Medicare Benefits Schedule Review Taskforce

Post Consultation Report from the Mental Health Reference Group

2019

Important note

The views and recommendations in this review report from the Mental Health Reference Group have been released for the purpose of seeking the views of stakeholders.

This report does not constitute the final position on these items, which is subject to:

- Consideration by the MBS Review Taskforce;

Then

- Consideration by the Minister for Health; and
- Government.

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1. Executive summary

1.1 Introduction

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is undertaking a program of work that considers how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister for Health (the Minister) that will allow the MBS to deliver on each of these four key goals:

- Affordable and universal access.
- Best-practice health services.
- Value for the individual patient.
- Value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by clinical committees, primary care reference groups (PCRGs) and working groups.

1.2 Review of Mental Health MBS items

The Mental Health Reference Group (the Reference Group) was established in 2018 to make recommendations to the Taskforce on MBS items in its area of responsibility, based on rapid evidence review and clinical expertise.

The PCRGs provide recommendations to the Taskforce in a review report. Once endorsed by the Taskforce, the review reports are released for targeted stakeholder consultation. The Taskforce then considers the revised review reports, which include stakeholder feedback, before making recommendations to the Minister for consideration by Government.

1.3 Key issues

The Reference Group's recommendations were guided by four overarching themes.

- Apply a stepped care approach to MBS mental health services – covering Recommendations 1, 3, 10 and 12.
- Increase the flexibility of MBS mental health services – covering Recommendations 2, 5, 6, 13, and 14.

- Incorporate the latest evidence into the MBS approach to mental health services – covering Recommendations 7, 8, 9 and 11.
- Address ongoing questions in the mental health provider community – covering Recommendation 4.

1.4 Key recommendations

The Reference Group is recommending significant amendments to existing items, the creation of new items, and the development of a new working group or committee to resolve outstanding questions. All recommendations seek to improve access to mental health services for Australians, taking into consideration the latest evidence and focusing on preventive, flexible and cost-efficient models of care.

The Reference Group's recommendations are summarised below.

- GP Mental Health Treatment Plans

1. Expand the Better Access program to at-risk people
2. Increase the maximum number of sessions per referral

- Better Access items

3. Introduce a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness
4. Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups
5. Reduce the minimum number of participants in group sessions
6. Add a new group item for therapy in larger groups

1.5 Longer term recommendations

Recommendations that are longer term are listed below:

7. Enable family and carers to access therapy and/or consultation
8. Measure Better Access outcomes
9. Update treatment options
10. Unlink GP focused psychological strategy items from M6 and M7 items
11. Encourage coordinated support for patients with chronic illness and patients with mental illness
12. Promote the awareness of digital mental health and other low-intensity treatment options
13. Support access to mental health services in residential aged care
14. Increase access to telehealth services

Error! Reference source not found.A full listing of all recommendations is at Appendix B.

1.6 Consumer impact

The Reference Group developed recommendations that are consistent with the Taskforce's objectives and focus on improving access and value for consumers through the delivery of appropriate mental health care. Reference Group members discussed a range of issues in the mental health space, considering challenges in consumer access, flexibility, outcomes and collaboration in a multidisciplinary care setting.

The Reference Group's recommendations are intended to enable the following.

- **Access and flexibility:** Changes to Mental Health Treatment Plans (MHTPs) will make them available to those at risk of developing a mental disorder, providing a platform for prevention and early diagnosis and treatment. This means that appropriate services will be available for consumers earlier in their treatment pathways. Other recommendations promote access to care in group settings, via telehealth and in aged care settings.
- **Stepped care triage:** Recommendation 3 will strengthen the Better Access items by creating a triaged structure. This will allow consumers to access the level of intervention that is right for them, and will ensure that treatment can be appropriately informed and planned. This will provide a broader range of services suited to individual needs, targeting people whose needs are more complex. Other recommendations enhance this format by updating the treatment options for mental health service delivery under Better Access, and by adding family and carer session options.
- **High-value care:** To ensure that the recommendations outlined in this report achieve the best possible outcomes, Recommendation 4 notes the additional work required to review access to the MBS for different professional groups and appropriate schedule fee for mental health services. Recommendation 2 enables flexibility in the referring clinician review structure, avoiding low-value reviews where unnecessary, while still allowing for high-value reviews and collaboration between providers. Other recommendations address interactions with other parts of the health system, such as acknowledging the physical health of those with mental illness (and vice versa) and the interaction between mental health services and the aged care sector.

1.7 Next Steps

The Taskforce considers the Review Reports from the reference groups and any stakeholder feedback before making recommendations, if required, to the Minister for consideration by Government.

2. About the Medicare Benefits Schedule (MBS) Review

2.1 Medicare and the MBS

2.1.1 What is Medicare?

Medicare is Australia's universal health scheme that enables all Australian residents (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost.

Introduced in 1984, Medicare has three components:

- Free public hospital services for public patients.
- Subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS).
- Subsidised health professional services listed on the MBS.

2.2 What is the MBS?

The MBS is a listing of the health professional services subsidised by the Australian Government. There are more than 5,700 MBS items that provide benefits to patients for a comprehensive range of services, including consultations, diagnostic tests and operations.

2.3 What is the MBS Review Taskforce?

The Government established the Taskforce as an advisory body to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The Taskforce will also modernise the MBS by identifying any services that may be unnecessary, outdated or potentially unsafe. The MBS Review is clinician-led, and there are no targets for savings attached to the review.

2.3.1 What are the goals of the Taskforce?

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals.

- **Affordable and universal access**—the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic, with some rural patients being particularly under-serviced.

- **Best-practice health services**—one of the core objectives of the MBS Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base when possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.
- **Value for the individual patient**—another core objective of the review is to have an MBS that supports the delivery of services that are appropriate to the patient's needs, provides real clinical value and does not expose the patient to unnecessary risk or expense.
- **Value for the health system**—achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

2.4 The Taskforce's approach

The Taskforce is reviewing existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice. Within the Taskforce's brief, there is considerable scope to review and provide advice on all aspects that would contribute to a modern, transparent and responsive system. This includes not only making recommendations about adding new items or services to the MBS, but also about an MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach, and to seize this unique opportunity to recommend changes to modernise the MBS at all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues. The Taskforce will also develop a mechanism for an ongoing review of the MBS once the current review has concluded.

As the MBS Review is clinician-led, the Taskforce decided that clinical committees should conduct the detailed review of MBS items. The Taskforce also established PCRGs to review MBS items largely provided by non-doctor health professionals. The committees and PCRGs are broad-based in their membership, and members have been appointed in an individual capacity, rather than as representatives of any organisation.

2.4.1 What is a primary care reference group?

The Taskforce established the PCRGs to focus on items that are primarily or exclusively provided by non-doctor health professionals, and which have a close relationship to primary care. The MBS Review Taskforce established five PCRGs:

- Aboriginal and Torres Strait Islander Health Reference Group
- Allied Health Reference Group
- Mental Health Reference Group
- Nurse Practitioner Reference Group, and
- Participating Midwives Reference Group.

The PCRGs are similar to the clinical committees established under the MBS Review. Each PCRG reviewed in-scope items, with a focus on ensuring that individual items and usage meet the four goals of the Taskforce. They also considered longer-term recommendations related to broader issues (not necessarily within the current scope of the MBS) and provided input to clinical committees, including the General Practice and Primary Care Clinical Committee (GPPCCC). Each PCRG makes recommendations to the Taskforce, as well as to other committees, based on clinical expertise, data, and evidence.

The PCRGs are unique within the MBS Review for several reasons:

- **Membership:** Similar to clinical committees, the PCRGs include a diverse set of stakeholders, as well as an ex-officio member from the MBS Review Taskforce. As the PCRGs focus on items that are primarily or exclusively provided by non-doctor health professionals, and which have a close relationship to primary care, membership includes many non-doctor health professionals, as well as an ex-officio member from the GPPCCC. Each PCRG also includes a general practitioner (GP), a nurse, and two consumers.
- **Connection to the GPPCCC:** As part of their mandate from the Taskforce, the PCRGs were tasked with responding to issues referred by the GPPCCC. The PCRGs also reviewed some items delivered by GPs and proposed recommendations with implications for GP care. The GPPCCC ex-officio member on each PCRG helped to strengthen the connection between the two bodies and supported communication of the PCRGs' responses to the GPPCCC.
- **Newer items:** The items reviewed by the PCRGs have a shorter history than other items within the MBS; many were introduced only in the last decade. While this means that there is less historical data to draw on, it also means that there are fewer items under consideration that are no longer relevant, or that no longer promote best-practice interventions, compared to other committees.
- **Growth recommendations:** Several of the PCRGs' in-scope items have seen significant growth since their introduction, often with the potential to alleviate cost pressures on other areas of the MBS or the health system, or to increase access in low-access areas. As a result, many recommendations focus on adjusting items that are already working

well, or recommending expansion of recently introduced items to facilitate access to evolving models of health care delivery.

2.4.2 The scope of the primary care reference groups

All MBS items will be reviewed during the course of the MBS Review. Given the breadth of the review, and its timeframe, each clinical committee and PCRG developed a work plan and assigned priorities, keeping in mind the objectives of the review.

The PCRG review model approved by the Taskforce required the PCRGs to undertake three areas of work, prioritised into two groups.

- Priority 1 - Review referred key questions on draft recommendations from the GPPCCC and develop recommendations on referred in-scope MBS items.

  As part of this work, the PCRGs also reviewed and developed recommendations on referred issues from other committees or stakeholders where relevant.

- Priority 2 - Explore long-term recommendations.

  These included recommendations related to other MBS items beyond the PCRGs' areas of responsibility, recommendations outside the scope of existing MBS items, and recommendations outside the scope of the MBS, including recommendations related to non-fee-for-service approaches to health care.

3. About the Mental Health Reference Group

The Mental Health Reference Group (the Reference Group) was established in June 2018 to make recommendations to the Taskforce on MBS items in its area of responsibility, as well as long-term issues, and to respond to referred questions from the GPPCCC.

3.1 Mental Health Reference Group members

The Reference Group consists of 21 members, whose names, positions/organisations and declared conflicts of interest are listed in Table 1.

Table 1: Mental Health Reference Group members

Name	Position/organisation	Declared conflict of interest
Dr Chris Mogan (Chair)	Clinical Psychologist; Director, The Anxiety & OCD Clinic, Richmond, Victoria; Senior Fellow, University of Melbourne School of Psychological Sciences	Provider of in-scope MBS items
Dr James Alexander	Psychologist	Provider of in-scope MBS items; Member of the Australian Association of Psychologists Inc (AAPI)
Ms Voula Antoniadis	Psychologist	Provider of in-scope MBS items
Ms Leanne Clarke	Clinical Psychologist; Director, Southside Health & Wellbeing	Provider of in-scope MBS items; previously on the Australian Clinical Psychology Association (ACPA) Board; Previous advocacy for MBS clinical psychology items; Contributed to the original ACPA (2017) submission to the MBS Review.
Mrs Christine Coop	Occupational Therapist; Director, Enable Occupational Therapy in Mental Health	Provider of in-scope MBS items
Mrs Amanda Curran	Psychologist; Director, Family Matters Psychology Services	Provider and consumer of MBS items; Family members are consumers of MBS items; Made a submission to the

Name	Position/organisation	Declared conflict of interest
		MBS Review; Previous advocacy work with Equality in Psychology and signed their Medicare review submission; Member of AAPI
Ms Jillian Harrington	Clinical Psychologist, Southern Cross Psychology Pty Ltd; Director, Wentworth Healthcare Ltd (provider of the Nepean Blue Mountains Primary Health Network)	Provider of in-scope MBS items; Employer of providers of in-scope MBS items; Member of the Australian Psychological Society, the Australian Association for Cognitive and Behaviour Therapy and the International Society for the Study of Trauma and Dissociation
Dr Caroline Johnson	General Practitioner; Senior Lecturer, Department of General Practice, Melbourne Medical School, University of Melbourne	Provider of in-scope MBS items; Made a submission to the MBS Review as a Member of the Royal Australian College of General Practitioners Expert Committee – Quality Care
Dr Clive Jones	Psychologist (Counselling Psychology and Sports and Exercise Psychology)	Provider of FPS MBS items as a registered psychologist; Personal submission made to the MBS Review
Ms Karen King	Counselling Psychologist at Brainbox Psychology Clinic	Provider of in-scope MBS items
Assoc. Prof. Beth Kotze	Executive Director, Mental Health, Western Sydney Local Health District	Nil
Ms Janne McMahon OAM (Consumer representative)	Chair, Private Mental Health Consumer Carer Network Australia	Nil
Ms Sonia Miller	Nurse Practitioner and Credentialed Mental Health Nurse; Director, MHNP Consulting; Chair, Australian College of Mental Health Nurses (ACMHN) Mental Health Nurse Practitioners (MHNP) Special Interest Group	Provider of Nurse Practitioner MBS items; Current Access to Allied Psychological Services (ATAPS) provider; Credentialed Mental Health Nurses (CMHN) provider under the Mental Health Nurse Incentive Program

Name	Position/organisation	Declared conflict of interest
		(MHNIP) until June 2018; Mental Health Services Coordinator for GPDiv/ML/PHN until 2013 across ATAPS and MHNIP funding
Dr Ann Moir-Bussy	Registered Counsellor and Psychotherapist	Nil
Ms Joanne Muller (Consumer representative)	Community Member	Nil
Ms Wendy Northey	Mental Health Consultant; Former Forensic Psychologist	Nil
Dr Di Stow	Counsellor, Accredited Clinical Registrant, Accredited Mental Health Practitioner, Accredited Supervisor, Accredited Surrogacy Counsellor; President, Psychotherapy and Counselling Federation of Australia	Nil
Ms Julianne Whyte	Accredited Mental Health Social Worker; Chief Executive Officer, Amaranth Foundation; Member of the Australian Association of Social Workers (AASW) Palliative Care Social Work Practice Group, Social Work in Private Practice Group, and Accredited Mental Health Social Work Practice Group	Provider of in-scope MBS items; Contributed to the AASW response to the Draft Mental Health Reference Group Report.
Mr Bill Buckingham (Department advisor)	Technical Advisor (Mental Health) to Department of Health	Nil. Non-voting member
Dr Lee Gruner (ex-officio member)	Member of the Medicare Benefits Schedule Review Taskforce	Nil Non-voting member
Professor Lyn Littlefield (ex-officio)	General Practice Primary Care Clinical Committee Ex-Officio	Nil Non-voting member

Note: Dr Anthony Cichello, clinical psychologist, attended the second Reference Group meeting as a member but stepped down from the position due to personal circumstances.

3.2 Conflicts of interest

All members of the Taskforce, clinical committees and PCRGs are asked to declare any conflicts of interest at the start of their involvement and reminded to update their

declarations periodically. A complete list of declared conflicts of interest is included in Table 1.

The majority of Reference Group members share a common conflict of interest in reviewing items that are a source of revenue for them (i.e. members claim the items under review). This conflict is inherent in a clinician-led process, and having been acknowledged by the Reference Group and the Taskforce, it was agreed that this should not prevent a clinician from participating in the review.

3.3 Areas of responsibility of the Reference Group

The Reference Group reviewed 47 MBS items:

- Three group therapy items (A6).
- Four pregnancy support counselling items (A27 and M8).
- Ten general practice mental health treatment items (A20).
- Five psychological therapy services items (M6).
- Fifteen FPT items (M7).
- Two allied health services items (M3), and
- Eight autism, pervasive developmental disorder and disability services items (M10).

