Medicare Benefits Schedule Review

Beyond Better Access

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Executive Summary

The current Medicare Benefits Schedule (MBS) Item Numbers for mental health services under *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* ("*Better Access*") have substantial flaws.

- Treatment sessions are allocated inefficiently because consumers are receiving services that are not tailored to their needs when alternative services that are better targeted and more cost-effective could be provided.
- Mental Health Plans, which are provided by General Practitioners (GPs), are an unnecessary barrier to service access for many consumers. GP review sessions are also unnecessary and have no additional clinical benefit.
- Mental Health Plans involve a formal diagnosis of a mental disorder, which is not appropriate or necessary for consumers with mild to moderate mental health issues.
- The range of interventions allowed within Focussed Psychological Strategies is too narrow. Focussed Psychological Strategies principally emphasises Cognitive Behavioural Therapy (CBT) which is not effective for all client groups. There is clear research evidence that other interventions are also effective for a range of presenting issues.
- Capping treatments at ten sessions is not supported by research evidence. The cap is problematic for consumers who require more extensive treatment and should be raised to a more appropriate level.

To address these issues, the Psychotherapy and Counselling Federation of Australia (PACFA) has developed a new Primary Care Mental Health Program aimed at better meeting the mental health needs of the Australian community. This alternative program is being proposed to the Health Minister as a replacement for *Better Access*. The proposed new model would provide a stepped care approach to mental health care and be more cost-effective and sustainable. The key elements of the proposed model are:

- Medicare funding should be based on the interventions provided, not on the professional status of the clinician providing the interventions. As such, Medicare should provide two classes of treatment: Primary Care Counselling for mild to moderate illnesses and Specialist Mental Health Treatment for moderate to severe illness.
- Primary Care Counselling would be delivered without the need for a Mental Health Plan by a range of suitable practitioners, including counsellors and psychotherapists.
- Specialist Mental Health Treatment would only be accessible for consumers with more serious mental health issues through a Mental Health Plan. Specialist Treatment should be provided by a wide range of suitable mental health practitioners, based on their competence to provide specialist interventions.
- The interventions offered should be a much wider range of evidence-based treatments than those currently available under *Better Access*.
- The cap of ten sessions should be increased to enable consumers to access the services they need for full recovery. The number of Specialist Treatment sessions should be higher than the cap for Primary Care Counselling where this is clinically necessary for clients with more serious mental health issues.

Recommendations

The Medicare Benefits Schedule should be amended to incorporate all elements of the proposed Primary Care Mental Health Program as outlined in PACFA's recommendations:

1. Require Mental Health Plans only for consumers with more serious mental illnesses who require specialist treatment.
2. Remove MBS Items for Mental Health Plans made by GPs without AMA-recommended mental health training.
3. Discontinue differential pricing for different practitioners where practitioners are providing the same service.
4. Target consumers with mild to moderate mental health issues with counselling services to be provided by a range of appropriate practitioners including counsellors and psychotherapists, at the rate of $74.80 per session.
5. Expand the range of evidence-based interventions allowed under Focussed Psychological Strategies to better meet consumers needs.
6. Reconsider the limit of ten sessions of Focussed Psychological Strategies to ensure that *Better Access* can be responsive to the clinical needs of consumers. The number of treatment sessions available under *Better Access* should be based on research evidence.
7. Expand the mental health workforce in rural and regional areas by extending Medicare numbers to Counsellors and Psychotherapists to provide *Better Access* services.
8. Target consumers with moderate to severe mental health issues with specialist treatment to be provided by a range of appropriate practitioners who receive the same fee.
9. Replace Focussed Psychological Strategies with Primary Care Counselling and allow a wider range of practitioners to provide these counselling services without the need for a Mental Health Plan.
10. Allow an appropriate number of sessions of Specialist Mental Health Treatment to ensure treatment is responsive to consumer needs. This should be higher than the 10 sessions available under *Better Access* based on the clinical needs of consumers with moderate and severe mental health issues.
11. Allow a wider range of practitioners to provide Specialist Mental Health Treatment if they can demonstrate competencies to deliver the specialist interventions.
12. Allow access to long-term psychotherapy with a Registered Psychotherapist for consumers with serious mental disorders requiring specialist treatment to support successful recovery, prevent hospitalisation and reduce suicide risks.
13. Reinvest projected savings of $109,112,273 in additional mental health services, from replacing *Better Access* with a new, better-targeted program.
14. Make compliance with new data collection requirements mandatory for approval to deliver Item Numbers under the proposed Primary Care Mental Health Program. This will ensure there is data to measure the effectiveness of services provided.

Background to PACFA

The Psychotherapy and Counselling Federation of Australia (PACFA) is the leading national peak body and professional association representing the self-regulating profession of counselling and psychotherapy. PACFA advocates for appropriate, accessible health services to meet the bio-psychosocial needs of consumers. Counselling and psychotherapy are interdisciplinary activities provided by a range of professionals, including psychologists, social workers and occupational therapists, as well as counsellors and psychotherapists.

Counselling and psychotherapy focus on the prevention of mental illness and the provision of psychotherapeutic interventions for psychological difficulties, while actively promoting the development, mental health and wellbeing of consumers. PACFA covers a range of therapeutic modalities including family therapy, relationship counselling, hypnotherapy, integrative counselling, body-focused psychotherapy, spiritually-informed counselling and psychotherapy, expressive arts therapies, psychodynamic psychotherapy and psychoanalysis.

