a period that may otherwise be a confronting and potentially distressing time.

"It is really important to create an environment of understanding and encouraging people to disclose - this will take time to occur and change paradigms. Stigma and fear is the biggest issue and the process can exacerbate the feelings of isolation, paranoia, negativity and general unwellness of a person who is vulnerable."

- Ingrid Ozols, Managing Director, MH@Work, Workplace Educator and Consultant

It is recommended that an accredited Case Manager* undertakes this interview due to the sensitive and complex nature of these cases. To establish a true case management model, a designated point of contact will need to be involved in the end to end assessment process. This means that the fund administrator will need to notify the insurer as soon as a claim is indicated, and allow the insurer to contact the member and undertake the Notification Interview. In recognition of the episodic nature of some mental illnesses, the member may wish to nominate a proxy to handle all communication relevant to the claim, or have a nominated support person attend all meetings (phone or face-to-face) with them.

*The Case Manager may be a team member for the administrator or insurer.

Benefits of this process include:

- Reduction in administration time, processing of claim documentation and system management
- Managing expectations; ensuring the member is eligible to claim before requesting they consult a doctor and complete claim documentation; and
- Early commencement of the claims management process.

A Notification Interview Proforma should be developed in accordance with the policy terms and conditions and should include as a minimum:

- Eligibility checklist
- Nature of the illness
- Date of onset of symptoms
- How the illness came about
- Contributing factors (including family history)
- Date ceased work
- Details of treatment
- Other claims (Workers Compensation, etc) so that medical information from other organisations may eliminate the need for the member to have to provide additional medical reports.

Where it is clear the member satisfies the criteria to make a claim, the interviewee should proceed to completing a claim form with the member over the phone.

Example template:

| Mental Illness Claim Notification Form - phone interview | |
|--|---|
| <i>*This form is to be completed by an accredited Case Manager</i> | |
| Date: | Policy Number: |
| Insured Members Details: | Policy Type: i.e. IP/TPD |
| Name of caller: | Sum Insured: |
| Contact Phone Number: | Within AAL: If no, medical history required |
| Disability Details: | |
| Nature of disability: | Diagnosis: What has the treating doctor explained to you about your disability? |
| Date ceased work: | Onset of symptoms: |
| Contributing factors (i.e. bereavement, workplace stress): | |
| Previous history: | |
| Family history: | |
| Treating Doctor Details: | |
| Doctors Name: | Doctor's Speciality: |
| Doctors Name: | Doctor's Speciality: |
| Treatment: | |
| Treatment Details: | |
| Expected Return to work: | |
| Employment details: | |
| Rehabilitation details: | |
| Assessment: | |
| Is the member eligible to claim? (insert eligible checklist) | |
| If so - outline next steps in claims process (i.e. completion of claim form etc) | |

Accreditation of Case Managers

Ideally the Case Manager will have a mental health background and/or experience working with individuals with mental illness. Alternatively experienced Case Managers should undertake training and accreditation via external providers or internal resources, such as chief medical officers, rehabilitation and independent medical examination providers.

Importantly the Case Manager requires the skills to competently communicate with the members' treating doctors, employers and any other relevant third parties.

With sufficient industry support, it is recommended that an accredited module be developed by industry providers to ensure a consistent skill set for Case Managers.

2. Completion of Claim Form with Member, Employer and Treating Doctor

After the notification process has been completed, we recommend the Case Manager completes the claim form with the relevant stakeholders over the phone.