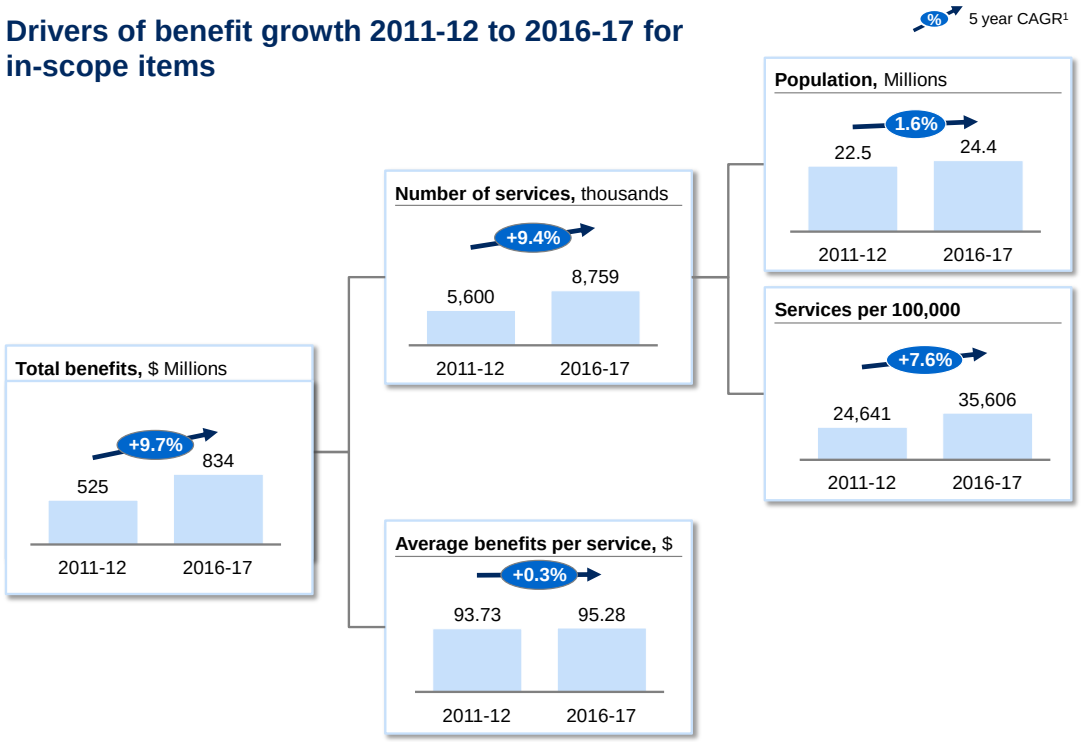
The M3 and M10 items are also being reviewed by the Allied Health Reference Group. One M3 item is also being reviewed by the Aboriginal and Torres Strait Islander Health Reference Group.

The 47 mental health items primarily cover Mental Health Treatment Plans (MHTPs) and associated psychological treatment strategies. In 2016/17, these items accounted for approximately 8.8 million services and $834 million in MBS benefits. Over the past five years, service volumes for these items have grown at 9.4 per cent per year, compounded annually (CAGR). The cost of benefits per service has increased by 0.3 per cent per year (CAGR) (Figure 1).

In 2016/17, the items for “Attendance for focussed psychological strategies services by psychologist” and “Assessment and therapy by clinical psychologist lasting at least 50 minutes” accounted for approximately 52 per cent of service volume (28 per cent and 24 per cent, respectively) (Figure 2).

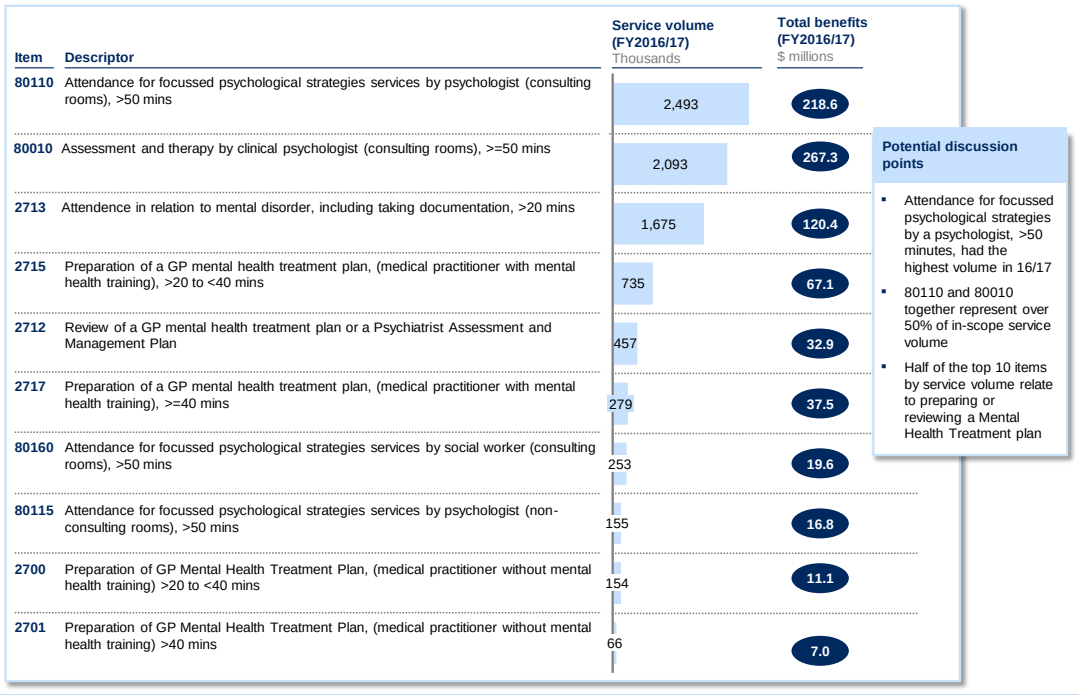
A full list of in-scope items is at Appendix A.

Figure 1: Drivers of benefit growth for in-scope items



1 Compound Annual Growth Rate
SOURCE: MBS data, 2011/12 – 2016-17

Figure 2: Mental health items, ordered by service volume



SOURCE: MBS data, 2011/12 – 2016-17

3.4 Summary of the Reference Group's review approach

The Reference Group completed a review of its items across four full meetings, during which it developed the recommendations and rationales contained in this report.

The review drew on various types of MBS data, including data on:

- utilisation of items (services, benefits, patients and growth rates)
- service provision (type of provider, geography of service provision)
- patients (services per patient); and
- additional provider and patient-level data, when required.

The review also drew on data presented in the relevant literature and clinical guidelines, all of which are referenced in the report. Guidelines and literature were identified through medical journals and other sources, such as professional societies.

The Reference Group considered relevant stakeholder submissions to the MBS Review in making its recommendations.

4. Flexibility, access and choice in mental health services

The Government's response to *Contributing Lives, Thriving Communities – Review of Mental Health Programs and Services* (1) recognised that services provided through the Better Access program have been the biggest drivers of advances in treatment rates since the program's inception in 2006. However, it also acknowledged that Better Access is a "one size fits all" program and may not be the most efficient pathway for everyone with a diagnosed mental health illness.

While the MBS is also a "one size fits all" program, the Reference Group agreed that there is sufficient scope to tailor services for populations in need. This became a focus of the Reference Group's recommendations. This theme is relevant not just to the recommendations contained in this report, but also to the current challenges and future directions of mental health care delivered through the MBS.

The Reference Group identified the following issues:

- **Access and choice in service provision:** A common theme, evident across several submissions and embedded throughout numerous discussions within the Reference Group, was the need to ensure that consumers have adequate access to mental health services through the MBS. The Reference Group also highlighted the importance of consumer choice in mental health provision to promote a strong therapeutic alliance, noting that the commercial interests of health professionals should not influence this choice. The Reference Group noted that several submissions discussed the proximity and affordability of services, and the complexity of the referral process.
- **Stepped care models and equitable access to care:** The Reference Group understands from many submissions that some patients are unable to access as much care as they need. At the same time, MBS data shows that many patients with an MHTP do not use all of the sessions to which they are entitled. The Reference Group also noted the preventive value (both in health outcomes and economic terms) of access to rebated services for patients who do not have a current diagnosable mental illness but are at risk of developing one in the immediate to short term.
- These factors formed the backdrop of several conversations on stepped care models. Stepped care models are evidence-based staged care systems consisting of a hierarchy of interventions, from the least to the most intensive, matched to an individual's needs. These models increasingly drive approaches to mental health services in Australia (for

example, in primary health network [PHN] services). The introduction of a comparable approach within Better Access would mean that 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”, or tier. Instead, an appropriate service level is assigned according to clinical need when the individual enters the system, and the number of sessions can be adjusted as treatment proceeds.

- Discussion about mental health service provision through the MBS highlighted GPs’ crucial role in the referral process, in collaboration with the consumer and service provider, as well as their role as mental health clinicians. This referral role is important within a stepped care model as GP stewardship can help guide patient access to the right level of care. Ongoing communication between the referring practitioner, the mental health service provider and the patient can ensure that the patient continues to navigate all health services effectively.

5. Recommendations

5.1 Mental Health Treatment Plans

Table 2: GP mental health treatment

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
2700	Preparation of GP Mental Health Treatment Plan, (medical practitioner without mental health training) >20 to <40 mins	71.70	154,195	11,084,468
2701	Preparation of GP Mental Health Treatment Plan, (medical practitioner without mental health training) >40 mins	105.55	65,974	6,970,266
2712	Review of a GP mental health treatment plan or a Psychiatrist Assessment and Management Plan	71.70	456,706	32,915,081
2713	Attendance in relation to mental disorder, including taking documentation, >20 mins	71.70	1,674,946	120,445,474
2715	Preparation of a GP mental health treatment plan, (medical practitioner with mental health training), >20 to <40 mins	91.05	734,815	67,072,887
2717	Preparation of a GP mental health treatment plan, (medical practitioner with mental health training), >=40 mins	134.10	279,234	37,484,095
2721	Consulting room attendance for focussed psychological strategies for assessed mental disorders (medical practitioner registered with the Chief Executive Medicare), >30 to <40 mins	92.75	3,916	364,226

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
2723	Non-consulting room attendance for focussed psychological strategies for assessed mental disorders (medical practitioner registered with the Chief Executive Medicare), >30 to <40 mins	92.75, plus $25.95 divided by the number of patients seen, up to a max of 6	20	2,374
2725	Consulting room attendance for focussed psychological strategies for assessed mental disorders (medical practitioner registered with the Chief Executive Medicare), >=40 mins	132.75	28,321	3,860,772
2727	Non-consulting room attendance for focussed psychological strategies for assessed mental disorders (medical practitioner registered with the Chief Executive Medicare), >=40 mins	132.75, plus $25.95 divided by the number of patients seen, up to a max of 6 patients	162	25,024

5.1.1 Recommendation 1 – Expand the Better Access Program to at-risk people

The Reference Group recommends expanding the Better Access program to at-risk people (items 2700, 2701, 2715 and 2717):

a. by amending the explanatory note (AN.0.56) to:
   (i) Include people who are considered at risk of developing a mental health disorder in the next 12 months in the section on eligibility for an MHTP.
   (ii) replace the words “structured approach” with “planned approach”.
   (iii) include in the definition of “at risk” both early presentations with no previous history and those who are currently relatively symptom free but require professional service for relapse prevention.

and

b. amending the explanatory note as follows:

Revision to Explanatory Note AN.0.56 – example text

What people are eligible - Mental Disorder

These items are for people with a mental disorder, or at risk of a mental disorder, who would benefit from a planned approach to the management of their treatment needs. Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional, behavioural, and/or social abilities (Refer to the World Health Organization, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version). Those at risk of mental disorder are either

(i) those with early, sub-syndromal symptoms of the disorders referenced above, who have a high likelihood of developing such a disorder in the next 12 months without timely and appropriate treatment; or

(ii) those who have recovered from a previously diagnosed disorder as referenced above and require treatment to maintain their mental health and prevent relapse

Dementia, delirium, tobacco use disorder and intellectual disability on their own are not regarded as mental disorders for the purposes of the GP Mental Health Treatment items.

Notes:

1. *The Reference Group noted that the 11th revision of the International Classification of Diseases (ICD-11) was published in June 2018 and expects item descriptors to be amended accordingly when this comes into force in January 2022.*
2. *The Reference Group also noted that this recommendation could interact with Recommendation 2 and Recommendation 3. Its expectation is that patients with an MHTP who are deemed part of the at-risk cohort will access a maximum of 10 Better Access sessions per 12-month period, with the referring provider making the initial referral for the maximum 10 sessions.*

5.1.2 Rationale 1

This recommendation focuses on making MHTPs more widely available to those who would derive high value from access to mental health services but are currently not able to access these services. It is based on the following:

- This recommendation would align eligibility for MBS-subsidised mental health care with requirements introduced for PHNs as part of recent Commonwealth mental health reforms (1). PHNs are mandated to commission services for individuals at risk who

present with early symptoms, and to ensure that early interventions are targeted at hard-to-reach groups who face obstacles in accessing MBS services.

- There is significant health value in preventing deterioration in mental health for those who experience early, sub-diagnostic symptoms, and for those who have recovered from a previous mental health disorder but remain at risk of relapse without adequate maintenance care, due to their heightened vulnerability.
- People who receive early treatment for potential mental health disorders need continued support to consolidate therapeutic gains. They remain vulnerable to relapse when conflicts arise, they are affected by comorbidities and/or previous behavioural patterns re-emerge. Use of relapse prevention strategies is inherent in treatment protocols across mental health.
- Access to mental health care for this population would reduce pressure on other MBS services, as well as potentially reducing costs for other health services. The Reference Group acknowledged that reduced costs may be seen across other budgets (for example, social welfare) as well as within health services, but these are harder to track and/or quantify. However, the Reference Group noted the following potential efficiencies resulting from this recommendation:
    - Within the MBS, this recommendation would reduce the total number of sessions used by some patients by addressing sub-syndromal symptoms earlier, when they are easier to manage.
    - There are follow-on advantages to this across the health system, including:
        - Reduced admissions into emergency departments (2).
        - Reduced hospital presentations (by number and bed days). Examples include patients referred at subthreshold levels for panic disorder and early psychosis, and women in the perinatal period (3) (4).
    - Research conducted at the London School of Economics noted the substantial savings from investing in early intervention for young people in the United Kingdom, with “perhaps £15 in costs avoided for every £1 invested” (5).
- The Reference Group also noted that people at risk of developing a mental disorder have limited alternative options for accessing care. While PHNs are now expected to commission services for those at risk of mental illness, PHN funding is limited and targeted at specific populations. For example, service eligibility is sometimes restricted to those with low incomes or health care card holders. Enabling access to care for the at-risk population through the MBS would ensure consistency and reliable access across communities.

- The role of public mental health services is to focus on the severe and acute end of the spectrum, and to provide access to treatment for people who require it under the provisions of the Mental Health Act for their respective jurisdiction (6).
- As the primary point of contact for other health concerns, GPs are well placed to assist in identifying and addressing risk factors for mental health, particularly for consumers who may otherwise not present to a mental health practitioner.
- Enabling access to care for the at-risk population without requiring a formal diagnosis could reduce stigma around mental health disorders, increasing the potential for healing without progression into full mental illness.

Members of the Reference Group noted clinical experience with patients who expressed concern about a diagnosis being recorded on their file, which may feature in future medical checks in applications to the military, police force, etc.