PACFA's 2,311 registered counsellors and psychotherapists have completed training in counselling or psychotherapy to at least Bachelor degree level or equivalent, and many are trained at postgraduate level. Registrants have completed at last two years full-time practice (950 client contact hours and 125 hours of clinical supervision), meet PACFA's annual requirements for professional development and supervision, and follow the PACFA Code of Ethics. PACFA Registrants are distributed throughout Australia in urban, regional and rural areas. PACFA also has a specialist registration category for Mental Health Practitioners who have demonstrated practice competencies in the area of mental health. Mental Health Practitioners provide psychotherapeutic interventions for consumers with more serious mental disorders.

PACFA Registrants are listed on the Australian Register of Counsellors and Psychotherapists (ARCAP), the national register and credentialing system, established jointly by PACFA and our partner the Australian Counselling Association (ACA).

1. Flaws in *Better Access*

PACFA's submission outlines the substantial flaws with the services provided under the *Better Access* program. It will focus on Mental Health Plans (Items 2700 to 2717), Focussed Psychological Strategies (Items 80100 to 80170), and Psychological Therapy (Items 80000 to 80020). The submission will provide analysis and recommendations on the appropriateness and targeting of services, best practice for the delivery of primary care mental health services, as well as advice on the level and frequency of Items provided through the MBS. The submission will also provide advice relating to health financing and appropriate mechanisms to access care.

The analysis and economic modelling are based on 2012 occasions of service data for *Better Access*. The modelling is provided to illustrate the points made in this submission. More recent data on occasions of service for the *Better Access* Item numbers are not available to PACFA. Given that the uptake of *Better Access* has continued to grow, it is likely that the projected savings in PACFA's costings would be significantly higher in 2018.

1.1 Mental Health Plans – Items 2700 to 2717

Mental Health Plans are not cost-effective

Better Access requires a Mental Health Plan in order to access mental health services. This is unnecessary and wastes precious mental health funding that could be allocated to provide additional mental health services. GPs, especially those who have not been trained in mental health, should not receive a fee to unlock access to mental health services. This is inappropriate and is not cost-effective for the many consumers who experience mild to moderate mental health issues which could be addressed through short-term counselling. GPs regularly write other types of referrals without receiving a fee and they could make referrals for counselling without an MBS Item.

Table 1: Cost of Mental Health Plans

Item No	Description	Current Fees	No of services (2012)	Cost
2700	MH Plan by untrained GP (20 mins)	$70.30	134,909	$9,484,103
2701	MH Plan by untrained GP (40 mins)	$77.65	66,484	$5,162,483
2712	Review of Mental Health Plan by GP (20 mins)	$52.75	320,767	$16,920,459
2713	GP Mental Health attendance (20 mins)	$70.30	1,056,344	$74,260,983
2715	Mental Health Plan by trained GP (20 mins)	$89.25	415,414	$37,075,700
2717	Mental Health Plan by trained GP (40 mins)	$98.60	196,450	$19,369,970
			Total	**$162,273,698**

Unnecessary mental health diagnoses

Mental Health Plans require a General Practitioner (GP) to make a diagnosis of a mental disorder. This is clinically inappropriate for clients presenting with mild to moderate mental health issues. The imposition of a formal diagnosis has significant detrimental effects. Specifically, research demonstrates that the diagnosis has adverse impacts on employment opportunities and access to insurance (beyondblue, 2017) as well as creating stigma which undermines a client's recovery as a result of disempowerment (Corrigan, 2004; Masterson & Owen, 2006).

Case Study 1: Mental Health Plan for mild depression

A client with mild to moderate depression or anxiety is often experiencing life difficulties and circumstances which contribute to their illness. For example, they may be experiencing relationship difficulties or breakdown, bereavement, unemployment, workplace bullying, illness, disability, loneliness or social isolation. Imposing a mental health diagnosis is inappropriate and may undermine recovery for these clients.

A Mental Health Pan and formal diagnosis of a mental disorder may be appropriate and necessary for a consumer with a more serious mental health issue requiring specialist treatment. However, for the vast majority of consumers with mild to moderate mental health issues, they are inappropriate. Diagnosis of mental disorders should never be a condition of accessing mental health services unless the diagnosis is necessary and appropriate for effective treatment.

Recommendation 1: Require Mental Health Plans only for consumers with more serious mental illnesses who require specialist treatment.

Mental Health Plans by untrained GPs

Approximately one-third of Mental Health Plans are prepared by GPs who have not completed the AMA-approved mental health training. This raises serious concerns about the quality of Mental Health Plans and the value that is being contributed by these MBS Items beyond unlocking access to treatment. The Mental Health Plan should be a comprehensive mental health assessment to enable referral to the most appropriate specialist mental health practitioner. If a Mental Health Plan is made by a GP without the appropriate training, the Mental Health Plan may reach not these standards. Instead, the only benefit to a consumer is access to a mental health practitioner which could be achieved with an ordinary referral letter.

Recommendation 2: Remove MBS Items for Mental Health Plans made by GPs without AMA-recommended mental health training.

1.2 Focussed Psychological Strategies – Items 80100 to 80170

Focussed Psychological Strategies are poorly targetted

Better Access targets consumers inefficiently with the services being provided by a range of practitioners who are paid different fees despite providing the same service. Psychologists are paid a schedule fee of $84.80 per session (Item Number 80110) compared to other allied health providers

who are paid a schedule fee of $74.80 per session (Item Numbers 80135 and 80160). This price differential privileges one profession over others, even though all of the providers are delivering the same service, that is, Focussed Pscyhological Strategies.