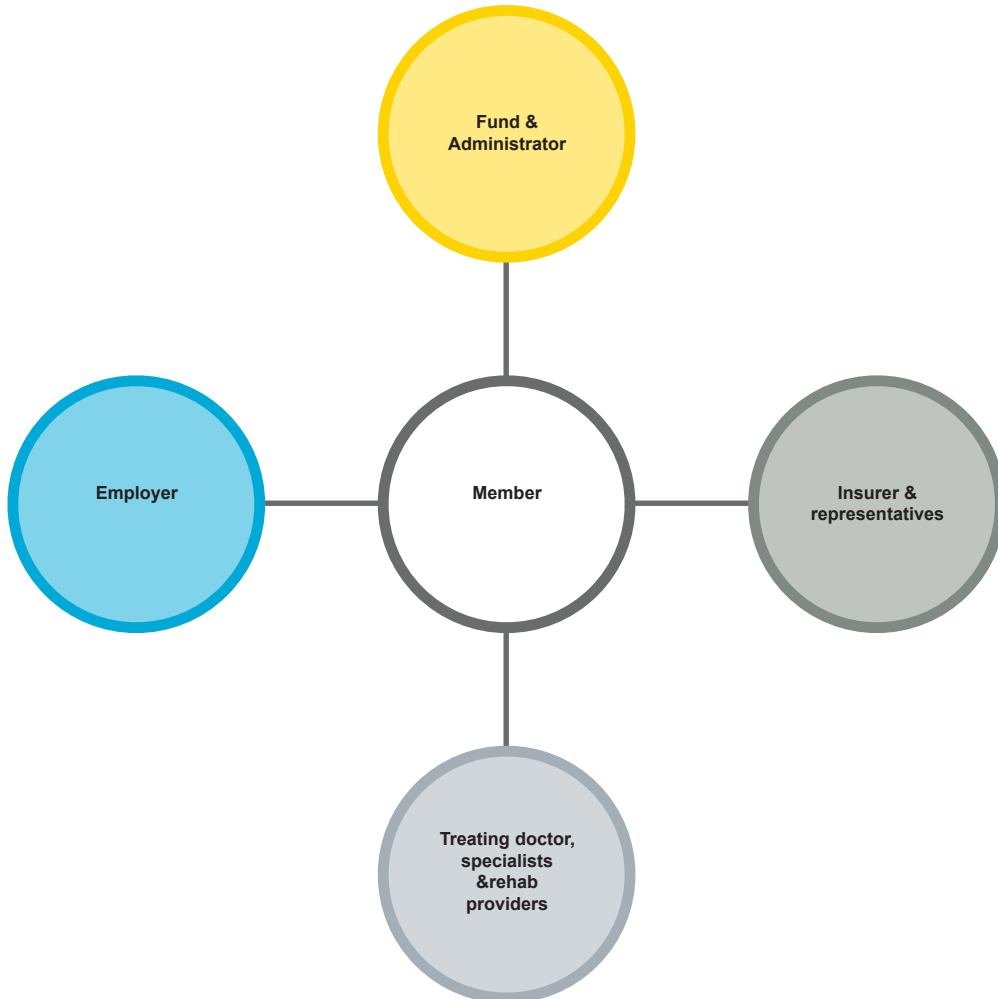
Process:



Completing the claim form over the phone allows the administrator or insurer to control assessment cycle times. It also provides an opportunity for the Case Manager to elicit additional information about the validity of the claim.

3. Assessment of Income Protection (IP) Claims

Effective communication is the key to the successful management of income protection claims. Ongoing entitlement to benefits is assessed on a monthly basis. Consequently, the assessment process is an interrelated five-point contact.



The Case Manager is responsible for instigating and maintaining contact with all stakeholders.

The benefits of regular contact include:

- Rapport building
- Additional support for the member
- Ability to closely monitor eligibility, in example agreed return to work goals
- Increased transparency; and
- Responsive to changes in the members' circumstances.

4. Assessment of TPD Claims

Completion of the Notification Interview and claim form over the phone with the Case Manager may not be a requirement of TPD assessment from an early intervention perspective but it can assist in the reduction of cycle times.

The assessment of TPD claims for mental illness can be challenging given the often episodic nature of the disability. For example, it is difficult to formulate a prognosis, especially if it is the member's first experience with mental illness.

Relevant considerations for assessment of TPD claims pertaining to mental illness may include:

- Treatment type and regularity of treatment, particularly relevant for late lodgment claims.
- Deferring a decision on a mental health claim may be the appropriate decision where permanency and severity of the condition cannot be determined until all evidence-based treatment options have been trialled. Industry-wide support should be garnered to encourage product development and widespread acceptance of this practice where it is in the best interests of the member.
- Policy definition. Most policies describe entitlement to benefits based on a disability that prevents the member from working in their own or any occupation. Where the disability is a result of workplace stress, you will need to consider if the member is prevented from carrying out their duties at another place of employment or with reasonable adjustments to work duties.

Late lodgment of TPD claims

- Where possible all stakeholders should encourage early submission of TPD claims. This may include the submission of TPD claims within the requisite *6 month waiting period.