5.1.3 Recommendation 2 – Increase the maximum number of sessions per referral

The Reference Group recommends increasing the number of sessions per referral (items 2700, 2701, 2715 and 2717), by:

a. by amending the explanatory note (AN.0.56) to:
   (i) increase the maximum number of sessions in any one referral from six to 10 sessions in the sections on “Preparation of a GP Mental Health Treatment Plan” and “Referrals”.
   (ii) clearly state that 10 sessions is the maximum number of sessions from any one referral (rather than a minimum or required number of sessions), and that the referring practitioner should use their discretion in setting the referred number of sessions for any course of treatment.
   (iii) encourage discussion with the patient, as well as with the mental health provider, in determining the appropriate number of sessions for initial and subsequent referrals.
b. amending the explanatory note as follows:

Revision to Explanatory Note AN.0.56 – example text

In the section titled "Preparation of a GP Mental Health Treatment Plan":

> On completion of a course of treatment provided through Medicare rebateable services, the service provider must provide a written report on the course of treatment to the GP. For the purposes of the Medicare rebateable mental health items, a course of treatment will consist of the number of services stated on the patient's referral (up to a maximum of ten in any one referral). The number of services that the patient is being referred for is at the discretion of the referring practitioner (e.g., GP). The referring practitioner is encouraged to discuss the appropriate number of referred sessions for a single course of treatment with the referred practitioner providing the mental health services, as well as with the patient.

In the section titled "Referral":

> When referring patients, GPs should provide similar information as per normal GP referral arrangements, and should include both a statement identifying that a GP Mental Health Treatment Plan has been completed for the patient (including, with the patient's agreement, attaching a copy of the patient's GP Mental Health Treatment Plan) and clearly nominating a specific number of sessions. Referrals for patients with either a GP Mental Health Treatment Plan or referred psychiatrist assessment and management plan (item 291) should be provided, as required, for a course of treatment (a maximum of ten services) but may be less depending on the referral and the patient's clinical need).

and

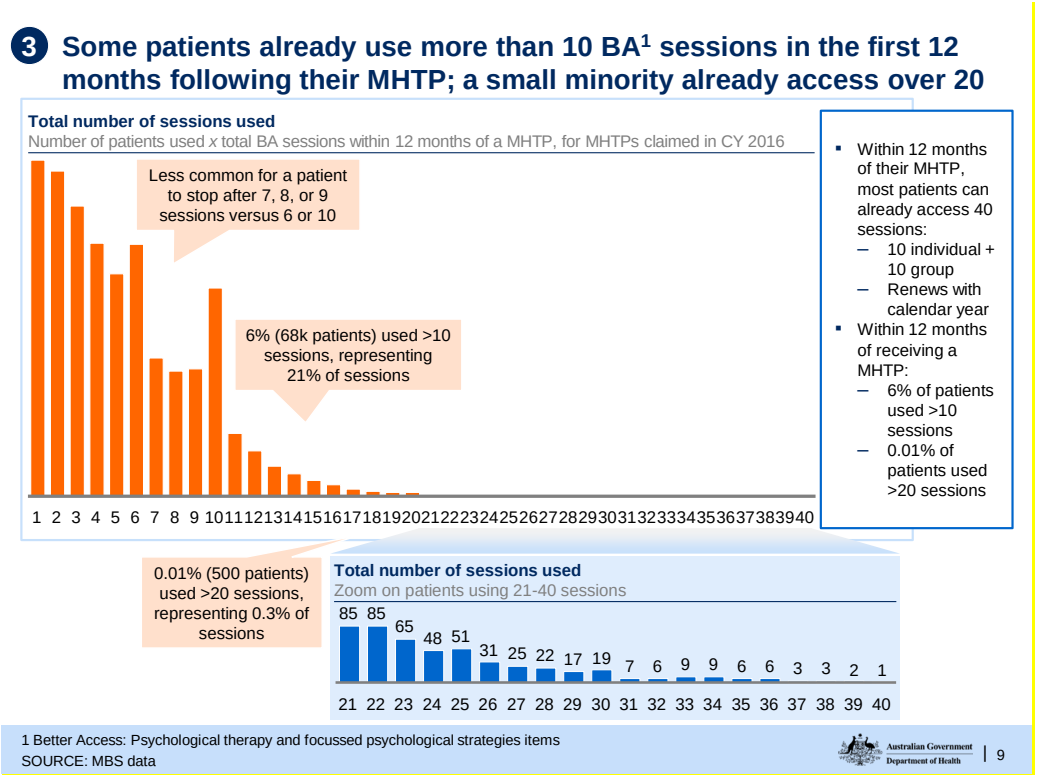
c. amending the explanatory note for the mental health provider (MN.7.1) to include:
   (i) a requirement for return communication from the mental health provider to the referring provider (in this case, a GP).
   (ii) that the mental health provider should communicate with the referring provider within the first four Better Access sessions, and
   (iii) that this could include, for example, confirming that the MHTP has been actioned and that the patient has attended Better Access sessions, and/or an indication of the estimated number of sessions the patient will require for a full course of treatment.

5.1.4 Rationale 2

This recommendation focuses on improving access to mental health treatment sessions for patients who have an MHTP. It is based on the following:

- The Reference Group agreed that enabling the provision of up to 10 sessions for the initial referral under an MHTP would simplify access to care for some patients:
    - Requiring the patient to return to the referring practitioner (generally a GP) after the sixth session creates a barrier to accessing further sessions if the patient does not follow up with their GP (Figure 3).
    - Requiring the patient to return to the referring practitioner may also interrupt the therapeutic flow of a course of treatment if the patient has to wait several weeks to see their GP.
    - The interruption to the course of treatment can be even more pronounced in rural areas, where access to the GP may be more infrequent.
- The Reference Group agreed that this recommendation would not impede the ability of the referring practitioner to exercise clinical discretion in determining the right amount of care for each patient. The referring practitioner may refer for any number of sessions between one and 10, based on their clinical discretion.

Figure 3: Difference in patients attending seven, eight or nine sessions, compared to six or 10 sessions



- The Reference Group encourages more pro-active and timely follow-up between the referring practitioner and the provider of mental health services. While the Reference Group expects follow up by the mental health provider, it noted that communication should be appropriate to the needs and complexity of the patient. The Reference Group also believes that practitioners should establish the means and interval of coordination and communication that is most practical and relevant.
    - The Reference Group noted that increased monitoring of outcomes may help to reduce risks of low communication between the GP and the mental health provider (although outcomes monitoring should not replace this communication). The Reference Group's recommendation on outcomes measurement can be found in Section 6.1.3.
- The Reference Group agreed that this recommendation has the potential to reduce spending on unnecessary GP reviews. Currently, GPs are required to review a patient's progress under an MHTP after a maximum of six sessions. This review may take the form of a standard GP attendance, an MHTP review item or a GP mental health treatment attendance (item 2713).
- This review may not always be clinically necessary and may provide low-value care in situations where the referring practitioner has ongoing communication with the provider of mental health services, and/or knows that the patient will require further sessions without modification of the referral. Offering GPs the flexibility to request more sessions per referral allows them to avoid a review when it may not be clinically necessary.
- Recommendation 2 needs to be considered in the context of Recommendation 3 that proposes a 3-tiered approach to accessing Better Access sessions. Within this model, a patient could be referred for an additional two courses of treatment beyond the initial referral, with each course requiring a separate referral by the GP and movement between the tiers determined by defined clinical criteria. Recommendation 2 however should be considered on its own merits in the event that government does not accept Recommendation 3.

5.2 Better Access items

Table 3: Psychological therapies

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
80000	Assessment and therapy by clinical psychologist (consulting rooms), >30 to <50 mins	99.75	14,618	1,254,655

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
80005	Assessment and therapy by clinical psychologist (non-consulting rooms), >30 to <50 mins	124.65	1,107	117,719
80010	Assessment and therapy by clinical psychologist (consulting rooms), >=50 mins	146.45	2,092,967	267,332,018
80015	Assessment and therapy by clinical psychologist (non-consulting rooms), >=50 mins	171.35	38,605	5,772,732
80020	Group therapy, 6-10 patients: Therapy by clinical psychologist, >=60 mins	37.20	15,355	590,441

Table 4: Focused psychological therapies

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
80100	Attendance for focussed psychological strategies services by psychologist (consulting rooms), >20 to <50 mins	70.65	31,592	1,954,150
80105	Attendance for focussed psychological strategies services by psychologist (non-consulting rooms), >20 to <50 mins	96.15	2,652	219,066
80110	Attendance for focussed psychological strategies services by psychologist (consulting rooms), >50 mins	99.75	2,493,291	218,621,512
80115	Attendance for focussed psychological strategies services by psychologist (out of rooms), >50 mins	125.30	154,851	16,771,822
80120	Group therapy, 6-10 patients: focussed psychological strategies services by psychologist, >=60 mins	25.45	21,450	587,021
80125	Attendance for focussed psychological strategies services by occupational therapist (consulting rooms), >20 to <50 mins	62.25	5,099	317,523

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
80130	Attendance for focussed psychological strategies services by occupational therapist (non-consulting rooms), >20 to <50 mins	87.70	998	81,349
80135	Attendance for focussed psychological strategies services by occupational therapist (consulting rooms), >50 mins	87.95	50,572	4,200,419
80140	Attendance for focussed psychological strategies services by occupational therapist (non-consulting rooms), >50 mins	113.35	11,040	1,143,529
80145	Group therapy, 6-10 patients: focussed psychological strategies services by occupational therapist, >=60 mins	22.35	1,613	60,129
80150	Attendance for focussed psychological strategies services by social worker (consulting rooms), >20 to <50 mins	62.25	2,782	150,046
80155	Attendance for focussed psychological strategies services by social worker (non-consulting rooms), >20 to <50 mins	87.70	2,055	153,333
80160	Attendance for focussed psychological strategies services by social worker (consulting rooms), >50 mins	87.95	253,143	19,565,965
80165	Attendance for focussed psychological strategies services by social worker (non-consulting rooms), >50 mins	113.35	52,110	5,032,336
80170	Group therapy, 6-10 patients: focussed psychological strategies services by social worker, >=60 mins	22.35	2,406	47,008

5.2.1 Recommendation 3 – Introduce a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness

The Reference Group recommends:

a. introducing a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness
b. changing the item 80000–80015, 80100–80115, 80125–80140 and 80150–80165 descriptors to specify that instead of 10 planned sessions in a calendar year, patients can access up to three tiers of Better Access sessions, with each tier allowing a greater number of sessions with:

   (i) each tier to provide access to a different maximum number of sessions within a 12-month period (for example, Tier 1 -10, Tier 2 – 20, Tier 3 - 40).

   (ii) access to, and progress through, the three tiers will depend on the severity of the patient's condition requiring treatment, defined by a number of factors outlined below.

   (iii) a patient's access to each higher level tier would require GP review. Thus, a GP would need to endorse, by way of a review, a patient's need to progress from Tier 1 to Tier 2 at the completion of Tier 1, and from Tier 2 to Tier 3 at the completion of Tier 2. The intent is that the GP's central stewardship role be maintained in the proposed tiered Better Access system.

c. amending the item descriptors are as follows:

Revision to descriptors – example text

These therapies are limited, being deliverable in a maximum number of planned sessions in a 12-month period, all of which may be provided via video conference for patients living in telehealth-eligible areas (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). The maximum number of planned sessions before review will fall into one of three tiers, and should be detailed by the referring practitioner at each transition between tiers.

d. consistent with Recommendation 1, a maximum of 10 sessions for the first tier and for higher tiers, a maximum of 20 sessions is recommended for the second tier and a maximum of 40 sessions for the third tier, within any 12-month period.

Note: The Reference Group noted that session maximums falling below this level would significantly limit the effectiveness of the recommendation for a range of conditions.

e. to align with Recommendation 2:
   (i) there may be two or more courses of treatment within a patient's entitlement of services per calendar year
   (ii) the GP should consider the patient's clinical need for further sessions after the initial referral, and

(iii) using a GP MHTP Review, a GP Mental Health Treatment Consultation or a standard consultation item.

and

f. adding a new explanatory note to:

(i) provide guidance to the referring practitioner on assessing whether a patient should be referred for additional sessions.

(ii) shift the relevant time period from the current arbitrary calendar year to per 12-month period, where the 12 months commences from the date of the initial referral.

(iii) detail the clinical criteria and thresholds to be met for the referral of patients from Tier 1 to higher levels, including:

- Criteria need to be based on, but not solely confined to, disorder type (diagnosis). Additional considerations in setting thresholds would include severity of symptoms, duration of mental health disorder (chronicity), impact of disorder on functioning, response to previous treatment (if applicable) and complexity (co-morbidity).
- Evidence of progress in therapy, the need for further therapy and the clinical rationale for ongoing treatment (comorbidities, additional trauma) should also be considered.
- The decision should emphasise evidence-based clinical need, collaboratively established with the referrer, mental health provider and consumer, rather than setting a number determined prescriptively.

5.2.2 Rationale 3

This recommendation focuses on increasing access to mental health services to appropriate levels for patients with moderate to severe mental health disorders. It is based on the following:

The Reference Group noted that patients with moderate to severe mental health disorders, a small cohort with the highest mental health illness burden, do not currently receive the treatment they need through the MBS.

Eleven per cent of patients with an MHTP used 10 or more Better Access sessions in 2016, and 12 per cent used 10 or more in 2015. This usage pattern suggests that a subset of patients with an MHTP need additional support and are extending their usage of the Better Access sessions.

Analysis by the Department of Health (the Department) showed that between 2006 and 2014, the one-third of patients who used 10 or more services in the four years following their first session accounted for 71 per cent of services. This group included 5 per cent of patients who used 31 or more services and accounted for 21 per cent of services (7).

- Patient session allocation should be determined based on clinical need, rather than arbitrary session limits. Evidence demonstrates the need for more than 10 sessions for specific disorders. See Appendix EE for detailed evidence.
- Under an earlier system, which enabled patients to access rebates for up to 18 sessions in exceptional circumstances, survey data showed that over one-third (37 per cent) of the subset of clients requiring more than 10 sessions required the full 18 sessions to achieve an effective clinical outcome. Another 37 per cent required 11 or 12 sessions to achieve effective outcomes (8).
- The Reference Group agreed that these patients do not currently receive adequate care through other mechanisms, e.g.:
    - Access to mental health services under PHNs is limited by funding and eligibility rules. Eligibility for the stepped care model of PHN funding is often restricted to disadvantaged groups (for example, those from lower socioeconomic backgrounds). People who do not meet these conditions are therefore unable to access stepped care support beyond the current maximum number of MBS-rebated sessions.
    - The Mental Health Nurse Incentive Program (MHNIP) provided support in this area, but the program was discontinued in June 2018. While the Reference Group is not aware of data collected on the impact of this change, clinical experience suggests that many MHNIP clients did not fully transition to PHN funding.
    - Public mental health services are focused on the most acute and severe presentations of low-prevalence mental illnesses. Those with chronic mental illness (who do not have a low-prevalence disorder or major mental health disorder), and particularly those with some functional capacity (i.e. still in employment), may have limited access to ongoing support from public mental health due to demand for services.
- The Reference Group agreed that the MBS is an important avenue through which to support these patients.
- Private practice settings are the most able to provide continuous care with the same therapist in the context of an effective therapeutic alliance. In private practice, mental health professionals and referring GPs work collaboratively within the MBS framework. In this setting, a GP can identify a therapist who is most likely to be a “good fit” for each

patient with chronic or severe mental illness, based on their knowledge of the patient's needs and the therapist's skill, experience and characteristics. The process is straightforward: a patient and/or GP can make direct contact with the treating clinician, and a collaborative approach to mental health care is more easily achieved.

- The short-lead funding cycle for PHNs affects staff quality and turnover and makes it difficult for the PHN system to consistently promise continuity of care.
- The MBS model enables more consumer choice and has fewer access limitations than services commissioned by PHNs (where patients and GPs are restricted to the staff of providers commissioned by the PHN).
- The Reference Group agreed that appropriate treatment would result in optimal outcomes for these patients. With long-term care, this group of patients gets better over time. This reduces hospital admissions, reduces the use of other health services, and improves community and workforce engagement.

  The current model can result in arbitrary interruptions to treatment. For example, when a patient's sessions "run out" for the year, they must wait for the next calendar year to continue treatment.
- The Reference Group noted that this change could be cost-effective in the medium to long term. A small proportion of patients are repeat users of the MBS and drive most service volume. Adequate care (i.e. an appropriate dosage) in the first year would ensure that fewer patients return for frequent psychological services in following years.