Table 2: Comparison of fees paid to different practitioners that are providing the same service

Item No	Description	Current Fees	No of services (2012)	Cost
80160	Focussed Psychol. Strategies by Soc. Wor. (>50 mins)	$74.80	168,529	$12,605,969
80135	Focussed Psychol. Strategies by Occ. Ther (>50 mins)	$74.80	31,662	$2,368,318
80110	Focussed Psychol. Strategies by Psych. (>50 mins)	$84.80	1,936,034	$164,175,683

According to 2012 occasions of service data, 90.6% of Focussed Psychological Strategy sessions are carried out by psychologists. However, the majority of consumers, who have mild to moderate depression and anxiety, do not specifically require intervention from psychologists. These consumers could be effectively assisted by receiving counselling from a registered counsellor or psychotherapist, a social worker or an occupational therapist.

The higher schedule fees paid to psychologists to deliver Focussed Psychological Strategies is an inefficient use of resources. There is no clinical rationale for paying more to providers based on their training and no evidence that the higher fees paid to psychologists result in better treatment outcomes. Services could be provided by a range of suitably qualified practitioners, including counsellors and psychotherapists, at the lower rate of $74.80 per session.

Recommendation 3: Discontinue differential pricing for different practitioners where practitioners are providing the same service.

Recommendation 4: Target consumers with mild to moderate mental health issues with counselling services to be provided by a range of appropriate practitioners including counsellors and psychotherapists, at the rate of $74.80 per session.

Focussed Psychological Strategies are too narrow

Focussed Psychological Strategies are limited to cognitive behavioural therapy (CBT), interpersonal therapy (IPT), skills training, psycho-education and relaxation strategies under the *Health Insurance (Allied Health Services) Determination 2014.* While these interventions can certainly be beneficial for clients, the narrow focus on these interventions, and particularly on CBT and IPT, is flawed. A Cochrane review found that there is evidence that CBT is not effective for all client groups (Hunot, Churchill, Teixeira & Silva de Lima, 2007). In particular, CBT can be ineffective for people with trauma and post-traumatic stress disorder (Gordon et al., 2008; Röhricht, 2009) and older people are more likely to drop out of CBT than other age groups (Hunot et al, 2007). The usefulness of IPT is also overstated (Parker et al., 2006). In developing IPT, researchers drew on research which demonstrates effectiveness because of common factors across all treatment models, such as the strength of the therapeutic alliance, use of empathy, acceptance and the client's hopefulness about change and openness (Parker et al., 2006). Therefore, the evidence of IPT usefulness does not differentiate it from other models.

Secondly, the restrictions on interventions also ignore the substantial evidence that other interventions are effective for a wide range of mental health issues. In particular, the research indicates that body-focused psychotherapy is effective for a range of issues (Bloch-Atefi & Smith, 2014) including where talking therapies are unable to effectively treat the condition, including PTSD (Gordon et al., 2008; Röhricht, 2009). There is also evidence that regular participation in counselling contributes to the prevention and treatment of mental illnesses including anxiety and depression (Cuijpers et al., 2008). There is also substantial evidence that counselling is an effective treatment for PTSD (Schottenbauer et al., 2006; Sherman, 1998). Lastly, recent systematic reviews have shown that couples counselling and family therapy can be more effective than individual treatment for treating substance abuse (O'Farrell & Clements, 2011; Ruff et al., 2010).

Confining clinical treatments limits the opportunity clients have to access treatments that are effective for their particular presenting issues and preferences. There are a number of interventions with a proven clinical effectiveness that should be incorporated into MBS Item Numbers.

Recommendation 5: Expand the range of evidence-based interventions allowed under Focussed Psychological Strategies to better meet consumers needs.

Table 3: Suggestions for additional interventions for Focussed Psychological Strategies

Intervention	Presenting issues
Solution-focused Brief Therapy	Substance misuse, depression
Motivational Interviewing	Substance misuse, problem gambling
Supportive counselling	Depression
Psychodynamic Psychotherapy	Depression, generalised anxiety, social anxiety, substance misuse, anorexia nervosa
Couples counselling	Depression, generalised anxiety, post-traumatic stress disorder, substance misuse
Humanistic-experiential therapies	Depression, anxiety, relationship / interpersonal distress

These interventions are supported by a range of research as studies as detailed in this submission, and by PACFA literature reviews on depression (Knauss & Schofield, 2009a), post-traumatic stress disorder (Knauss & Schofield, 2009b), anxiety (Knauss & Schofield, 2009c), eating disorders (Knauss & Schofield, 2011), supportive counselling (Jacobs & Reupert, 2014), psychodynamic psychotherapy (Gaskin, 2012) and experiential psychotherapy (Mullings, 2017). Table 3 also considers the findings in *Evidence-based Psychological Interventions in the Treatment of Mental Disorders: A Literature Review* (Australian Psychological Society, 2010).

The session cap for Focussed Psychological strategies is too low

Better Access currently limits the number of sessions a client may access to ten per the calendar year. There is no underlying clinical justification for this limit which can result in consumers who are mentally ill not being able to access additional services that they need for full recovery.

The policy decision to restrict treatment under *Better Access* to ten sessions seems intended to ensure that the program is efficient by limiting the number of sessions that consumers with mild or moderate mental illness can receive. This was described in the 2011/12 Federal Budget documents

as 'rebalancing the number of annual allied health sessions to better align treatment to the needs of people' (Australian Government, 2011). However, this decision assumes that patients using *Better Access* have only mild or moderate mental illness, which is clearly not the case.