*Correspondence to the member should clearly outline that the claim will not be prematurely assessed.

Financial evidence such as tax returns and notice of assessments is a useful tool in assessing a member's gainful employment status between date of injury and lodgement of claim. Clinical notes from the treating GP or psychiatrist can also assist this process. It is especially important in late lodgment situations which are often the case with group TPD claims.

Mutual Benefits for the insurer, fund/administrator and member

There is undoubtedly a shared social and economic interest by all stakeholders to ensure that members remain free from illness that impact on their ability to function at home and at work. Where members do experience a mental illness requiring an absence from work, the focus must be placed on effective treatment and facilitating a return to work as soon as possible, whilst employing the necessary steps to facilitate this process.

Further to the development of these guidelines, our shared purpose is to explain our service proposition which will require the consideration and cooperation of the fund, administrator, insurer and member.

It is hoped that by providing an information brochure / information pack to the member at the commencement of their membership and at regular intervals, we can raise and enhance awareness and understanding of mental health issues including how, when and where to seek the health assistance members may require.

Clearly the intent on this level is to provide those members with information and points of reference should they or a family member identify that assistance is necessary. This may either negate the need to claim at all or reduce the severity of a claimable event through these early intervention strategies.

Where a claim is submitted, the practice model recommended is reliant on the Case Manager communicating directly and regularly with all relevant stakeholders in order to proactively manage the claim.

In terms of communication, the Code of Practice Claims guidelines represent a paradigm shift from the traditional approach where the insurer's claims consultants normally accept responsibility for assessing often complicated claims material without having the benefit of direct access to the member or employer. Applying such traditional methodology to initial and ongoing claims assessment can easily lead to misunderstandings or disagreements in matters of interpretation, create unnecessary delays in the assessment process, and in the worst case, exacerbate the member's condition.

It is certainly our experience, and that of the industry, that holistic Case Management can only be achieved when all the information and necessary access to parties is made available. The absence of direct communication with the employer and member constitutes a considerable barrier to expediting the decision making process and can possibly lead to an assessment outcome without due consideration to all the facts.

It is mutually beneficial to have a Case Manager establish contact and rapport with the member from the beginning of a claim. This streamlines the fact-finding process and also eliminates any misunderstandings created from liaising with a third party. It will also allow the Case Manager to gain a far greater understanding of the circumstances and provide all parties with an opportunity to articulate their expectations, circumstances or concerns in a clear and precise manner.

This Claims Practice Model would also include, where applicable, the engagement and support of a rehabilitation / medical officer to converse directly with the employer; member and treating doctor to coordinate any return to work programs which have been requested or identified.

The benefits are mutual and include:

- To expedite the claims decision making process
- To negate the need for further requirements via correspondence where direct contact can resolve the enquiry
- More accurate, informed and timely claims assessment
- Building of relationships between claims consultants, members and an enhanced understanding of both parties
- Easier identification of those members who seek assistance returning to work and therefore greater chance of successful outcomes; and
- In certain cases, limit the need for some requirements.

These improvements will seek to improve the member's experience throughout the duration of the claim. It is important to understand that improvements to process, education and product offering will greatly assist those with a mental illness in reducing the fear, anxiety and confusion that could potentially be present during a claim.

These benefits include:

- Personalised service delivery, one point contact and greater feeling of confidentiality through the Case Manager;
- Enhanced understanding of the claims process, information required, management of expectations and time frames
- Ability to nominate support proxies to manage the claim when the member is unwell
- To expedite the claims decision making process
- Increased awareness of mental health conditions and treatment options.