  Some patients are referred to psychiatry sessions when their 10 sessions have run out, which is not cost-effective and is disruptive for the patient (the model of care is different under psychiatry, and the patient has to change their mental health provider). When these patients do not receive adequate treatment, costs increase for the rest of the health system—for example, through emergency department presentations and hospital admissions (9) (10).

  Under the MHNIP, providing flexible and unlimited contacts for clients reduced emergency department presentations, hospitalisations and length of stay in hospital; allowed for early discharge management; and prevented relapse overall (11). Twenty-six per cent of emergency presentations and 25 per cent of inpatient admissions to mental health beds were for people with personality disorders, when measured over four years for one local health district in New South Wales (12).
- Appropriate treatment for these patients could also reduce the long-term cost burden on other major agency budgets, such as the social welfare system.
- The specific language of the explanatory note will require further consultation, research and expert input from professional bodies and relevant academic units. The Reference

Group discussed but did not arrive at a clear consensus on the different factors that would determine a patient's level of care, as outlined above, but noted that there is a significant body of research and evidence-based treatment protocols available to inform the development of the tier threshold criteria. For more detail on this discussion, please see **Error! Reference source not found.**F.

- The Reference Group did not align different levels of care with different professions or qualifications. Some members of the Reference Group, dissented from the part of the recommendation which states that the Reference Group did not align different levels of care with different professions or qualifications. Instead, they noted that their understanding was that a new working group or committee (see Section 5.2.3) would establish whether different levels of care should be associated with different professions or qualifications.
- The Reference Group acknowledged that this recommendation may involve complex system changes for the Department of Human Services.

5.2.3 Recommendation 4 – Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups

The Reference Group recommends establishing a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups, noting that:

(i) the group would need adequate time and resources to complete its mandate,
(ii) government would need to carefully consider membership of the group to ensure unbiased, balanced and well-informed discussion and recommendations, and
(iii) this new group should be established urgently to maximise value for the patient and the health system.

5.2.4 Rationale 4

This recommendation focuses on resolving an outstanding debate within the mental health provider community, which concerns access to, and rebates for, different Better Access items for patients within the MBS. It is based on the following:

- Several different professions provide services focused on treating patients with mental health concerns under the MBS. With the aim of improving treatment and management of mental illness in the community, Better Access relies heavily on mental health professionals from a range of professional backgrounds to provide appropriate services to meet these needs.
- By design, there are a number of constraints attached to the MBS Better Access items related to the treating practitioner's type of training, accreditation and registration. For

example, social workers must be a member of the Australian Association of Social Workers (AASW) and certified as meeting the relevant standards.

- Items are currently grouped by service type and profession, such:
    - Registered clinical psychologists currently access items 80000–80021 for psychological therapy services.
    - Non-clinically endorsed registered psychologists, occupational therapists with mental health training and accredited mental health social workers currently access items 80100–80135 for FPS.
    - GPs who meet the appropriate credentialing requirements currently access items 2721–2727 for FPS.
    - Mental health nurses do not have MBS Better Access items, but they received funding to provide clinical nursing and care coordination services for those with severe disorders under the MHNIP up until June 2016. They are currently providing psychological services under programs commissioned through PHNs, as well as psychological services under GP Management Plans (GPMPs).
    - Other mental health professionals such as counsellors and psychotherapists registered under the Australian Register of Counsellors and Psychotherapists (ARCAP) do not have MBS Better Access items.
- Members of the Reference Group disagreed on whether the current item and rebate structure should be changed. Members disagreed on the implications:
    - of different training and qualifications and, in the case of psychology, areas of practice endorsement for access to items and rebates
    - of Australian Health Practitioner Regulation Agency (AHPRA) registration and protected titles for access to items and rebates, and
    - on whether additional professions should be eligible to provide services under the MBS Better Access items.
- The Reference Group agreed that these questions were not resolvable within the timeframe and resources available to the Reference Group. Part of this disagreement reflects a debate within the psychology community that extends beyond the structure of the MBS. Members noted that a review of the evidence and arguments for and against the various perspectives would require significant resources to process and evaluate. The Reference Group agreed that there was a risk of not progressing with recommendations on other important topics related to mental health services within the MBS if this topic became the focus of the Reference Group.
- The Reference Group agreed that this is a critical issue and that the new working group or committee tasked with resolving the issue should be formed carefully, giving due

consideration to membership. The Reference Group agreed that resolution of this issue is a matter of urgency, given the influence of MBS rebates on patient access to mental health services.

5.2.5 Recommendation 5 – Reduce minimum number of participants in group sessions

The Reference Group recommends:

a. reducing the minimum number of participants in group sessions (items 80020, 80120, 80021, 80145, 80146, 80170 and 80171) to four people
b. clarifying that family and couples therapy is not included under the group therapy items, and
c. amending the proposed item descriptor (using psychology as an example) is as follows:

Revision to descriptors – example text

Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration, where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year, all of which may be provided via video conference (including services to which items 80020, 80021, 80120, 80121, 80145, 80146, 80170 and 80171 apply).

Group therapy with a group of 4 to 10 patients.

5.2.6 Rationale 5

This recommendation focuses on increasing the uptake of group sessions by making them more accessible, viable and responsive to the needs of patients. It is based on the following:

- The Reference Group agreed that group-based therapies are both effective and cost-effective. There are many published research reports supporting the efficacy of group-based therapies, e.g. for the treatment of depression (13) (14) (15).

- Group therapy has a long tradition in mental health service delivery, including psychodynamic groups, encounter groups, family groups, mindfulness-based cognitive therapy (MBCT), and a wide range of symptom-specific cognitive and behaviour change groups for generalised anxiety disorder (GAD), depression, social anxiety, post-traumatic stress disorder (PTSD), anger management, panic, agoraphobia, hoarding disorder, obsessive compulsive disorder (OCD), social skills training, problem-solving therapy (PST), weight management and eating disorders.
- The uptake of group work items in the MBS should be higher, given the proven effectiveness of group therapy and the greater access to services it provides.
- The existing M6 and M7 items for group therapy are hampered by limiting patient attendance numbers to six to 10 people. This is restrictive and impractical, particularly in rural settings, where it is difficult to get six people to attend due to challenges associated with travel, fluctuating participant motivation and wellness.

5.2.7 Recommendation 6 – Add a new group item for therapy in larger groups

The Reference Group recommends adding a new group item (801AA) for psychological services in larger groups to cover 11 or more patients, with one or two therapists in attendance, with the proposed item descriptor as follows:

New Item – example descriptor

Professional attendance for the purpose of providing psychoeducation or skills training for an assessed mental disorder by one or mental health therapists, lasting for at least 60 minutes with a group of 11 or more patients.

Two therapists should be in attendance for any patient group greater than 15

These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year

5.2.8 Rationale 6

This recommendation focuses on ensuring efficient opportunities for psychological services and increasing the cost-effectiveness of group therapies. It is based on the following:

- The Reference Group agreed that some group therapies could be effectively delivered in larger group settings. Examples included mindfulness, acceptance and commitment therapy (ACT), relaxation groups and goal-setting groups (16).
- MBCT was developed with a specific focus on preventing relapse/recurrence of depression. It can be delivered as an eight-week group program, with eight to 15 patients per group (17).

- Coping with Depression (CWD) is a highly structured, multi-modal group psychoeducational treatment with a strong record of reducing the risk of major depression (14).

6. Longer-term recommendations

6.1.1 Recommendation 7 – Enable family and carers to participate in therapy and/or consultation

The Reference Group recommends:

a. amending the item for psychological therapies and FPS (items 80000–80015, 80100–80115, 80125–80140 and 80150–80165) to allow sessions with family members, guardians, carers and/or residential staff, where:

   (i) The identified patient is not present.

   (ii) The primary focus is the identified patient's treatment or assessment needs.

   (iii) The decision to use sessions (as outlined above) is made by the identified patient (or the patient's guardian, if the patient is a minor or if guardianship is in place; or the patient's nominated representative if the patient does not have legal capacity to provide informed consent).

and

b. introducing a new item for the specific purpose of enabling consultation between health professionals and carers and/or support people, with the proposed item descriptor as follows:

New Item – example descriptor

Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes duration, in the course of continuing management of a patient - payable not more than 4 times in any 12 month period.

Note: Recommendation 7a is intended to provide more immediate access in the short term with Recommendation 7b able to replace Recommendation 7a in the longer term, with a view to creating a more flexible future for psychological therapies under the MBS.

6.1.2 Rationale 7

This recommendation focuses on delivering the most efficient therapies in order to achieve the best possible outcomes. It is based on the following:

- In many situations, a fundamental element of evidence-based best practice in the delivery of psychological therapies is the provision of sessions for carers. These sessions are not currently eligible for a Medicare rebate if the "identified patient" is not physically present.
- Many submissions to the MBS Review recommended that the MBS mental health items provide for consultation between mental health professionals and carers/support people wherever appropriate, with the aim of enhancing collaboration, increasing engagement and recognising carers/support people as valuable resources. In some cases, group and individual service delivery would be relevant for carers.
- The importance of family and carer sessions can be underlined by looking at patient subsets within an MHTP:
    - Children and adolescents with an MHTP: The inclusion of one or more parent/carer-only session is a standard component of child and adolescent psychological therapy. Parenting/carer approaches, parenting skills and parental attitudes to the attributes of their child can seriously affect the child's wellbeing, and it is likely to be detrimental to discuss these with the child present. Parents/carers also need to develop more positive approaches to child management and need to have the rationale for these addressed at an adult level without the child present (18).
    - People living with dementia and/or in residential aged care with an MHTP: The recommendations made by the Senate Inquiry into Care and Management of Younger and Older Australians Living With Dementia and Behavioural and Psychiatric Symptoms of Dementia (BPSD) strongly supported the value of and need for carer involvement in therapy (19). The report noted that training family caregivers in behavioural management techniques is effective in reducing depression.
    - People with intellectual disabilities with an MHTP: The University of New South Wales' *Guide to Accessible Mental Health Services for People with an Intellectual Disability* emphasises the importance of a collaborative partnership between family and carers, the person with an intellectual disability, and providers of health and disability services (20).
- The importance of informed patient consent (where the patient has legal capacity to provide consent) in relation to the engagement of carers was emphasised, in order to

preserve the confidentiality and boundaries of the therapeutic relationship between the provider and the identified patient.

- For specific patient groups, it may be appropriate for most sessions to be provided directly to the carer without the identified patient present, e.g. children (such as infants and children under three years of age) and some adolescents and adults with significant cognitive impairment related to intellectual disability, dementia and/or a mental disorder. For all other patient groups, the importance of restricting the number of carer-only sessions provided under the MBS mental health items was emphasised, with a suggested limit of 20 per cent of the patient's available sessions for the 12-month period.
- Recommendation 7b proposes a new item for family and carer services. This would bring psychology and allied mental health providers in line with psychiatry and could parallel item 352.

6.1.3 Recommendation 8 – Measure Better Access outcomes

The Reference Group recommends that:

a. the Government invest time and resources in building outcomes measurement into the MBS as mental health, and the Better Access program in particular, could provide an arena for a trial of outcomes measurement within the MBS and provide an opportunity to test the response of consumers to regulated outcomes monitoring, and

b. the outcomes measures used for Better Access should be:

   (i) Consistent: To the extent possible, the same measures should be used across all sectors and funding systems in the mental health space (for example, the MBS, PHNs, non-governmental organisations (NGOs), state health services).

   (ii) Comprehensive: Ideally, outcomes measures would incorporate holistic measures as well as covering clinical symptoms, functioning, morbidity, quality of life, patient satisfaction, clinical governance processes, the evidence base for interventions, and psychosocial and environmental impact.

   (iii) Carefully implemented: Measures should have high uptake and should result in behaviour change, rather than simply serving as tracking tools. Training and incentives for use (at least initially) could support this.

   (iv) Flexible: Multiple stakeholders at multiple levels should be able to use measures to improve quality of care. This includes health care providers, consumers and policy makers.

6.1.4 Rationale 8

This recommendation focuses on collecting data to help ensure that patients are improving as a result of mental health treatment, and to guide improvements in services into the future. It is based on the following:

- Monitoring outcomes in psychological therapies is recognised as important both for the welfare of the client and to confirm the effectiveness of treatment. (21) Outcomes are already measured within mental health services in Australia (22). However, there are inconsistencies in both the use of outcome measures and the measures themselves.
- While the Reference Group noted that some (and maybe even most) mental health providers use some sort of outcomes measure, there is variability in the implementation, sustainability and subsequent use of routine outcome data (23).
- The Reference Group also noted variability in the measures themselves. Some measures are used by public and community health services in Australia (see Appendix F), but the Reference Group noted that there are cases where different measures are appropriate. It agreed that it is important to have both "routine outcomes measures" and a range of outcome measures for specific purposes.
- The Reference Group identified two reasons for inconsistencies in outcomes measurement: inadequate infrastructure to develop and implement quality measures and the lack of a cohesive strategy to apply mental health quality measurement across different settings.
- While the Reference Group did not specify the measurement tool to be used by mental health providers within the MBS, members noted several possibilities and agreed that the selected tool should reflect the priorities outlined in the recommendation and repeated below:
    - Consistent measures: Coordinating a culture of measurement-based care would enhance the quality and outcomes of mental health services across different mental health provider groups, including medical practitioners, psychiatrists, psychologists, accredited mental health social workers, nurses, occupational therapists and other health professionals.
    - Comprehensive measures: These are less likely to present a skewed view of outcomes. In particular, the Reference Group noted that most measures focus on mental illness; far fewer assess mental health (24).
    - Carefully implemented measures: The Reference Group noted that many outcome measures already exist. The challenge is in developing structures and processes to ensure that these measures contribute to a feedback loop that

helps clinicians better target their therapies to achieve better health outcomes for patients.

- Flexible measures: Measures that can be used and understood by multiple stakeholders are more likely to succeed, and to have lower costs, than a series of different measures developed for different contexts.

- The Reference Group noted that outcome measures would support feedback-informed treatment. This leverages feedback from the patient on both psychological function and the therapeutic alliance to improve treatment (25).
- The Reference Group noted that there could be advantages to this recommendation beyond directly improving treatment outcomes for consumers. For example, outcome monitoring could enable large-scale outcome studies.
- The Reference Group recognised that developing structures and processes for outcome measurement within the MBS would have an associated cost and, no matter how streamlined, would likely add to the administrative burden for individual providers and for the MBS as a whole.
- Part of the function of PHNs is collecting, collating and analysing data to be reported back to the Department, which adds to their costs. The MBS does not have this function, which means that whatever data is tracked is not used productively. For example, the MHTP provides space to track an approved outcome measure, but the data is not collected and analysed.
- The Reference Group discussed the possibility of making compliance with the collection of outcome measures data mandatory for approval to deliver item numbers under the MBS.

6.1.5 Recommendation 9 – Update treatment options

The Reference Group recommends updating treatment options by:

a. adding all therapies (items 80000–80171) with National Health and Medical Research Council (NHMRC) Level I or Level II evidence to the list of approved therapies under Better Access
b. updating the terminology for Better Access services for consistency across service providers, renaming items 80100–80171 as psychological therapy services

Note: The Chair of the Reference Group noted his dissent from the recommendation to rename items 80100-80171.

c. frequently review and update the list of therapies covered under the MBS based on evolving evidence of effectiveness, and

d. adding the following therapies to the Better Access list of approved psychological interventions:

(i) ACT.

(ii) Dialectical behaviour therapy (DBT).

(iii) Emotion-focused therapy.

(iv) Eye movement desensitisation and reprocessing (EMDR).

(v) Family intervention (FI).

(vi) Psychodynamic therapy.

(vii) Metacognitive therapy (MCT).

(viii) MBCT.