The limit of ten sessions should be reconsidered to ensure *Better Access* can respond to consumer needs. PACFA notes that the 2011 evaluation of *Better Access* found that, on average, consumers had five to six sessions of Focussed Psychological Strategies (Pirkis, Harris, Hall & Ftanou, 2011). This is supported by other research which found that six to eight counselling sessions are the optimum amount of counselling required for effective outcomes for most consumers (Frame, Hanlon, MacLean, & Nolan, 2005). However, longer-term therapy is required for more serious and long-term mental illnesses. Raising the current ten session cap for those that require more sessions in order to recover fully will not impact on the vast majority of consumers who do not require additional sessions but who are effectively treated by five to eight counselling sessions.

Although evidence indicates short-term therapy is effective for some consumers, it is important that clinicians are able to provide treatments that are responsive to consumer needs. Research on consumer engagement with community mental health services demonstrates that "a minimum of eleven to thirteen sessions of evidence-based interventions are needed for 50% - 60% of clients to be considered recovered" (Barrett, Chua, Crits-Cristoph, Gibbons & Thompson, 2008, p. 248). For some patients with more long-term or severe mental health challenges, limiting the number of treatment sessions available under *Better Access* to ten sessions could have a detrimental effect on treatment outcomes.

Recommendation 6: Reconsider the limit of ten sessions of Focussed Psychological Strategies to ensure that *Better Access* can be responsive to the clinical needs of consumers. The number of treatment sessions available under *Better Access* should be based on research evidence.

Service access issues in rural and regional areas

The current model also has substantial issues catering to the demand for mental health services in regional and rural Australia. Demand is high and is not being met by the current pool of MBS providers. In rural, regional and remote areas, only 4% of psychiatrists and 21.5% of psychologists provide services (Vines, 2011), compared to 28.3% of counsellors and psychotherapists (Schofield, 2008; Schofield & Roedel, 2012). The high demand for MBS services in rural and regional areas could be alleviated by registered counsellors and psychotherapists in rural and regional areas who could deliver *Better Access* services.

Case Study 2: Access to services in rural and regional areas

PACFA's partner, the ACA, reported that in 2011 in Whyalla in South Australia, there was only one psychologist for a population 22,000 and the waiting time was 6 months. There were ten counsellors in Whyalla at that time that could have provided *Better Access* services.

Recommendation 7: Expand the mental health workforce in rural and regional areas by extending Medicare numbers to Counsellors and Psychotherapists to provide *Better Access* services.

1.3 Psychological Assessment or Treatment – Items 80000 to 80020

Psychological Assessment and Treatment (Items 8000 to 80020) also have substantial flaws. Firstly, the Item Numbers are poorly targeted. Clinical psychologists are paid a schedule fee of $124.50 to provide the treatment, regardless of what intervention they provide. As there is no data collected on the interventions provided under these Item Numbers or on the treatment outcomes, it is not clear whether the interventions are in fact any different from the CBT provided under Focussed Psychological Strategies. PACA's analysis is that it costs $49.70 more for a clinical psychologist to provide CBT to a consumer, compared with CBT provided under Focussed Psychological Strategies.

This special pricing for clinical psychologists is open to misuse and is potentially contributing to poor service targeting. The Australian Psychological Society scheduled fees for both Clinical Psychological Assessment and Psychological Assessment are identical (Australian Psychological Society, 2017). Therefore, if a clinical psychologist provides the service, the consumer receives a higher MBS rebate and has a lower out of pocket expense that if they see a psychologist. This may encourage referral to clinical psychologists over other practitioners in order to get a higher rebate, even though this may not be clinically necessary. This system incentivises consumers to choose a clinical psychologist when another practitioner could provide the same service for a lower fee. PACFA submits that the combination of these two factors results in a substantial misallocation of *Better Access* funds. These funds could be better targeted to provide more services.

Secondly, the *Health Insurance (Allied Health Services) Determination 2014,* which set out the details of the *Better Access* scheme, limits the number of treatment sessions that can be provided for Psychological Assessment and Treatment (Items 8000 to 80020) to ten sessions. This limit has been universally criticised as inappropriate, particularly for consumers with moderate or severe mental illnesses who are likely to require more than ten treatment sessions for full recovery.

CBT is still the primary form of intervention administered. Although the *Health Insurance (Allied Health Services) Determination 2014* does not define the interventions that clinical psychologists can provide under Items 80000 to 80020, the Department of Health Guidance (Australian Government, Department of Health and Ageing) states "It is recommended that cognitive-behaviour therapy is provided in Psychological Therapy Services. However, other evidence-based therapies, such as Interpersonal Therapy, may be used if considered clinically relevant." As outlined on page 7 of this submission, there is evidence that CBT is not effective for all client groups. There is also substantial evidence that many other interventions are effective.