Appendix I: Health Care Panel for remote areas

| State | Company Name | Contact Last Name | Address | Phone No. | Fax No. | Email Address |
|-------|--|-------------------------|--|--------------|--------------|--|
| ACT | Advanced Personnel Management | Tamsen Marriott | Level 1, 39 London Circuit, Canberra 2600 | 02 6262 7766 | 02 6257 5306 | tamsen.marriott@apm.net.au |
| ACT | Dysaran Consulting | Roslyn Crawley | 131 Canberra Ave, Griffith 2603 | 02 6295 9399 | 02 6295 9855 | dysaran@netspeed.com.au |
| ACT | Work Solutions | Sue Ellis (ACT Manager) | PO Box 9821, Canberra. 2601 | 02 6269 2040 | 02 6269 2049 | sue.ellis@worksolutions.com.au |
| ACT | Konekt | Jenny Thomas | Unit 3, 116-118 Wollongong St, Fyshwick 2609 | 02 6239 1822 | 02 6239 1853 | jthomas@konekt.com.au |
| NSW | Injury Management Assist | Jennifer Kairouz | 8 Speed St, Liverpool 2170 | 02 9821 3612 | 02 9601 5537 | Jennifer.Kairouz@injury-management.com |
| NSW | Health & Safety Solutions | Victoria Riley | PO Box 2, New Lambton 2305 | 02 4903 3200 | 02 4903 3201 | |
| NSW | Konekt | Mathew Smith | Newcastle | 02 4926 3461 | 02 4927 0076 | msmith@konekt.com.au |
| NSW | Konekt | | Orange | 02 6361 7880 | 02 6362 0754 | |
| NSW | Lifeworks Health Service | Jane Wilkins | 23 Tulip St, (PO Box 996) Chatswood 2067 | 9411 3131 | 9411 4242 | |
| NSW | Konekt | Brenda Simpson | Level 3, 83-85 Market St, Wollongong 2500 | 02 4229 8688 | 02 4229 6606 | bsimpson@konekt.com.au |
| NSW | Crawford Healthcare Management Service | Mark McKie | PO Box 5110, West Chatswood 1515 | 02 9411 8144 | 02 9411 5119 | mark.mckie@crawco.com.au |
| NSW | Work Solutions | Nichole Pereira | Level 4, 28 Foveaux St, Surry Hills 2010 | 9288 9555 | 9288 9500 | nichole.pereira@worksolutions.com.au |
| NSW | WorkFocus | Marc D'Amico | PO Box 695, Newcastle 2300 | 02 4929 6565 | 02 4929 3380 | mdamico@workfocus.com |

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|-----|--|----------------------------------|--|--------------|--------------|--|
| NSW | Empact | Sanja Zeman; Melanie Westlake | PO Box 313, Kenthurst. 2156 | 1300 721 944 | 02 9654 8153 | szeman@ empact.com. au; mwest- lake@empact. com.au |
| NSW | Injury Management Assist | | Sydney 2000 | 02 9994 8002 | | |
| NSW | Advanced Personnel Management | Karen Stewart | 11/1 Margaret St, Sydney 2000 | 02 8296 5700 | 02 8296 5707 | karen.stew- art@apm.net. au |
| NSW | DSP Consulting | Diane Prattley | PO Box 5116, Greenwich 2065 | 9901 4825 | 9901 4825 | dprattley@ optusnet.com. au |
| NSW | Rehab Management | Michael Byrne | PO Box 2271, North Parra- matta. 2151 | 1300 762 989 | 1300 762 654 | michael@ rehabmanage- ment.com.au |
| NSW | Life In Balance | Rick Robinson | "Bolton Tower, Suite 5, Level 1, 19 Bolton Street, New- castle, NSW 2300 | 0419 847 441 | | rick@lifeinbal- ance.net.au |
| NSW | WorkFocus | | P.O.Box 369 Merewether, NSW, 2291" | 9516 3966 | 9516 4905 | |
| NSW | Konekt | | 1 Erskineville Rd, Newtown 2042 | 02 9650 5111 | 02 9650 5133 | |
| NSW | IOH (Injury & Occupational Health) | Brendan Delaney | Level 5, 345 George Street, Sydney 2000 | 02 4229 8439 | 02 4225 9294 | |
| NSW | Lifeworks Health Service | Jane Jaggs | 32 Swan Street, Wol- longong 2500 | 02 9411 3131 | 02 9411 4242 | |
| NSW | Konekt | Fiona Livermore | 3/221 The Entrance Rd, Erina 2250 & Suite 8, 47 Neridah St, Chatswood 2067 | 02 9630 8311 | 02 9630 5739 | fivermore@ konekt.com.au |
| NSW | Konekt | Sally Singe | PO Box 1127, Parramatta 2124 | 02 6041 3950 | 02 6041 3960 | ssinge@ konekt.com.au |
| NSW | Konekt | | PO Box 294, Albury 2640 | 02 8440 5844 | 02 8440 5858 | |
| NSW | Pronto Health | Michelle Brophy | Chatswood | 9904 2546 | 9531 7842 | michelle. brophy@ prontohealth. com.au |
| NSW | Pro Fit Rehabilitation | Ben Herd | PO Box 1150, Glebe 2037 | 02 8821 8821 | 02 8821 8822 | benherd@pfr. net.au |