(ix) Schema-based therapy.

(x) Solution-focused therapies.

(xi) Exposure treatments.

(xii) Narrative therapy.

(xiii) Narrative exposure therapy.

(xiv) Trauma-focused cognitive behaviour therapy (CBT).

6.1.6 Rationale 9

This recommendation focuses on aligning the MBS with current evidence. It is based on the following:

- The Reference Group discussed whether to include an exhaustive list of all therapies, or to instead note that any other therapies with strong evidence (Level I and Level II) could be provided. (Currently, items 80000–80021 have a non-exhaustive list, while items 80100–80171 have an exhaustive list.) The Reference Group did not reach consensus on this question.
- The Reference Group also discussed the value of other evidence (i.e. evidence that is not classified as Level I or Level II) for some therapies. It noted that the NHMRC has outlined specific conditions under which Level III studies may provide a good evidence base that can be trusted to guide practice in most situations (26).
- The current list of FPS/psychological therapies is out of date and does not reflect current evidence. Many psychological therapies that have demonstrated a sufficient evidence base are not included in this list.

- The range of therapies for which an MBS rebate is available should be expanded to better meet patients' needs. See Appendix G for a summary of the evidence for additional therapies. The Reference Group noted that patients receiving treatment from a range of mental health practitioners (who are appropriately trained to deliver the therapies listed in this recommendation) should have access to these therapeutic approaches, in line with current best-practice evidence.
- Mental health providers under both sections of the MBS are expected to provide evidence-based psychological therapies within their scope of practice. All providers should therefore be considered as providing "psychological therapies", as opposed to "focused psychological strategies".
- Some therapies show promise but have yet to meet the required level of evidence (for example, dignity therapy). Others may be considered effective today but may not be in the future. For this reason, it is important that the MBS:
    - Continues to review the evidence for different psychological therapies.
    - Updates evidentiary standards, as reflected in NHMRC guidelines, where appropriate (26).

6.1.7 Recommendation 10 – Unlink GP focused psychological strategy items from M6 and M7

The Reference Group recommends:

a. unlinking GP FPS items (items 2721-2727) from M6 and M7 items to enable GP FPS items to be provided in addition to M6 and M7 items, rather than within the allocated number of sessions under M6 or M7
b. still restricting access to GP FPS items to patients with an MHTP
c. the maximum number of allowable GP FPS items per patient should still be capped
d. the maximum number of sessions should be per 12-month period, as opposed to per calendar year.

Notes:

1. *The Reference Group noted that this recommendation would interact with Recommendation 1, and that patients at risk of mental illness would also have access to GP FPS sessions.*
2. *The Reference Group noted the interaction with Recommendation 9 in simplifying the language used to refer to psychological services provided to patients under the MBS.*
3. *The Reference Group noted that where multiple providers are involved in care, collaboration should be promoted.*

6.1.8 Rationale 10

This recommendation focuses on ensuring flexible access to care. It is based on the following:

- This recommendation increases access to psychological interventions in Australia.
- GPs play a key role in engaging the "unengaged" population in need of mental health care—i.e. the 65 per cent noted in the National Survey of Mental Health and Wellbeing as not accessing services for mental health problems (27).
- Facilitating use of items 2721–2727 encourages GPs to upskill in the use of psychological strategies and therapies, growing a psychologically minded primary care workforce.
- GPs can play a key role in stepped care models. They are well placed to offer lower-intensity interventions for less severe, high-prevalence conditions like depression and anxiety, freeing up other resources to be offered to patients where the potential benefit is much greater.
- Increased uptake of these items would improve patient access to psychological interventions (particularly in rural areas).
- The Reference Group also discussed the interaction with Recommendation 3 when evaluating whether the appropriate cap for GP FPS sessions should sit at 10 sessions, or follow the same severity tiers proposed in Recommendation 3, enabling a different number of maximum sessions depending on the patient's tier level. The Reference Group did not reach a decision on this point.

6.1.9 Recommendation 11 – Encourage coordinated support for patients with chronic illness and patients with mental illness

The Reference Group recommends:

a. not counting mental health sessions within the allied health sessions (referred as part of team care arrangements under a GPMP) as part of a patient's capped number of sessions (items 10956 and 10968)
b. item 10956 should not contribute towards the cap of five allied health sessions per year under a GPMP and have its own maximum number of sessions
c. encouraging GPs to use the ICD-10 (and ICD-11 from 2022) in the identification of mental health concerns and illnesses for people with chronic and terminal illnesses
d. updating the descriptor and explanatory note for item 721 (GPMP) to enable patients with severe mental illness who are at risk of chronic disease to have a GPMP and team care arrangements alongside their MHTP, and
e. still retaining the ability to claim both a GPMP and an MHTP on the same day.

6.1.10 Rationale 11

This recommendation focuses on ensuring flexible access to care for those who need it most. It is based on the following:

- The interrelationship between mental illness and poor physical health is well established. This relationship contributes to worse health outcomes for both those with a chronic disease and those with a mental illness (28) (29). On the subject of depression, for example, an article published in the Medical Journal of Australia in 2009 noted: "Having a physical illness is one of the strongest risk factors for depression. Moreover, evidence now shows that depression is also a risk factor for physical illness and for early death. Thus, both the depression and the physical illness need to be considered if we are to understand the complexities of this association and the best ways to treat each." (30).
- A growing body of national and international research evidence demonstrates that mental health concerns for all people with chronic, advanced chronic and terminal illness are under-reported, underdiagnosed and poorly treated (31). For example:
    - Childhood chronic illness can severely impair psychosocial functioning and become a precursor to future mental health difficulties (32).
    - Mental illness in the terminally ill is under-diagnosed and undertreated. Having a life-limiting illness does not preclude the possibility of also having a pre-existing mental illness, or the possibility of mental illness developing as a result of the psychological impact of the diagnosis or prognosis. Many people experience symptoms of PTSD as a result of a serious complex medical condition.
        - O'Connor et al. (pp. S44–47) showed that 45.8 per cent of cancer patients were possibly depressed, 36.9 per cent were possibly anxious and about 25 per cent had probable combined anxiety and depression (33).
- Enabling a GPMP to be developed for people with severe mental illnesses, even if only at risk of chronic illness, would ensure that they can access appropriate support to prevent and manage that risk. For example, a 2015 review of 25 studies around the world found that people with schizophrenia are 2.5 times more likely to have diabetes compared with the general population. Similarly, high rates of, and risk for, metabolic syndrome have been documented in bipolar disorder, depression and other mental disorders such as post-traumatic stress disorder. Specific to psychosis, the rate of metabolic syndrome is 32.5 per cent, with rates of up to 60 per cent observed in those with a longer duration of illness and use of antipsychotic medication (28).
- Coordinating mental and physical health care for patients with both disorders not only optimises health outcomes, but can also reduce hospitalisations and emergency

department use (34) (35). The Fifth National Mental Health and Suicide Prevention Plan states that "in addition to the personal cost of physical illness for people living with severe mental illness, the total cost to the Australian economy has been estimated at $15 billion per annum. This includes the cost of health care, lost productivity and other social costs." (6).

- The Reference Group noted that Nurse Practitioners (NP) are primary care providers, and those who specialise in mental health and psychiatry are well placed to deliver comprehensive physical and mental health assessment and treatment. The Reference Group further noted that the most recent budget provided funding to improve both consumer and health professional knowledge and understanding of the scope of practice of MHNPs.
- The Reference Group also noted the role of mental health nurses and nurse practitioners in this space, as their scope of practice covers both physical health and mental health assessment, monitoring and treatment.
- The Reference Group acknowledges that this recommendation will have intersections with other item numbers e.g. chronic disease management items, and that the objective of the recommendation is to ensure that patients with complex physical and/or mental health needs are not disadvantaged.

6.1.11 Recommendation 12 – Promote the awareness of digital mental health and other low-intensity treatment options

The Reference Group recommends promoting the awareness of digital mental health and other low-intensity treatment options integrated with therapist support. The Group discussed various options for, and challenges associated with, increasing uptake of low-intensity treatments. It decided that effective digital solutions exist, and that the important next steps would involve investigating the best solutions to complement MBS services.

6.1.12 Rationale 12

This recommendation focuses on flexible access to mental health services. It is based on the following:

- The Reference Group noted both the cost-effectiveness and the access advantages of digital mental health and other low-intensity solutions.
- The Group discussed various options for, and challenges associated with, increasing uptake of low-intensity treatments. It decided that effective digital solutions exist, and that the important next steps would involve investigating which solutions to bring into the MBS fold and encouraging their use.

6.1.13 Recommendation 13 – Support access to mental health services in residential aged care

The Reference Group recommends continued monitoring of new funding recently announced for residents in residential aged care facilities (RACFs) and it hopes that this funding decision results in:

(i) Greater awareness of the overlap between and management approach to terminal illness and mental health

(ii) Improved assessments of mental health conditions at RACFs

(iii) A reduction in prescribed medications, and

(iv) Improved equity of access to the MBS for consumers.

6.1.14 Rationale 13

- This recommendation focuses on access to mental health services in aged care. It is based on the following:
- The Reference Group noted that care and treatment in RACFs can sometimes be fragmented or erratic. There is no nationally consistent system for the delivery of mental health services to older people, the quality and accessibility of services vary from place to place, and rural and remote locations tend to be less well served.
- The Reference Group welcomes the budget announcement regarding funding for residents in RACFs. This has been designated to fund services commissioned by PHNs to deliver a range of preventive, educative and other interventions to reduce the prevalence, severity and duration of mental health issues in residents in RACF's.
- However, it was the view of some members of the Reference Group that previous experience with PHN funding suggests that there is often a lack of consistency or transferability across the programs implemented. Concerns related to this include uncertainty about the continuity of mental health programs under the PHN commissioning model, and about the provision of evidence-based mental health services for older people with severe and enduring mental health issues, or with co-morbid mental health and advanced chronic illness, terminal care issues, pre-existing mental health issues or substance use issues.
- The Reference Group noted that the MBS could follow the example of the Department for Veteran's Affairs in enabling access to MBS rebates. This would enable access to rebates for mental health services for residents in RACFs, if their treating GP determines that they have a diagnosable mental disorder or are at risk of a developing a mental health disorder (as assessed by ICD-10, or ICD-11 once in force).

- Notwithstanding the new budget measures, allowing residents in RACFs to access the mental health clinician of their choice, or to continue seeing the treating mental health clinician from whom they were receiving therapeutic services prior to entering the RACF, provides these individuals with consistency and continuity of care. It also respects the therapeutic relationship that may have been established between the treating mental health clinician and resident prior to entering the RACF.
- The Reference Group acknowledges the current work being undertaken in the Aged Care Royal Commission and the Group would support recommendations from the Commission including regarding patients with dementia in Residential Aged Care Facilities in the MBS mental health items.

6.1.15 Recommendation 14 – Increase access to telehealth services

The Reference Group recommends a review of the recent announced expansion of access to mental health telehealth services in rural and remote areas in two years to:

(i) Assess whether it has delivered the hoped-for outcomes, and

(ii) Ensure that the change is a permanent one and is not seen as a temporary emergency fix.

6.1.16 Rationale 14

This recommendation notes the Reference Group's agreement with a recent decision to increase availability of telehealth services. It is based on the following:

The Reference Group agreed that telehealth services were high value care for patients. However, the Reference Group agreed that there was a risk that this decision reflected a temporary change given the current state of drought, and emphasised that this decision should permanently enable all Better Access sessions to be offered via telehealth.

- The Reference Group discussed the recent announcement expanding access to telehealth services in rural and remote areas. The change, effective from 1 September 2018, allows eligible patients in rural and remote areas to access all of their Better Access sessions via videoconference (as opposed to seven out of 10 sessions) (36).
- The Reference Group supports telehealth access for people with disabilities, frail and elderly people and those residing in rural and remote areas, when accessed through their usual GP.

7. Impact statement

Mental health consumers, carers and professionals are expected to benefit from the recommendations in this report. In making its recommendations, the Reference Group considered the access that consumers and carers would have to high-quality mental health services.

Consumers and carers will benefit from a shift in the MBS mental health continuity of care model, aligning it with the national approach to the provision of stepped care. This will *improve access to mental health services* and update the approach to mental health service delivery based on the best available evidence, including:

- **Stepped mental health care:** The Reference Group has recommended some changes to the fundamental approach to the delivery of mental health services, to align with the stepped care approach proposed by the National Mental Health Commission and included in the Fifth National Mental Health and Suicide Prevention plan.

  Opening up MBS mental health services to consumers at risk of developing a mental health disorder means that services will be provided early in the treatment pathway, aiding significantly in the prevention of more serious mental health disorders.

  Evolving the structure of MBS mental health services so that consumers can be triaged according to diagnosis, severity and complexity gives GPs and mental health professionals more freedom to match a patient's treatment pathway to their individual circumstances, particularly for more severe and complex consumers.

  Considering how digital and low-intensity services can be provided through the MBS will further support a stepped care model within a fee-for-service arrangement.
- **Access and flexibility:** The Reference Group has also recommended some changes to the way mental health services are accessed. These changes will make it easier for consumers to access services as and when they need them.

  Increasing the number of sessions available per referral will ensure that consumers and carers can focus on accessing needed treatment from mental health professionals and reduce any unnecessary interruption in service. In addition, these recommendations should reduce the burden on GPs associated with reviewing patients, acknowledging the importance of continued liaison and care coordination between mental health professionals and GPs throughout treatment.

Making group sessions more efficient should increase access to these services. This is important as some forms of mental health treatment are more effectively provided in a group setting.

Building on current government initiatives regarding the provision of mental health services to residents of aged care facilities, and through telehealth arrangements, is key to ensuring ongoing access to mental health services for people in rural and remote Australia and for the elderly.

- **Incorporating the latest evidence:** This is the first holistic look at the delivery of MBS mental health services since the Better Access program was introduced in 2006. The Reference Group's recommendations on treatment options, outcome measurement, family and carer access, and treating the physical health of those with a mental health disorder will align the MBS with contemporary evidence.

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9. Glossary

Term	Description
AASW	Australian Association of Social Workers
ACT	Acceptance and commitment therapy
Better Access	The Better Access initiative provides better access to mental health practitioners through Medicare
CAGR	Compound annual growth rate or the average annual growth rate over a specified time period.
CBT	Cognitive behaviour therapy
Change	When referring to an item, "change" describes when the item and/or its services will be affected by the recommendations. This could result from a range of recommendations, such as: (i) specific recommendations that affect the services provided by changing item descriptors or explanatory notes; (ii) the consolidation of item numbers; and (iii) splitting item numbers (for example, splitting the current services provided across two or more items).
DBT	Dialectical behaviour therapy
Delete	Describes when an item is recommended for removal from the MBS and its services will no longer be provided under the MBS.
Department, The	Australian Government Department of Health
EMDR	Eye movement desensitisation and reprocessing
FI	Family intervention
FY	Financial year
GP	General practitioner
GPMP	GP Management Plan
GPPCCC	General Practice and Primary Care Clinical Committee
High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.