Table 4: Suggestions for additional interventions for Psychological Assessment or Treatment

Intervention	Presenting issues
Psychodynamic Psychotherapy	Depression, generalised anxiety, social anxiety, substance misuse, anorexia nervosa
Couples counselling	Depression, generalised anxiety, post-traumatic stress disorder, substance misuse
Humanistic-experiential therapies	Depression, anxiety, relationship / interpersonal distress

Intervention	Presenting issues
Mindfulness-based Cognitive Therapy	Depression, generalised anxiety, bipolar disorder, anorexia nervosa
Acceptance and Commitment Therapy	Depression, generalised anxiety, obsessive-compulsive disorder, anorexia nervosa
Dialectical Behaviour Therapy	Borderline personality disorder, anorexia nervosa
Family Therapy	Anorexia nervosa
Creative Arts Therapies	Depression, post-traumatic stress disorder
Psychoanalytic Psychotherapy	Depression, anxiety, personality disorders
Somatic psychotherapy	Post-traumatic stress disorder, trauma

These interventions are supported by a range of research studies as detailed in this submission, including the PACFA literature reviews detailed on page 8, and PACFA's literature reviews on psychoanalytic psychotherapy (Gaskin, 2014), creative arts therapies (Dunphy, Mullane & Jacobsson, 2013) and body-oriented psychotherapy (Bloch-Atefi & Smith, 2014).

Thirdly, there is no clinical justification for paying a higher fee to clinical psychologists based solely on their professional status. A higher fee could be justified clinically if a specialist intervention is being provided based on the consumer's clinical needs. However, clinical psychologists are not to only practitioners who have the competencies to deliver specialist interventions.

Recommendation 8: Target consumers with moderate to severe mental health issues with specialist treatment to be provided by a range of appropriate practitioners who receive the same fee to provide the same service.

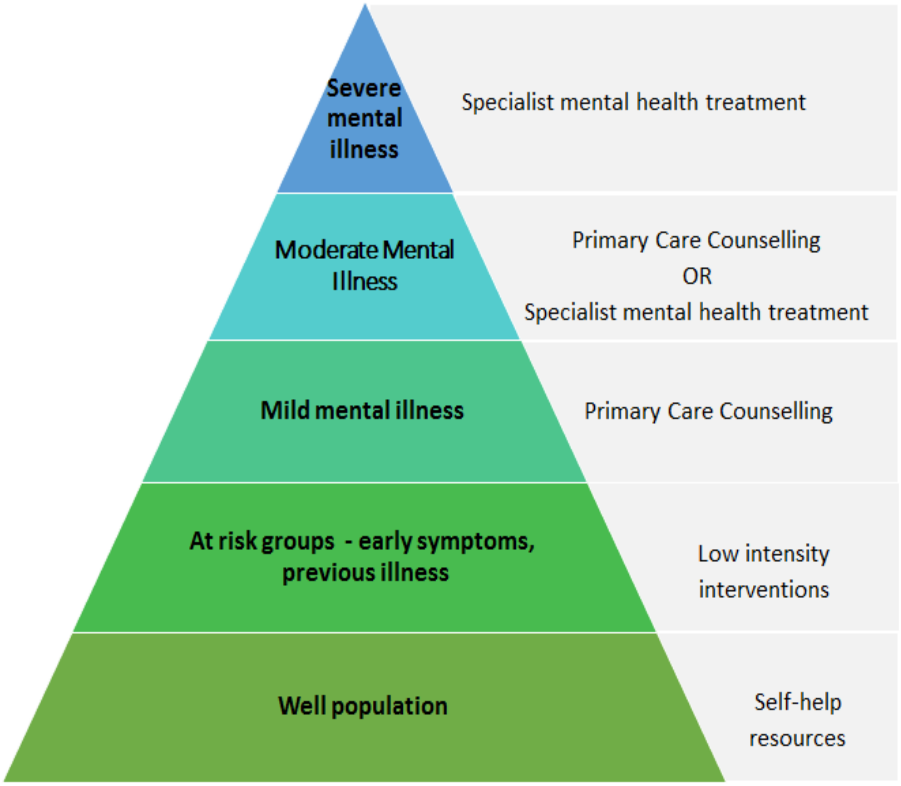
2. Primary Care Mental Health Program

The flaws in the *Better Access* model and the corresponding MBS Item Numbers mean that a new model for primary care mental health service delivery is required. PACFA suggests a Primary Care Mental Health Program which moves away from the current system of mandatory but unnecessary Mental Health Plans, and moves towards a stepped care approach as outlined in the Government's response to the National Mental Health Commission Report *Contributing Lives, Thriving Communities – Report on the National Review of Mental Health Programmes and Services*.

The stepped care approach emphasises matching the needs of individuals with the intervention they receive (National Mental Health Commission, 2014). The approach focuses on making sure individuals get the right care at the right time and reducing over servicing and under servicing (National Mental Health Commission, 2014). For consumers, this will mean there is a broader range of services available to better target their clinical needs.

By appropriately identifying issues and engaging with the right level of care, particularly for consumers with mild to moderate mental health issues, services will support optimal use of resources for those cases that are more severe and complex (National Mental Health Commission,

2014). This means matching MBS Item Numbers to the intervention supplied rather than the profession supplying the intervention.



The proposed new model aims to reduce the inefficiencies created by poor targeting and the narrow range of interventions offered by *Better Access* to better match the needs of consumers with the appropriate practitioners and interventions. The Primary Care Mental Health Program would ensure people get the right treatment in a cost-efficient manner.

The new model would free up $109,163,500 for investment in an estimated 1,090,000 additional occasions of service.

2.1 Restrict use of Mental Health Plans

Mental Health Plans - Items 2700 to 2717

Mental Health Plans are unnecessary, wasteful and are a barrier to treatment. The proposed Primary Care Mental Health Program would reduce their use for consumers with mild to moderate mental health issues.