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|---------|-------------------------------|----------------------------------|---|--------------|--------------|--------------------------------------|
| NSW/QLD | Colleen Hartcher | Colleen Hartcher | PO Box 3870 Parramatta 2124 | 02 6629 5072 | 02 6629 5072 | chartche@nor.com.au |
| NSW/QLD | Peak Work Performance | Mark Sullivan (Exercise Physio) | 23 Willis Rd, Tregearle 2480 | 0409 650 385 | 02 6674 9969 | pwperformance@optusnet.com.au |
| QLD | Rehablife | Lyn Hand (Clinical Psychologist) | PO Box 1606, Kingscliff. 2487 | 07 3393 2001 | 07 3393 2002 | admin@rehablife.com |
| QLD | Konekt | Fiona McIntosh | Taylor Medical Centre, Suite 15, Level 2, 40 Annerley Road, Woolloongabba. 4102 | 07 4724 4310 | 07 4724 4308 | fmcintosh@konekt.com.au |
| QLD | Career Clarity | Jenni Proctor | PO Box 157, Townsville 4810 | 0413 602 096 | | jenni@careerclarity.com.au |
| QLD | Konekt | | "74 Bolan Street | 07 5562 5972 | | |
| QLD | Konekt | Brad Forge | Bulimba Qld 4171" | 07 3370 0555 | 07 3370 0599 | bforge@konekt.com.au |
| QLD | Konekt | | Southport/ Gold Coast | 07 4951 2095 | 07 4951 2045 | |
| QLD | Advanced Personnel Management | Brenton Fielke | "PO Box 288 | 07 3229 1500 | 07 3229 1577 | brenton.fielke@apm.net.au |
| QLD | Konekt | | Fortitude Valley 4006" | 07 4976 9658 | 07 4976 9569 | |
| QLD | Working Well Australia | Georgia Blackwell | Mackay | 07 5630 6507 | 07 5630 6531 | georgia.blackwell@wwa.net.au |
| QLD | Barolin Physio | Peter & Jenny Dolan | Level 17, 300 Adelaide St, Brisbane 4000 | 07 4153 4333 | 07 4153 3303 | |
| QLD | Konekt | Katrina Thompson | Gladstone | 07 3370 0555 | 07 3370 0599 | toowoomba@konekt.com.au |
| QLD | Work Solutions | Nichole Pereira | PO Box 6489, Gold Coast Mail Centre 9726 | 07 3307 0000 | 07 3307 0023 | nichole.pereira@worksolutions.com.au |
| QLD | EKCO Occupational Services | Suzanne Jesser | "55-57 Walker Street | 07 3833 3222 | 07 3833 3200 | suzanne.jesser@ekco.com.au |
| QLD | Advanced Personnel Management | Tim Williams | Bundaberg. 4670" | 07 5571 2041 | 07 5571 2045 | tim.williams@apm.net.au |
| QLD | Recovre | Julie Yule (Business Manager) | PO Box 4577, Toowoomba. 4350 | 07 3834 5880 | 07 3834 5888 | |