AASW	Australian Association of Social Workers
Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours, from failing to adhere to particular item descriptors or rules through to deliberate fraud.
Low-value care	Services that evidence suggests confer no or very little benefit for consumers; or for which the risk of harm exceeds the likely benefit; or, more broadly, where the added costs of services do not provide proportional added benefits.
MBCT	Mindfulness-based cognitive therapy
MBS	Medicare Benefits Schedule
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, consisting of an item number, service descriptor and supporting information, schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure or test to which the relevant MBS item refers.
MCT	Metacognitive therapy
MHNIP	Mental Health Nurse Incentive Program
MHPT	Mental Health Treatment Plan
Minister, The	Minister for Health
MSAC	Medical Services Advisory Committee
New service	Describes when a new service has been recommended, with a new item number. In most circumstances, new services will need to go through the MSAC. It is worth noting that implementation of the recommendation may result in more or fewer item numbers than specifically stated.
NHMRC	National Health and Medical Research Council
No change or leave unchanged	Describes when the services provided under these items will not be changed or affected by the recommendations. This does not rule out small changes in item descriptors (for example, references to other items, which may have changed as a result of the MBS Review or prior reviews).
PBS	Pharmaceutical Benefits Scheme
PCRG	Primary care reference group
PHN	Primary health network
PST	Problem-solving therapy

AASW	Australian Association of Social Workers
PTSD	Post-traumatic stress disorder
RACF	Residential aged care facility
Reference Group, The	Mental Health Reference Group of the MBS Review
Services average annual growth	The average growth per year, over five years to 2014/15, in utilisation of services. Also known as the compound annual growth rate (CAGR).
Taskforce, The	MBS Review Taskforce

Appendix A Full list of in-scope items

Family group therapy

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
170	Family Group Therapy (excluding psychiatrist) >=1 hour, 2 patients	117.55	9,010	1,186,406
171	Family Group Therapy (excluding psychiatrist) >=1 hour, 3 patients	123.85	1,542	204,109
172	Family Group Therapy (excluding psychiatrist) >=1 hour, 4+ patients	150.70	471	70,080

GP mental health treatment

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
2700	Preparation of GP Mental Health Treatment Plan, (medical practitioner without mental health training) >20 to <40 mins	71.70	154,195	11,084,468
2701	Preparation of GP Mental Health Treatment Plan, (medical practitioner without mental health training) >40 mins	105.55	65,974	6,970,266
2712	Review of a GP mental health treatment plan or a Psychiatrist Assessment and Management Plan	71.70	456,706	32,915,081
2713	Attendance in relation to mental disorder, including taking documentation, >20 mins	71.70	1,674,946	120,445,474
2715	Preparation of a GP mental health treatment plan, (medical practitioner with mental health training), >20 to <40 mins	91.05	734,815	67,072,887
2717	Preparation of a GP mental health treatment plan, (medical practitioner with mental health training), >=40 mins	134.10	279,234	37,484,095

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
2721	Consulting room attendance for focussed psychological strategies for assessed mental disorders (medical practitioner registered with the Chief Executive Medicare), >30 to <40 mins	92.75	3,916	364,226
2723	Non-consulting room attendance for focussed psychological strategies for assessed mental disorders (medical practitioner registered with the Chief Executive Medicare), >30 to <40 mins	92.75, plus $25.95 divided by the number of patients seen, up to a max of 6	20	2,374
2725	Consulting room attendance for focussed psychological strategies for assessed mental disorders (medical practitioner registered with the Chief Executive Medicare), >=40 mins	132.75	28,321	3,860,772
2727	Non-consulting room attendance for focussed psychological strategies for assessed mental disorders (medical practitioner registered with the Chief Executive Medicare), >=40 mins	132.75, plus $25.95 divided by the number of patients seen, up to a max of 6 patients	162	25,024

Pregnancy support counselling

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17	Item number
4001	Attendance for non-directive pregnancy support counselling (medical practitioner registered with the Chief Executive Medicare), >20 mins	4001: Attendance for non-directive pregnancy support counselling (medical practitioner registered with the Chief Executive Medicare), >20 mins	76.60	13,414	1,027,779

Allied health services

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
10956	Mental Health service for person with chronic condition under a care plan, >20 mins	62.25	5,726	332,292
10968	Psychology service for person with chronic condition under a care plan, >20 mins	62.25	28,390	2,131,564

Psychological therapies

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
80000	Assessment and therapy by clinical psychologist (consulting rooms), >30 to <50 mins	99.75	14,618	1,254,655
80005	Assessment and therapy by clinical psychologist (non-consulting rooms), >30 to <50 mins	124.65	1,107	117,719
80010	Assessment and therapy by clinical psychologist (consulting rooms), >=50 mins	146.45	2,092,967	267,332,018
80015	Assessment and therapy by clinical psychologist (non-consulting rooms), >=50 mins	171.35	38,605	5,772,732
80020	Group therapy, 6-10 patients: Therapy by clinical psychologist, >=60 mins	37.20	15,355	590,441

Focused psychological therapies

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
80100	Attendance for focussed psychological strategies services by psychologist (consulting rooms), >20 to <50 mins	70.65	31,592	1,954,150
80105	Attendance for focussed psychological strategies services by psychologist (non-consulting rooms), >20 to <50 mins	96.15	2,652	219,066

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
80110	Attendance for focussed psychological strategies services by psychologist (consulting rooms), >50 mins	99.75	2,493,291	218,621,512
80115	Attendance for focussed psychological strategies services by psychologist (out of rooms), >50 mins	125.30	154,851	16,771,822
80120	Group therapy, 6-10 patients: focussed psychological strategies services by psychologist, >=60 mins	25.45	21,450	587,021
80125	Attendance for focussed psychological strategies services by occupational therapist (consulting rooms), >20 to <50 mins	62.25	5,099	317,523
80130	Attendance for focussed psychological strategies services by occupational therapist (non-consulting rooms), >20 to <50 mins	87.70	998	81,349
80135	Attendance for focussed psychological strategies services by occupational therapist (consulting rooms), >50 mins	87.95	50,572	4,200,419
80140	Attendance for focussed psychological strategies services by occupational therapist (non-consulting rooms), >50 mins	113.35	11,040	1,143,529
80145	Group therapy, 6-10 patients: focussed psychological strategies services by occupational therapist, >=60 mins	22.35	1,613	60,129
80150	Attendance for focussed psychological strategies services by social worker (consulting rooms), >20 to <50 mins	62.25	2,782	150,046

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
80155	Attendance for focussed psychological strategies services by social worker (non-consulting rooms), >20 to <50 mins	87.70	2,055	153,333
80160	Attendance for focussed psychological strategies services by social worker (consulting rooms), >50 mins	87.95	253,143	19,565,965
80165	Attendance for focussed psychological strategies services by social worker (non-consulting rooms), >50 mins	113.35	52,110	5,032,336
80170	Group therapy, 6-10 patients: focussed psychological strategies services by social worker, >=60 mins	22.35	2,406	47,008

Pregnancy support counselling

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
81000	Non-directive pregnancy support counselling service by eligible psychologist >=30 mins	73.15	209	16,474
81005	Non-directive pregnancy support counselling service by eligible social worker >=30 mins	73.15	125	7,813
81010	Non-directive pregnancy support counselling service by eligible mental health nurse >=30 mins	73.15	460	34,110

Autism, pervasive developmental disorder and disability services

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
82000	Psychology service provided to a child (<13 years) by eligible psychologist, >=50 mins	99.75	10,258	1,300,699

Item number	Description	Schedule fee	Services FY2016/17	Benefits FY2016/17
82015	Psychology service provided to a child (<15 years), for treatment of PDD or an eligible disability by eligible psychologist, >=50 mins	99.75	4,645	540,563
82005	Speech pathology service provided to a child (<13 years) for diagnosis or PDD/disability treatment, >=50 mins	87.95	4,697	506,642
82010	Occupational therapy service provided to a child (<13 years) for diagnosis or PDD/disability treatment, >=50 mins	87.95	1,146	110,387
82020	Speech pathology service provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	20,016	1,741,776
82025	Occupational therapy service provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	10,154	928,442
82030	Audiology, optometry, orthoptic or physiotherapy service provided to a child (<13 years) for diagnosis or PDD/disability treatment, >=50 mins	87.95	533	40,522
82035	Audiology, optometry, orthoptic or physiotherapy provided to a child (<15 years) for PDD/disability treatment, >=30 mins	87.95	1,245	118,236

Appendix B Full list of recommendations

Recommendation 1 – Expand the Better Access Program to at-risk people

The Reference Group recommends expanding the Better Access program to at-risk people (items 2700, 2701, 2715 and 2717):

by amending the explanatory note (AN.0.56) to:

Include people who are considered at risk of developing a mental health disorder in the next 12 months in the section on eligibility for an MHTP.

replace the words “structured approach” with “planned approach”.

include in the definition of “at risk” both early presentations with no previous history and those who are currently relatively symptom free but require professional service for relapse prevention.

and

amending the explanatory note as follows:

Revision to Explanatory Note AN.0.56 – example text

What patients are eligible - Mental Disorder

These items are for people with a mental disorder, or at risk of a mental disorder, who would benefit from a planned approach to the management of their treatment needs. Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual’s cognitive, emotional, behavioural, and/or social abilities (Refer to the World Health Organization, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version). Those at risk of mental disorder are either

(i) those with early, sub-syndromal symptoms of the disorders referenced above, who have a high likelihood of developing such a disorder in the next 12 months without timely and appropriate treatment; or

(ii) those who have recovered from a previously diagnosed disorder as referenced above and require treatment to maintain their mental health and prevent relapse

Dementia, delirium, tobacco use disorder and intellectual disability on their own are not regarded as mental disorders for the purposes of the GP Mental Health Treatment items.

Notes:

1. *The Reference Group noted that the 11th revision of the International Classification of Diseases (ICD-11) was published in June 2018 and expects item descriptors to be amended accordingly when this comes into force in January 2022.*
2. *The Reference Group also noted that this recommendation could interact with Recommendation 2 and Recommendation 3. Its expectation is that patients with an MHTP who are deemed part of the at-risk cohort will access a maximum of 10 Better Access sessions per 12-month period, with the referring provider making the initial referral for the maximum 10 sessions.*

Recommendation 2 – Increase the maximum number of sessions per referral

The Reference Group recommends increasing the number of sessions per referral (items 2700, 2701, 2715 and 2717), by:

a. by amending the explanatory note (AN.0.56) to:
   (i) increase the maximum number of sessions in any one referral from six to 10 sessions in the sections on "Preparation of a GP Mental Health Treatment Plan" and "Referrals".
   (ii) clearly state that 10 sessions is the maximum number of sessions from any one referral (rather than a minimum or required number of sessions), and that the referring practitioner should use their discretion in setting the referred number of sessions for any course of treatment.
   (iii) encourage discussion with the patient, as well as with the mental health provider, in determining the appropriate number of sessions for initial and subsequent referrals.
b. amending the explanatory note as follows:

Revision to Explanatory Note AN.0.56 – example text

In the section titled "Preparation of a GP Mental Health Treatment Plan":

> On completion of a course of treatment provided through Medicare rebateable services, the service provider must provide a written report on the course of treatment to the GP. For the purposes of the Medicare rebateable mental health items, a course of treatment will consist of the number of services stated on the patient's referral (up to a maximum of ten in any one referral). The number of services that the patient is being referred for is at the discretion of the referring practitioner (e.g., GP). The referring practitioner is encouraged to discuss the appropriate number of referred sessions for a single course of treatment with the referred practitioner providing the mental health services, as well as with the patient.

In the section titled "Referral":

> When referring patients, GPs should provide similar information as per normal GP referral arrangements, and should include both a statement identifying that a GP Mental Health Treatment Plan has been completed for the patient (including, with the patient's agreement, attaching a copy of the patient's GP Mental Health Treatment Plan) and clearly nominating a specific number of sessions. Referrals for patients with either a GP Mental Health Treatment Plan or referred psychiatrist assessment and management plan (item 291) should be provided, as required, for a course of treatment (a maximum of ten services) but may be less depending on the referral and the patient's clinical need).

and

c. amending the explanatory note for the mental health provider (MN.7.1) to include:
   (i) a requirement for return communication from the mental health provider to the referring provider (in this case, a GP).
   (ii) that the mental health provider should communicate with the referring provider within the first four Better Access sessions, and
   (iii) that this could include, for example, confirming that the MHTP has been actioned and that the patient has attended Better Access sessions, and/or an indication of the estimated number of sessions the patient will require for a full course of treatment.

Recommendation 3 – Introduce a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness

The Reference Group recommends:

a. introducing a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness
b. changing the item 80000–80015, 80100–80115, 80125–80140 and 80150–80165 descriptors to specify that instead of 10 planned sessions in a calendar year, patients can access up to three tiers of Better Access sessions, with each tier allowing a greater number of sessions with:

   (i) each tier to provide access to a different maximum number of sessions within a 12-month period (for example, Tier 1 -10, Tier 2 – 20, Tier 3 - 40).

   (ii) access to, and progress through, the three tiers will depend on the severity of the patient's condition requiring treatment, defined by a number of factors outlined below.

   (iii) a patient's access to each higher level tier would require GP review. Thus, a GP would need to endorse, by way of a review, a patient's need to progress from Tier 1 to Tier 2 at the completion of Tier 1, and from Tier 2 to Tier 3 at the completion of Tier 2. The intent is that the GP's central stewardship role be maintained in the proposed tiered Better Access system.

c. amending the item descriptors are as follows:

Revision to descriptors – example text

These therapies are limited, being deliverable in a maximum number of planned sessions in a 12-month period, all of which may be provided via video conference for patients living in telehealth-eligible areas (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). The maximum number of planned sessions before review will fall into one of three tiers, and should be detailed by the referring practitioner at each transition between tiers.

d. consistent with Recommendation 1, a maximum of 10 sessions for the first tier and for higher tiers, a maximum of 20 sessions is recommended for the second tier and a maximum of 40 sessions for the third tier, within any 12-month period.

Note: The Reference Group noted that session maximums falling below this level would significantly limit the effectiveness of the recommendation for a range of conditions.

e. to align with Recommendation 2:
   (i) there may be two or more courses of treatment within a patient's entitlement of services per calendar year

(ii) the GP should consider the patient's clinical need for further sessions after the initial referral, and

(iii) using a GP MHTP Review, a GP Mental Health Treatment Consultation or a standard consultation item.

and

f. adding a new explanatory note to:

(i) provide guidance to the referring practitioner on assessing whether a patient should be referred for additional sessions.

(ii) shift the relevant time period from the current arbitrary calendar year to per 12-month period, where the 12 months commences from the date of the initial referral.

(iii) detail the clinical criteria and thresholds to be met for the referral of patients from Tier 1 to higher levels, including:

- Criteria need to be based on, but not solely confined to, disorder type (diagnosis). Additional considerations in setting thresholds would include severity of symptoms, duration of mental health disorder (chronicity), impact of disorder on functioning, response to previous treatment (if applicable) and complexity (co-morbidity).
- Evidence of progress in therapy, the need for further therapy and the clinical rationale for ongoing treatment (comorbidities, additional trauma) should also be considered.
- The decision should emphasise evidence-based clinical need, collaboratively established with the referrer, mental health provider and consumer, rather than setting a number determined prescriptively.

Recommendation 4 – Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups

The Reference Group recommends establishing a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups, noting that:

(i) the group would need adequate time and resources to complete its mandate,

(ii) government would need to carefully consider membership of the group to ensure unbiased, balanced and well-informed discussion and recommendations, and

(iii) this new group should be established urgently to maximise value for the patient and the health system.

Recommendation 5 – Reduce minimum number of participants in group sessions

The Reference Group recommends:

a. reducing the minimum number of participants in group sessions (items 80020, 80120, 80021, 80145, 80146, 80170 and 80171) to four people
b. clarifying that family and couples therapy is not included under the group therapy items, and
c. amending the proposed item descriptor (using psychology as an example) is as follows:

Revision to descriptors – example text

Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a psychologist registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration, where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year, all of which may be provided via video conference (including services to which items 80020, 80021, 80120, 80121, 80145, 80146, 80170 and 80171 apply).

Group therapy with a group of 4 to 10 patients.

Recommendation 6 – Add a new group item for therapy in larger groups

The Reference Group recommends adding a new group item (801AA) for psychological services in larger groups to cover 11 or more patients, with one or two therapists in attendance, with the proposed item descriptor as follows:

New Item – example descriptor

Professional attendance for the purpose of providing psychoeducation or skills training for an assessed mental disorder by one or more mental health therapists, lasting for at least 60 minutes with a group of 11 or more patients.