The new model would remove Items 2700 and 2701 which are Mental Health Plans provided by an untrained GP. This would improve the effectiveness of Mental Health Plans when they are provided by GPs, and achieve an overall reduction in the cost of Mental Health Plans. GPs who are not trained in mental health can provide ordinary referrals by letter without a Mental Health Plan.

The new model would reduce the use of Items 2712, 2713, 2715 and 2717 by fifty percent by only requiring a Mental Health Plan if the consumer requires Specialist Mental Health Treatment. Where a consumer requires Primary Care Counselling, an ordinary referral should be made by letter to an

appropriate practitioner, without the need for a Mental Health Plan and the associated fee. This will reduce inappropriate mental health diagnoses and support better targeting of service for consumers with moderate or severe mental illness.

Table 5: Proposed Mental Health Plan Item Numbers

Item No	Description	Current Fee	Proposed No. of services	Cost
2700	MH Plan by untrained GP (20 mins) **REMOVE**	$70.30	0	$0
2701	MH Plan by untrained GP (40 mins) **REMOVE**	$77.65	0	$0
2712	Review of Mental Health Plan by GP (20 mins)	$52.75	160,384*	$8,460,230
2713	GP Mental Health attendance (20 mins)	$70.30	528,172*	$37,130,492
2715	Mental Health Plan by trained GP (20 mins)	$89.25	207,707*	$18,537,850
2717	Mental Health Plan by trained GP (40 mins)	$98.60	98,225*	$9,684,985
			Total	**$73,813,557**

This will also prevent Mental Health Plans from restricting service access and instead make them a key part of an integrated response to moderate and severe mental health issues. These changes create projected savings of $88,460,141 which can be reinvested in additional mental health services.

2.2 Replace Focussed Psychological Strategies with Primary Care Counselling

Increased efficiency could be achieved by abolishing MBS Items 80160, 80135 and 80110 as well as the associated Items 80100, 80105, 80115, 80120, 80125, 80130, 80140, 80145, 80150, 80155, 80165 and 80170 and replacing them with four new Item Numbers. These Item Numbers would be Primary Care Counselling targeted at 'Moderate to Mild Mental Illness' with services to be provided by counsellors, psychotherapists, psychologists and other Allied Health Professionals.

Primary Care Counselling should be expanded to include a larger range of evidence-based interventions which allow practitioners to use the appropriate treatment on the appropriate client.

Table 6: Proposed Medicare Item Numbers

Item No.	Description	Proposed Fees	Proposed No. of services	Cost
NEW	Primary Care Counselling (<50 mins)	$52.95	37,564	$1,989,014
NEW	Primary Care Counselling (<50 mins) other location	$74.55	5,359	$399,513
NEW	Primary Care Counselling (>50 mins)	$74.80	2,136,225	$159,789,630
NEW	Primary Care Counselling (>50 mins) other location	$96.35	126,665	$12,204,173

Primary Care Counselling services could be provided by suitably qualified counsellors or psychotherapists. Other suitably qualified practitioners such as social workers, occupational therapists and psychologists would also continue to be included as providers of Primary Care

Counselling. Generally, it is not necessary for more highly qualified health professionals such as clinical psychologists to be delivering Primary Care Counselling services. These services are more appropriately delivered by counsellors and psychotherapists. However, given that the same schedule fee would apply to all practitioners, clinical psychologists could be included to allow for client preference and choice.

The new Item Numbers would better target the treatment and clearly associate the proposed fee with the type of care being provided rather than the provider. This will save $20,652,132 for reinvestment in new mental health services. Fees should not vary based on the professional background of the service provider because all practitioners are providing the same service.

Table 7: Eligible Practitioners and suggested interventions for Primary Care Counselling

Intervention	Eligible Practitioners	Interventions
Primary Care Counselling	Registered Counsellor Registered Psychotherapist Mental Health Social Worker Mental Health Occupational Therapist Clinical Psychologist Psychologist	Cognitive-Behaviour Therapy Narrative Therapy Interpersonal Therapy Skills Development Relaxation Strategies Psycho-education Solution-focused brief therapy Motivational Interviewing Couples therapy Family Therapy Mindfulness-based Cognitive Therapy Acceptance & Commitment Therapy Supportive Counselling Psychodynamic Psychotherapy Humanistic-experiential therapies

Recommendation 9: Replace Focussed Psychological Strategies with Primary Care Counselling and allow a wider range of practitioners to provide these counselling services without the need for a Mental Health Plan.

2.3 Replace Psychological Treatment & Assesment with new Items for Specialist Mental Health Treatment

MBS Item Numbers 80000 to 80020 would be replaced with new Items for Specialist Mental Health Treatment. These Items would be targeted at moderate to severe mental illness and should require a Mental Health Plan in order to access treatment. The number of sessions provided should not be limited but should be based on clinical necessity. Review sessions with the GP who made the Mental Health Plan should be done at six-monthly intervals during the treatment process.

Table 8: Proposed Medicare Item Numbers

Item No.	Description	Proposed Fees	Proposed No. of services	Cost
New	Specialist Mental Health Treatment (<50 mins)	$84.80	14,988	$1,270,982
New	Specialist Mental Health Treatment (<50 mins) other loc'n	$106.00	883	$93,598
New	Specialist Mental Health Treatment 50 mins)	$124.50	1,681,463	$209,342,144
New	Specialist Mental Health Treatment (>50 mins) other loc'n	$145.65	23,591	$3,436,029
New	Group therapy per consumer (>60 mins)	$31.65	9,882	$312,765

Recommendation 10: Allow an appropriate number of sessions of Specialist Mental Health Treatment to ensure treatment is responsive to consumer needs. This should be higher than the 10 sessions available under *Better Access* based on the clinical needs of consumers with moderate and severe mental health issues.