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|-----|-----------------------------------|-------------------|--|----------------|----------------|---------------------------------------|
| QLD | Intouch Physio | Tim Robinson | "Level 7, 87 Wickham Terrace, | (07) 54425666 | (07) 5442 6935 | intouch@cafeoz.net.au |
| QLD | Chase Clinic (Uni of QLD) | | Spring Hill 4000" | 07 5459 4489 | | |
| SA | Bridge Consulting (Psychologists) | Lisa Chantler | GPO Box 309, Brisbane 4001 | 08 8212 7740 | 08 | inquiries@bridgepsychologists.com.au |
| SA | Corporate Health Group | Sam Shirmer | PO Box 5163 Gold Coast Mail Centre 9726 | (08) 8354 9800 | (08) 8443 7080 | sschirmer@corporatehealthgroup.com.au |
| SA | Work Solutions | Nichole Pereira | "Suite 2, 290 Boundary St, | 08 8468 6800 | 08 8468 6898 | nichole.pereira@worksolutions.com.au |
| SA | De Poi Consultancy Services | | Spring Hill" | 08 8364 5990 | 08 8364 6020 | |
| SA | Dewing Ergonomics & Safety P/L | Paul Dewing | 7 Myall Street Cooroy | 08 8354 9209 | 08 8234 0680 | janepaul@cobweb.com.au |
| SA | Advanced Personnel Management | | University of the Sunshine Coast, Sippy Downs Drive, Sippy Downs. 4556 | 08 8362 2322 | 08 8362 5291 | |
| SA | Konekt | | 245 Sturt Street Adelaide 5000 | 08 8130 0222 | 08 8130 0233 | |
| SA | Personnel Placement Consultancies | Christine Smitham | 55 Henley Beach Road MILE END SA 5031/PO Box 562 Torrens-ville SA 5031 | 08 8379 2500 | 08 8379 2599 | Christine.Smitham@ppcon.com.au |
| TAS | Konekt | Brad Ellis | "Level 8 West, 55 Currie Street, | 03 6331 9911 | 03 6331 7700 | bellis@konekt.com.au |
| TAS | Lifestyle Management Systems | | Adelaide 5000" | 03 6224 0366 | 03 6224 1566 | lms@trump.net.au |
| TAS | Lifestyle Management Systems | | Suite D/83 Fullarton Rd, Kent Town 2057 | 03 6432 3255 | | |
| VIC | Advanced Personnel Management | | "10 Railway Terrace | 03 9602 4544 | 03 9602 4944 | |

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|-----|--|--------------------------|--|--------------|--------------|--|
| VIC | Konekt | | Mile End 5031" | 03 5332 9969 | 03 5332 8234 | |
| VIC | Konekt | | PO Box 966, Kent Town 5071 | 03 5224 1568 | 03 5224 1687 | |
| VIC | Crawford Healthcare Management Service | Yasmin Haley/ Dale Scott | 177 Payneham Rd, St Peters 5069 | 03 8646 9630 | 03 9686 9676 | yasmin.haley@ crawco.com. au |
| VIC | Counselling Appraisal Consultants (North East) | Janinie Moll | 3/202 Glen Osmond Rd, Fullarton 5063 | 03 9499 4333 | 03 9499 1300 | canortheast@ cac.com.au |
| VIC | Konekt | Sally Singe | Level 1, 87 Brisbane St, Launceston 7250 | 02 6041 3950 | 02 6041 3960 | ssinge@ konekt.com.au |
| VIC | WorkFocus | | 151 Davey St, Hobart 7000 | 03 9646 5011 | 03 9646 8011 | |
| VIC | Konekt | Matthew May | Burnie | 03 9642 8900 | 03 9642 8228 | mmay@ konekt.com.au |
| VIC | Work Solutions | Nichole Pereira | Level 5, 90 William St, Melbourne 3000 | 03 9224 8800 | 03 9224 8801 | nichole. pereira@ worksolutions. com.au |
| WA | Konekt | Penny Pettingill | Ballarat | 08 9202 7200 | 08 9202 7211 | ppettingill@ konekt.com.au |
| WA | WorkFocus | | Geelong | 08 9388 7788 | | |
| WA | Christine Poynton P/L | Christine Poynton | The Tea House, Level 1, 28 Clarendon Street, Southbank. 3006 | 08 9317 6700 | 08 9317 6711 | christine@ christinepoynton.com.au |
| WA | Rocky Bay | Ian Burns | Level 1, Suite 7, 50 Upper Heidelberg Road, Ivanhoe. 3079 | 08 9383 5111 | 08 9383 1230 | |
| WA | Mount Injury Management Service | Trish Leonhardt | PO Box 294, Albury 2640 | 08 9445 9555 | 08 9445 9222 | Trish@mount- injury.com.au |
| WA | Advanced Personnel Management | | "PO Box 640 | 08 9486 1244 | 08 9486 1344 | |
| WA | Absolute Balance | Derek Knox | Port Melbourne 3207" | 08 9244 5580 | 08 9244 5582 | derek@abso- lutebalance. com.au |
| WA | Cambridge Career Counselling Service | | Level 8, 179 Queen St, Melbourne 3000 | 08 93876567 | | |