Two therapists should be in attendance for any patient group greater than 15

These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year

Recommendation 7 – Enable family and carers to participate in therapy and/or consultation

The Reference Group recommends:

a. amending the item for psychological therapies and FPS (items 80000–80015, 80100–80115, 80125–80140 and 80150–80165) to allow sessions with family members, guardians, carers and/or residential staff, where:

   (i) The identified patient is not present.

   (ii) The primary focus is the identified patient's treatment or assessment needs.

   (iii) The decision to use sessions (as outlined above) is made by the identified patient (or the patient's guardian, if the patient is a minor or if guardianship is in place; or the patient's nominated representative if the patient does not have legal capacity to provide informed consent).

and

b. introducing a new item for the specific purpose of enabling consultation between health professionals and carers and/or support people, with the proposed item descriptor as follows:

New Item – example descriptor

Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes duration, in the course of continuing management of a patient - payable not more than 4 times in any 12 month period.

Note: Recommendation 7a is intended to provide more immediate access in the short term with Recommendation 7b able to replace Recommendation 7a in the longer term, with a view to creating a more flexible future for psychological therapies under the MBS.

Recommendation 8 – Measure Better Access outcomes

The Reference Group recommends that:

a. the Government invest time and resources in building outcomes measurement into the MBS as mental health, and the Better Access program in particular, could provide an arena for a trial of outcomes measurement within the MBS and provide an opportunity to test the response of consumers to regulated outcomes monitoring, and

b. the outcomes measures used for Better Access should be:

   (i) Consistent: To the extent possible, the same measures should be used across all sectors and funding systems in the mental health space (for example, the MBS, PHNs, non-governmental organisations (NGOs), state health services).

   (ii) Comprehensive: Ideally, outcomes measures would incorporate holistic measures as well as covering clinical symptoms, functioning, morbidity, quality of life, patient satisfaction, clinical governance processes, the evidence base for interventions, and psychosocial and environmental impact.

   (iii) Carefully implemented: Measures should have high uptake and should result in behaviour change, rather than simply serving as tracking tools. Training and incentives for use (at least initially) could support this.

   (iv) Flexible: Multiple stakeholders at multiple levels should be able to use measures to improve quality of care. This includes health care providers, consumers and policy makers.

Recommendation 9 – Update treatment options

The Reference Group recommends updating treatment options by:

a. adding all therapies (items 80000–80171) with National Health and Medical Research Council (NHMRC) Level I or Level II evidence to the list of approved therapies under Better Access
b. updating the terminology for Better Access services for consistency across service providers, renaming items 80100–80171 as psychological therapy services

Note: The Chair of the Reference Group noted his dissent from the recommendation to rename items 80100-80171.

c. frequently review and update the list of therapies covered under the MBS based on evolving evidence of effectiveness, and
d. adding the following therapies to the Better Access list of approved psychological interventions:

(i) ACT.

(ii) Dialectical behaviour therapy (DBT).

(iii) Emotion-focused therapy.

(iv) Eye movement desensitisation and reprocessing (EMDR).

(v) Family intervention (FI).

(vi) Psychodynamic therapy.

(vii) Metacognitive therapy (MCT).

(viii) MBCT.

(ix) Schema-based therapy.

(x) Solution-focused therapies.

(xi) Exposure treatments.

(xii) Narrative therapy.

(xiii) Narrative exposure therapy.

(xiv) Trauma-focused cognitive behaviour therapy (CBT).

Recommendation 10 – Unlink GP focused psychological strategy items from M6 and M7

The Reference Group recommends:

a. unlinking GP FPS items (items 2721-2727) from M6 and M7 items to enable GP FPS items to be provided in addition to M6 and M7 items, rather than within the allocated number of sessions under M6 or M7
b. still restricting access to GP FPS items to patients with an MHTP
c. the maximum number of allowable GP FPS items per patient should still be capped
d. the maximum number of sessions should be per 12-month period, as opposed to per calendar year

Notes:

1. *The Reference Group noted that this recommendation would interact with Recommendation 1, and that patients at risk of mental illness would also have access to GP FPS sessions.*
2. *The Reference Group noted the interaction with Recommendation 9 in simplifying the language used to refer to psychological services provided to patients under the MBS.*
3. *The Reference Group noted that where multiple providers are involved in care, collaboration should be promoted.*

Recommendation 11 – Encourage coordinated support for patients with chronic illness and patients with mental illness

The Reference Group recommends:

a. not counting mental health sessions within the allied health sessions (referred as part of team care arrangements under a GPMP) as part of a patient's capped number of sessions (items 10956 and 10968)
b. item 10956 should not contribute towards the cap of five allied health sessions per year under a GPMP and have its own maximum number of sessions
c. encouraging GPs to use the ICD-10 (and ICD-11 from 2022) in the identification of mental health concerns and illnesses for people with chronic and terminal illnesses
d. updating the descriptor and explanatory note for item 721 (GPMP) to enable patients with severe mental illness who are at risk of chronic disease to have a GPMP and team care arrangements alongside their MHTP, and
e. still retaining the ability to claim both a GPMP and an MHTP on the same day.

Recommendation 12 – Promote the awareness digital mental health and other low-intensity treatment options

The Reference Group recommends promoting the awareness of digital mental health and other low-intensity treatment options integrated with therapist support. The Group discussed various options for, and challenges associated with, increasing uptake of low-intensity treatments. It decided that effective digital solutions exist, and that the important next steps would involve investigating the best solutions to complement MBS services.

Recommendation 13 – Support access to mental health services in residential aged care

The Reference Group recommends continued monitoring of new funding recently announced for residents in residential aged care facilities (RACFs) and it hopes that this funding decision results in:

(i) Greater awareness of the overlap between and management approach to terminal illness and mental health

(ii) Improved assessments of mental health conditions at RACFs

(iii) A reduction in prescribed medications, and

(iv) Improved equity of access to the MBS for consumers.

Recommendation 14 – Increase access to telehealth services

The Reference Group recommends a review of the recent announced expansion of access to mental health telehealth services in rural and remote areas in two years to:

(i) Assess whether it has delivered the hoped-for outcomes, and

(ii) Ensure that the change is a permanent one and is not seen as a temporary emergency fix.

Appendix C Summary for consumers

This table describes the medical service, the recommendation(s) of the clinical experts and why the recommendation(s) has been made.

Recommendation 1: Expand the Better Access program to at-risk people

Item	What it does	Committee recommendation	What would be different	Why
2700, 2701, 2715, 2717	Items 2700 and 2701: Preparation of a GP Mental Health Treatment Plan (medical practitioner without mental health training); 20 to 40 minutes, and more than 40 minutes. Items 2715 and 2717: Preparation of a GP Mental Health Treatment Plan (medical practitioner with mental health training); 20 to 40 minutes, and 40 minutes or longer.	Change the explanatory note for items 2700, 2701, 2715 and 2717 to include (in the section on eligibility for a Mental Health Treatment Plan) patients who are considered at risk of developing a mental health disorder in the next 12 months.	Patients with a mental disorder, or who are at risk of a mental disorder, who would benefit from a planned approach to the management of their treatment needs would now be able to access a GP Mental Health Treatment Plan and receive MBS mental health services.	There is significant health value in preventing deterioration in mental health for those who experience early symptoms, and for those who have recovered from a previous mental health disorder but remain at risk of relapse if they do not receive the necessary maintenance care due to their heightened vulnerability. Access to mental health care for patients at risk of developing a mental health disorder would reduce pressure on other MBS services, as well as potentially reducing costs for other health services.

Recommendation 2: Increase the maximum number of sessions per referral

Item	What it does	Committee recommendation	What would be different	Why
2700, 2701, 2715, 2717	Items 2700 and 2701: Preparation of a GP Mental Health Treatment Plan (medical practitioner without mental health training); 20 to 40 minutes, and more than 40 minutes. Items 2715 and 2717: Preparation of a GP Mental Health Treatment Plan (medical practitioner with mental health training); 20 to 40 minutes, and 40 minutes or longer.	Change the explanatory note for items 2700, 2701, 2715 and 2717 (in the sections on "Preparation of a GP Mental Health Treatment Plan" and "Referrals") to increase the maximum number of sessions in any one referral to 10 sessions. (The current limit is six sessions.)	Patients would be able to access a maximum of 10 MBS mental health sessions from any one referral. (This would not be the minimum or required number of sessions.) The referring practitioner should use their discretion, and discuss with the patient, when setting the referred number of sessions for any course of treatment.	Requiring the patient to return to the referring practitioner (generally a GP) after the sixth session creates a barrier to accessing further sessions if the patient does not follow up with their GP. In addition, requiring the patient to return to the referring practitioner may interrupt the therapeutic flow of a course of treatment if the patient has to wait several weeks before seeing their GP.

Recommendation 3: Introduce a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness

Item	What it does	Committee recommendation	What would be different	Why
80000–80015 80100–80115 80125–80140 80150–80165	Assessment and therapy by clinical psychologist, psychologist, occupational therapist or accredited mental health social worker (consulting and non-consulting rooms); 30 to 50 minutes, and 50 minutes or longer.	Change the item descriptor and explanatory note to state that instead of 10 planned sessions in a calendar year, patients can access up to three tiers of Better Access sessions, with each tier allowing a greater number of sessions within a 12-month period (e.g. 10, 20 or 40). Access to, and progress through, the three tiers will depend on the type of condition (diagnosis), severity of symptoms, duration of mental health disorder (chronicity), impact of disorder on functioning, response to previous treatment (if applicable) and complexity (co-morbidity).	Patients with more complex mental health conditions and co-morbidities would be able to receive mental health services that are more appropriate to their individual condition.	Patients with severe and complex mental health conditions require longer-term care to ensure appropriate treatment is received, and to allow them to get better over time. This new model will ensure that unnecessary interruptions to treatment are avoided where possible.

Recommendation 4: Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups

Item	What it does	Committee recommendation	What would be different	Why
80000–80015 80100–80115 80125–80140 80150–80165	Assessment and therapy by clinical psychologist, psychologist, occupational therapist or accredited mental health social worker (consulting and non-consulting rooms); 30 to 50 minutes, and 50 minutes or longer.	Establish a new group as a matter of urgency to review access to and rebates for mental health services under the MBS delivered by different professional groups.	There would be no immediate change to the MBS as a result of this recommendation. However, this recommendation would resolve an important debate within the mental health provider community about access to, and rebates for, different Better Access items for patients within the MBS.	The members of the Reference Group disagreed on whether the current item and rebate structure should be changed. The Reference Group agreed that these questions were not resolvable within the timeframe and resources available to the Reference Group. The Reference Group agreed that this is a critical issue and that a follow-up group should be formed, with careful consideration of membership. This is an urgent matter, due to the influence of MBS rebates on patient access to mental health services.

Recommendation 5: Reduce the minimum number of participants in group sessions

Item	What it does	Committee recommendation	What would be different	Why
80020, 80120, 80021, 80145, 80146, 80170, 80171	Group therapy, six to 10 patients: Therapy by clinical psychologist, psychologist, occupational therapist or accredited mental health social worker, 60 minutes or longer.	Change the item descriptor to reduce the minimum number of attendees at a group session from six to two.	Group mental health services could be provided with as few as four people. This item does not cover family or couples therapy.	This is intended to increase the use of group sessions by making them more responsive to the needs of patients.

Recommendation 6: Add a new group item for therapy in larger groups

Item	What it does	Committee recommendation	What would be different	Why
New item 801AA	Professional attendance for the purpose of providing larger group-based psychological therapies for an assessed mental disorder by one or two psychologists, lasting for at least 60 minutes.	Introduce a new item for larger groups of 11 or more patients, with one or two therapists in attendance.	The Reference Group agreed that some group therapies could be effectively delivered in larger group settings. Examples include mindfulness, acceptance and commitment therapy (ACT), relaxation groups and goal-setting groups.	This would provide opportunities for psychoeducation, problem-solving and related strategies to increase both the application of psychology to health care and the cost-effectiveness of group therapies.

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Recommendation 7a: Enable family and carers to participate in therapy and/or consultation

Item	What it does	Committee recommendation	What would be different	Why
80000–80015 80100–80115 80125–80140 80150–80165	Assessment and therapy by clinical psychologist, psychologist, occupational therapist or accredited mental health social worker (consulting and non-consulting rooms); 30 to 50 minutes, and 50 minutes or longer.	Change the item descriptors for psychological therapies and focused psychological strategies to allow sessions with family members, guardians, carers and/or residential staff where the patient is not present.	Mental health professionals would be able to engage with family members, guardians, carers and/or residential staff about the mental health needs of the patient as part of their course of treatment.	A fundamental element of evidence-based best practice in the delivery of psychological therapies is providing sessions for carers. This enhances collaboration, increases engagement and recognises carers/support people as valuable resources.

Recommendation 7b: Enable family and carers to participate in therapy and/or consultation

Item	What it does	Committee recommendation	What would be different	Why
New item 800BB	Provides a mechanism for consultation between health professionals and carers and/or support people.	Introduce an item number for the specific purpose of enabling consultation between health professionals and carers and/or support people.	Mental health professionals would be able to engage with family members, guardians, carers and/or residential staff about the mental health needs of the patient as part of their course of treatment.	A fundamental element of evidence-based best practice in the delivery of psychological therapies is providing sessions for carers. This enhances collaboration, increases engagement and recognises carers/support people as valuable resources.

Recommendation 8: Measure Better Access outcomes

Item	What it does	Committee recommendation	What would be different	Why
N/A	N/A	Invest time and resources in building outcome measurement into the MBS.	Patient outcomes would be collected through the MBS to help ensure that patients are improving as a result of mental health treatment, and to guide improvements in services into the future.	Monitoring outcomes in psychological therapies is important both for the welfare of the client and to confirm the effectiveness of treatment.

Recommendation 9: Update treatment options

Item	What it does	Committee recommendation	What would be different	Why
80000–80171	Assessment and therapy by clinical psychologist, psychologist, occupational therapist or accredited mental health social worker (consulting and non-consulting rooms); 30 to 50 minutes, and 50 minutes or longer. Group therapy, six to 10 patients: Therapy by clinical psychologist, psychologist, occupational therapist or accredited mental health social worker; 60 minutes or longer.	Add all therapies with National Health and Medical Research Council (NHMRC) Level I or Level II evidence to the list of approved therapies available under Better Access. Frequently review and update the list of therapies covered under the MBS.	Patients would be able to receive a broader range of evidence-based treatments appropriate to their mental health needs.	The current list of treatments is out of date and does not reflect current evidence. Many more psychological therapies have demonstrated a sufficient evidence base but are not included on the list. The range of therapies for which an MBS rebate is available should be expanded to better meet patients' needs. •

Recommendation 10: Unlink GP focused psychological strategy items from M6 and M7 items

Item	What it does	Committee recommendation	What would be different	Why
2721–2727	Consulting and non-consulting room attendance for focused psychological strategies for assessed mental disorders (medical practitioner registered with the Chief Executive Medicare); 30 to 40 minutes, and 40 minutes or longer.	Unlink these items from the M6 and M7 items for the number of available sessions per calendar year.	Patients would be able to receive up to 10 mental health sessions per calendar year from a GP, regardless of the number of sessions they receive from other mental health professionals.	GPs play a key role in engaging "unengaged" people who need mental health care. This recommendation would increase access to psychological interventions.

Recommendation 11: Encourage coordinated support for patients with chronic illness and patients with mental illness

Item	What it does	Committee recommendation	What would be different	Why
10956, 10968	Mental health and psychology service for person with chronic condition under a care plan; more than 20 minutes.	These items should not contribute towards the cap of five allied health sessions per year under a GPMP.	Patients who need mental health services would be able to access more than five sessions under GPMPs.	National and international evidence and research demonstrates that mental health concerns for all people with chronic, advanced chronic and terminal illness are under-reported, underdiagnosed and poorly treated.