These Item Numbers should no longer be defined by the professional status of the practitioner providing the service (such as clinical psychologists), but by whether the practitioner is trained in the specialist intervention to be provided. There is no clinical rationale for restricting specialist intervention to clinical psychologists. Any qualified mental health practitioner who has trained in the specialist intervention should be able to provide these interventions for the same fee.

Recommendation 11: Allow a wider range of practitioners to provide Specialist Mental Health Treatment if they can demonstrate competencies to deliver the specialist interventions.

The specialist interventions should be those for which there is clinical evidence to support their effectiveness. PACFA has identified a number of suitable specialist interventions.

Table 9: Eligible practitioners and suggested interventions for Specialist Assessment & Treatment

Intervention	Eligible Practitioners	Interventions
Specialist Mental Health Treatment	Registered Counsellor Registered Psychotherapist Mental Health Social Worker Mental Health Occupational Therapist Clinical Psychologist Psychologist	Cognitive-Behaviour Therapy Interpersonal Psychotherapy Mindfulness-based Cognitive Therapy Acceptance and Commitment Therapy Psychoanalytic Psychotherapy Dialectical Behaviour Therapy Psychotherapy Family Therapy Creative Arts Therapy

Case Study 3: Long-Term Psychotherapy

Consumers requiring long-term psychotherapy currently have very limited opportunities to access the treatment they require. Specifically clients with Borderline Personality Disorder, which is frequently related to unresolved trauma. These clients often present with a dual diagnoses such as drug or alcohol dependence and are at risk of self-harm and suicide.

One of the few options available to these clients is psychotherapy provided by a psychiatrist under Medicare, but this is at significant cost to the healthcare system. Some Clinical Psychologists may have trained in psychotherapy, but many would not have this type of specialisation. This means access to long-term psychotherapy, for clients with serious mental disorders, is not available and this may result in hospitalisation and a higher risk of suicide.

PACFA submits that long-term psychotherapy treatment does not need to be provided by psychiatrists or clinical psychologists but could be provided by qualified, registered psychotherapists. The Primary Care Mental Health Program should include the option of long-term psychotherapy for consumers requiring this type of treatment, and PACFA Registered Psychotherapists would be suitable providers to provide long-term psychotherapy.

Recommendation 12: Allow access to long-term psychotherapy with a Registered Psychotherapist for consumers with serious mental disorders requiring specialist treatment to support successful recovery, prevent hospitalisation and reduce suicide risks.

2.4 Reinvest Savings in Primary Care Mental Health Program

The proposed changes to the MBS Item Numbers will remove inefficient and inappropriate spending and create new services that meet standards for clinical best practice. The savings made changes to these Item Numbers should be reinvested in providing additional mental health services.

Table 10: Projected Savings

Proposed change	Savings
Reduction in Mental Health Plans	$88,460,141
Better Targeting with Primary Care Counselling	$20,652,132
Total	**$109,112,273**

Table 11: Proposed re-investment in Primary care Mental Health Program

Additional Services	Sessions	Funding
Primary Care Counselling	545,000	$40,766,000
Specialist Treatment	545,000	$68,397,500
Total	**1,090,000**	**$109,163,500**

Recommendation 13: Reinvest projected savings of $109,112,273 in additional mental health services, from replacing *Better Access* with a new, better-targeted program.

2.5 Data Collection and Service Evaluation

Currently, data collection from *Better Access* is limited to demographic data. *Better Access* does not require practitioners to collect client feedback to measure treatment outcomes. A review was undertaken by the Centre for Health Policy and Programs at the University of Melbourne in 2011 which outlines that consumers reported positive outcomes (Pirkis, Harris, Hall & Ftanou, 2011). However, there is no ongoing data collection to measure outcomes against standardised measures.

Direct feedback from clients is one of the most informative and accurate ways to measure the effectiveness of the services. Some form of data collection to measure treatment outcomes should be a mandatory requirement of provision of MBS Item Numbers.

Beyonblue has implemented a data collection system, CORE, as part of a pilot program they have developed for low-intensity interventions. CORE is used in the UK as a mandatory data collection requirement for service providers delivering the IAPT program (Improving Access to Psychological Therapies). PACFA is interested in partnering with beyondblue to implement data collection by our registered counsellors and psychotherapists nationally. Our goal is to prepare our members for future requirements around a mandatory collection of outcome data.

***Recommendation 14*:** Make compliance with new data collection requirements mandatory for approval to deliver Item Numbers under the proposed Primary Care Mental Health Program. This will ensure there is data to measure the effectiveness of services provided.

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Appendix 1

Better Access Initiative Costs - Based on 2012 data

Item No.	Description	Unit Benefit	Services Jan-Dec 2012	Total Cost of Medicare Jan-Dec 2012
2700	MH Plan by untrained GP (20 mins)	$70.30	134,909	$9,484,103
2701	MH Plan by untrained GP (40 mins)	$77.65	66,484	$5,162,483
2712	Review of Mental Health Plan by GP (20 mins)	$52.75	320,767	$16,920,459
2713	GP Mental Health attendance (20 mins)	$70.30	1,056,344	$74,260,983
2715	Mental Health Plan by trained GP (20 mins)	$89.25	415,414	$37,075,700
2717	Mental Health Plan by trained GP (40 mins)	$98.60	196,450	$19,369,970
80000	Assessment & Treatment by Clinical Psych. (<50 mins)	$84.80	14,988	$1,270,982
80005	Assessment & Treatment by Clinical Psych. (<50 mins) other loc'n	$106.00	883	$93,598
80010	Assessment & Treatment by Clinical Psych. (>50 mins)	$124.50	1,418,542	$176,608,479
80015	Assessment & Treatment by Clinical Psych. (>50 mins) other loc'n	$145.65	23,591	$3,436,029
80020	Group therapy by Clinical Psych. per patient (>60 mins)	$31.65	9,882	$312,765
80100	Focussed Psychol. Strategies by Psych. (<50 mins)	$60.10	32,252	$1,938,345
80105	Focussed Psychol. Strategies by Psych. (<50 mins) other location	$81.75	3,809	$228,921
80110	Focussed Psychol. Strategies by Psych. (>50 mins)	$84.80	1,936,034	$164,175,683
80115	Focussed Psychol. Strategies by Psych. (>50 mins) other location	$106.55	98,970	$10,545,254
80120	Group therapy by Psych. per patient (>60 mins)	$21.65	15,275	$330,704
80125	Focussed Psychol. Strategies by Occ. Therapist (<50 mins)	$52.95	3,255	$172,352
80130	Focussed Psychol. Strategies by Occ. Ther. (<50 mins) other loc'n	$74.55	1,012	$75,445
80135	Focussed Psychol. Strategies by Occ. Therapist (>50 mins)	$74.80	31,662	$2,368,318
80140	Focussed Psychol. Strategies by Occ. Ther. (>50 mins) other loc'n	$96.35	7,782	$749,796
80145	Group therapy by Occ. Therapist per patient (>60 mins)	$19.00	1,408	$26,752
80150	Focussed Psychol. Strategies by Soc. Worker (<50 mins)	$52.95	2,057	$108,918
80155	Focussed Psychol. Strategies by Soc. Worker (<50 mins) other loc'n	$74.55	538	$40,108
80160	Focussed Psychol. Strategies by Soc. Worker (>50 mins)	$74.80	168,529	$12,605,969
80165	Focussed Psychol. Strategies by Soc. Worker (>50 mins) other loc'n	$96.35	19,913	$1,918,618
80170	Group therapy by Soc. Worker per patient (>60 mins)	$19.00	853	$16,207
	Total		**5,981,603**	**$539,379,404**

Appendix 2

Future Program Cost - Based on 2012 data

Item No.	Description	Unit Price	Services Future	Total Cost Future
2712	Review of Mental Health Plan by GP (20 mins)	$52.75	160,384	$8,460,256
2713	GP Mental Health attendance by GP (20 mins)	$70.30	528,172	$37,130,492
2715	Mental Health Plan by GP (20 mins)	$89.25	207,707	$18,537,850
2717	Mental Health Plan by GP (40 mins)	$98.60	98,225	$9,684,985
NEW	Primary Care Counselling (<50 mins)	$52.95	37,564	$1,989,014
NEW	Primary Care Counselling (<50 mins) other location	$74.55	12,603	$399,513
NEW	Primary Care Counselling (>50 mins)	$74.80	2,681,225	$236,168,209
NEW	Primary Care Counselling (>50 mins) other location	$96.35	126,665	$12,204,173
NEW	Primary Care Group Therapy per patient (>60 mins)	$19.00	17,536	$373,663
NEW	Specialist Mental Health Treatment (<50 mins)	$84.80	14,988	$1,270,982
NEW	Specialist Mental Health Treatment (<50 mins) other loc'n	$106.00	883	$93,598
NEW	Specialist Mental Health Treatment 50 mins)	$124.50	1,963,542	$209,342,144
NEW	Specialist Mental Health Treatment (>50 mins) other loc'n	$145.65	23,591	$3,436,029
NEW	Specialist Group therapy per consumer (>60 mins)	$31.65	9,882	$312,765
	Total		**5,882,967**	**539,409,464**

Assumptions:

1. Delete MBS Items 2700 and 2701 for GPs that have not undertaken AMA-approved mental health training. GP Mental Health Plans to only be provided by GPs who are appropriately trained.
2. Reduce by half the number of Mental Health Plans provided by trained GPs under Items 2712, 2713, 2715 and 2717 numbers. Mental Health Plans will only be provided to consumers requiring Specialist Mental Health Treatment.
3. Delete items 80100 to 80170 for "Focussed Psychological Strategies". Add new Items for "Primary Care Counselling". Primary Care Counselling to be provided at the rates currently paid to Social Workers and Occupation0al Therapists.
4. Occasions of service data combined for all providers that previously provided Focussed Psychological Strategies.
5. Delete MBS Items 80005, 80010, 80015, 80020. Add new Items for "Specialist Mental Health Treatment". Add new Items for "Specialist Mental Health Treatment". Provide Specialist Mental Health Treatment only to consumers who require it.
6. Primary Care Counselling and Specialist Mental Health Treatment to be provided by a range of practitioners all paid the same fee: Registered Counsellors and Psychotherapists, Psychologists, Clinical Psychologists, Mental Health Social Workers and Mental Health Occupational Therapists.
7. Program growth achieved by reinvesting savings in additional mental health services: 545,000 sessions of Primary Care Counselling & 545,000 sessions of Specialist Mental Health Treatment.