Recommendation 12: Promote the awareness of digital mental health and other low-intensity treatment options

Item	What it does	Committee recommendation	What would be different	Why
N/A	N/A	Link existing digital mental health discussions to MBS services.	Effective digital options exist. Important next steps would be to explore how these solutions can be included in the MBS, and to encourage their use.	Digital mental health is both cost-effective and improve access to mental health services.

Recommendation 13: Support access to mental health services in residential aged care

Item	What it does	Committee recommendation	What would be different	Why
N/A	N/A	Continue monitoring new funding recently announced for residents in residential aged care facilities (RACFs).	The Reference Group welcomes the budget announcement regarding funding for residents in RACFs. This funding will go to primary health networks (PHNs), which will then ask agencies to deliver a range of preventive, educative and other interventions to reduce the incidence, severity and duration of mental health issues in residents in RACF.	Mental health care and treatment in RACFs can be fragmented, piecemeal and sometimes non-existent. There is no nationally consistent system for delivering mental health services to older people. The quality and accessibility of services varies from place to place, and rural and remote locations tend to be less well served.

Recommendation 14: Increase access to telehealth services

Item	What it does	Committee recommendation	What would be different	Why
N/A	N/A	Review the recent announcement expanding access to mental health telehealth services in rural and remote areas in two years.	N/A	A review of this announcement in two years would ensure that the initiative has delivered the hoped outcomes and that the change is permanent. •

Appendix D Better Access triage levels

Figure 4: Summary of ideas explored by the Reference Group in determining triage levels

Ideas explored by the MHRG in determining triage levels

Dimension	Examples or sample definitions	Advantages	Disadvantages
Disorder	▪ L3: Personality disorders, Bipolar disorders ▪ L2: Binge Eating Disorder; Obsessive Compulsive Disorder ▪ L1: Anxiety; Depression; anything covered in L2 or L3	▪ Clearest evidence base for number of sessions required	▪ Does not account for variability in need within a disorder
Clinical judgement in collaboration with the consumer	▪ L3: Assessed as chronic or treatment resistant ▪ L2: Assessed as moderate/severe ▪ L1: Assessed as moderate/mild	▪ Maximizes flexibility for consumer and clinicians involved in care	▪ Difficult to monitor for compliance
Co-morbidity	▪ L3: Co-morbidity with ID or 2+ mental disorders ▪ L2: Co-morbid with chronic condition, drug/alcohol/opioid abuse ▪ L1: Single disorder	▪ Acknowledge challenges of managing multiple conditions and interactions ▪ Logic to additional treatment need	▪ Lack of evidence to support appropriate number of sessions
Effect on functioning, (symptom severity and duration)	▪ L3: Severe and unremitting effect on functioning ▪ L2: Considerable impact ▪ L1: Any diagnosed disorder	▪ Tools exist to evaluate patient functioning (e.g., WHOOAS) ▪ If not tool-based, highly subjective	▪ Lack of evidence to support appropriate number of sessions ▪ Increased administration burden it tool used
Context	▪ L3: History if treatment non-response to lower intensity ▪ L2: Social/environment factors compound treatment ▪ L1: Stable context	▪ Accounts for social determinants of treatment outcomes	▪ Lack of evidence to support appropriate number of sessions ▪ Difficult to monitor for compliance

The MHRG noted that these dimensions are not mutually exclusive; several could be used in triaging

SOURCE: Brainstorming exercise from Meeting 3 of the Mental Health Reference Group

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Appendix E Sample evidence for additional sessions by condition

The Reference Group acknowledged that a more detailed review of the literature would be required to establish the exact parameters for access to additional sessions. It has provided the following sample evidence for Recommendation 3.

Table 55: Sessions required for a clinically significant improvement, by condition – sample data

Condition	Number of sessions suggested	Source
Generalised anxiety disorder	16–20 sessions of cognitive behaviour therapy (CBT)	Lambert, 2013
Anxiety	8–13 sessions for 50 per cent of patients	Gabbard, 2000
Panic disorder	12–16 sessions of CBT	Lambert, 2013
Post-traumatic stress disorder	10–16 sessions of prolonged exposure	Lambert, 2013
Depression	12–20 sessions, with treatment including behavioural therapy (BT), CBT, cognitive therapy (CT), mindfulness-based cognitive therapy (MBCT), interpersonal psychotherapy for depression (IPT) and emotion-focused Therapy (EFT)	Lambert, 2013
Depression	8–13 sessions for 50 per cent of patients	Gabbard, 2000
Anorexia nervosa	20 sessions in the third phase of family-based treatment (FBT), after the first phase (reversal of acute starvation) and second phase (returning control of eating to the patient) of treatment have been completed	Lambert, 2013
Bulimia nervosa	20 sessions of CBT, IPT or FBT	Lambert, 2013
Binge eating disorder	20 sessions of CBT or IPT	Lambert, 2013
Borderline personality disorder	26–52 sessions	Gabbard, 2000
Personality disorders	50+ sessions of schema therapy	Klerk et al., 2016
General “negative dose-effect curve”	30 per cent of clients show measurable improvement after two sessions; 53 per cent improve after eight sessions; 75 per cent improve after 26 sessions. Different groups have different “widths”.	Howard et al., 1986
Overall psychotherapy	15–19 sessions for 50 per cent recovery rate	Hansen and Lambert, 2003

Appendix F Examples of outcome measures in mental health in Australia

Some measurement data is already collected by public-sector and community mental health services in Australia, according to the National Outcome and Casemix Collection (NOCC) protocol. Collections occur at set points and for different reasons: at admission (new referral, transfer from another setting), at review and at discharge.

Table 15 is a measurements and usage table adapted from the Review of Standardised Measures Used in the National Outcomes and Casemix Collection (NOCC), published by the Australian Mental Health Outcomes and Classification Network in 2005 (37).

Table 66: Mental health outcome measures

Measurement	Detail
HoNOS	Health of the Nation Outcome Scales; clinician-rated
HoNOSCA	Health of the Nation Outcome Scales for Children and Adolescents; clinician-rated
LSP-16	Life Skills Profile 16; clinician-rated
MHI	Mental Health Inventory; consumer-rated
BASIS-32	Behaviour and Symptom Identification Scale; consumer-rated
K-10+	Kessler 10 Plus; consumer-rated
CGAS	Children's Global Assessment Scale; clinician-rated
SDQ	Strengths and Difficulties Questionnaire
HoNOS65+	Health of the Nation Outcome Scales 65+; clinician-rated
RUG-ADL	Resource Utilisation Groups – Activities of Daily Living; clinician-rated

Population	Measurement data collected
Children and adolescents	• HoNOSCA • CGAS • FIHS • Principal and additional diagnoses • Mental health legal status
Adults	• HoNOS • LSP-16

Population	Measurement data collected
	• Consumer self-report • Principal and additional diagnosis • Focus of care • Mental health legal status
Older person	• HoNOS 65+ • LSP-16 • RUG-ADL • Consumer self-report • Principal and additional diagnoses • Focus of care • Mental health legal status

Appendix G Summary of evidence for the addition of therapies

A 2018 literature review by the Australian Psychological Society (APS) (38) provides the evidence base for the therapies recommended for inclusion in Section 6.1.5. It is based on therapies with adequate Level I and Level II evidence (Figure 5). A sample summary table (Source: *National Health and Medical Research Council*

Table) is included below. For the full range of therapies reviewed by the Reference Group, please refer to the APS literature review noted above.

Members of the Reference Group also acknowledged the importance of other forms of evidence and noted that the NHMRC has outlined specific conditions under which Level III studies may provide a good evidence base that can be trusted to guide practice in most situations (21). The Reference Group did not reach consensus on whether to include additional therapies in the APS list that might fulfil the conditions outlined by the NHMRC. However, it noted that these should be considered going forward.

Figure 5: Overview of levels of evidence from the National Health and Medical Research Council

Table 3 NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes)

Level	Intervention [1]	Diagnostic accuracy [2]	Prognosis	Aetiology [3]	Screening Intervention
I [4]	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies
II	A randomised controlled trial	A study of test accuracy with: an independent, blinded comparison with a valid reference standard,[5] among consecutive persons with a defined clinical presentation[6]	A prospective cohort study[7]	A prospective cohort study	A randomised controlled trial
III-1	A pseudorandomised controlled trial (i.e. alternate allocation or some other method)	A study of test accuracy with: an independent, blinded comparison with a valid reference standard,[5] among non-consecutive persons with a defined clinical presentation[6]	All or none[8]	All or none[8]	A pseudorandomised controlled trial (i.e. alternate allocation or some other method)
III-2	A comparative study with concurrent controls: • Non-randomised, experimental trial[9] • Cohort study • Case-control study • Interrupted time series with a control group	A comparison with reference standard that does not meet the criteria required for Level II and III-1 evidence	Analysis of prognostic factors amongst persons in a single arm of a randomised controlled trial	A retrospective cohort study	A comparative study with concurrent controls: • Non-randomised, experimental trial • Cohort study • Case-control study
III-3	A comparative study without concurrent controls: • Historical control study • Two or more single arm study[10] • Interrupted time series without a parallel control group	Diagnostic case-control study[9]	A retrospective cohort study	A case-control study	A comparative study without concurrent controls: • Historical control study • Two or more single arm study
IV	Case series with either post-test or pre-test/post-test outcomes	Study of diagnostic yield (no reference standard)[11]	Case series, or cohort study of persons at different stages of disease	A cross-sectional study or case series	Case series

Source: National Health and Medical Research Council (26)

Table7: Sample of intervention methods supported by Level I and Level II evidence for mental health issues in adults

ADULTS	Level I evidence	Level II evidence
Anxiety disorders	CBT	Online CBT(G+UG), ACT, Online ACT(G), MBCT, MBSR, MCT, Psychodynamic therapy, Online Psychodynamic therapy(G), Psychoeducation (group)
Post-traumatic stress disorder (PTSD)	CBT (trauma-focused), EMDR	DBT, EFT, MCT, MBSR
Obsessive compulsive disorder	CBT (ERP), Online CBT(G), Computer-based ERP (G)	ACT, FI, MBCT, MCT
Attention deficit hyperactivity disorder	CBT	Online CBT(G+UG), DBT, MCT, MBCT, Psychoeducation
Borderline personality disorder	DBT, Psychodynamic therapy, Schema therapy	ACT, CBT, IPT, Psychoeducation
Eating disorders	CBT (for BED and BN only)	CBT (eating-disorder focused), Online CBT, FI, Psychodynamic therapy, Bibliotherapy (for BED and BN only), DBT (for BED and BN only)
Mood disorders / depression	CBT, Online CBT(G+UG), IPT, MBCT, PST, Psychodynamic therapy, Psychoeducation	ACT, Online ACT(G), DBT, EFT, EMDR, FI, Online PST(G), Schema therapy, SFT
Bipolar disorder	CBT	FI, MBCT, Psychoeducation
Psychotic disorders	CBT, FI, Psychoeducation	ACT, MCT
Substance use disorders	CBT (including motivational interviewing)	ACT, DBT, FI, Mindfulness-based relapse prevention, Psychodynamic therapy

Source: adapted from the 2018 APS literature review. (38)

Appendix H Referred questions from the GPPCCC

Figure 6: Responses from the MHRG on the first topic referred from the GPPCCC

MENTAL HEALTH REFERENCE GROUP

1 Rebate attendance at a case conference by non-doctor health professionals

PRELIMINARY

Question	Summary draft response	Rationale and evidence
To what extent do mental health professionals currently attend case conferences? What are the main barriers to attendance?	It is difficult to measure mental health professional attendance at case conferences, as this is not currently tracked by any item number or statistic, but anecdotally private mental health professionals already attend case conferences, often outside of normal operating hours. For example, case conferencing is a bedrock of the social work profession, and is vital to coordinating care in rural and remote communities for all allied health professionals. Barriers to attendance outlined by the MHRG (two can be addressed by adding mental health professionals to the case conferencing item): ▪ Lack of rebate makes it harder to dedicate time to case conferences ▪ Lack of item: signals that AHPs are not valued at case conferences ▪ Coordination: Many case conferences which AHPs attend currently are via telephone. Video- or tele-conferencing would be more practical than an in-person item ▪ Synchronicity: Asynchronous options would also help to ensure that more case conferences could be held. The MHRG also noted that the introduction of a case conference line item for mental health professionals may encourage 'box ticking' behaviour instead of true multi-disciplinary approaches.	▪ Existence of guide papers for GPs and AHPs on MBS case conference process indicates they are involved with the current GP items (e.g., Albury Wodonga Regional GP Network, Case Conference Resource Guide) ▪ Anecdotal: Mental health professionals already hold case conferences, but generally do this during non-billable hours (e.g., lunch break) ▪ Anecdotal: GPs case conference with social workers frequently, especially in rural / remote
What does the evidence say about the benefit of mental health professionals attendance at case conferences?	Integrated, collaborative care is an underlying principal of high-value patient care, and mental health professionals already engage with systemic, coordinated approaches to care. Collaborative care arrangements are considered a cornerstone of evidence-based psychological interventions While there are other ways of coordinating care, some of which will be further enabled by My Health Record, case conferencing is a core element of integrated care. It would not be possible to deliver a shared care model, across different types of care, systems, and sectors, without case conferencing. While case conferencing is incorporated into expectations for public health professionals, within FFS and for private practitioners, case conference MBS items enable reimbursement for this activity for the practitioner (who otherwise faces an opportunity cost of attending a case conference versus engaging in a rebated activity). All private practitioners who participate in these activities should be able to access a rebated MBS item for attending a case conference.	▪ On the importance of coordinated care involving mental health professionals: *McDaniel, Susan H.; Salas, Eduardo The science of teamwork, American Psychologist, Vol 73(4)*

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Figure 7: Response from the MHRG on the second topic referred from the GPPCCC

MENTAL HEALTH REFERENCE GROUP

2 Consider integrating mental health management plans with Chronic Disease Management plans

PRELIMINARY

Question	Draft response	Rationale and evidence
Should mental health treatment plans be integrated with chronic disease management plans?	While the MHRG acknowledges the overlap between MHTPs and GPMPs, the Reference Group's view is that additional coordination and interoperability are needed between the two items, but that this does not amount to combining the two items into a single option for patients. The MHRG noted that the schedule fees for the two services are inconsistent, with the amount paid for a MHTP significantly less per minute versus a CDMP, creating a disincentive for doing both properly when required. This is connected to the fact that an MHTP includes an assessment as well as developing the plan, whereas a CDMP does not include an assessment within the description. There are circumstances where an integrated option for MHTPs and GPMPs may make sense for some cohorts, for example in palliative care, where there may be significant overlap between mental and physical illness. It is also important to recognise physical health problems are more likely for those with mental health conditions. The MHRG will continue to review the MHTP items to improve delivery of high-value care. Some initial suggestions discussed by the MHRG include: ▪ a partial item for a patient who already had one item but might require the other; ▪ changing the wording in each item's description to make it clearer that a person can be eligible for both plans and should receive both ▪ an integrated item for patients who need elements of both mental health and chronic care treatment. ▪ Splitting out assessment element from plan element of MHTPs; in which case GPs could have comprehensive assessment and then determine whether CDMP, MHTP, or both are needed ▪ Chronic disease management plan should be billable the same day as a MHTP	▪ The plans are quite distinct, requiring different work to build out, and the plans support patient cohorts which do not necessarily overlap ▪ Often a patient might have an issue which is predominantly physical, or predominantly mental, but that still requires an element of the other - and it is this that is hardest to manage within the current framework. ▪ Anecdotal: In rural / remote communities, having one plan and then needing come back for the other later (waiting a month or 6 weeks between) can be a significant disadvantage for patients and impede access to care

1 This recommendation is about adding an item for care facilitation of the same type as the AHP chronic care items (10950-10970 in the MBS)

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