19 December 2019

Professor Bruce Robinson  
Chair, Medicare Benefits Schedule Review Taskforce  
Department of Health

By email to: mbsreviews@health.gov.au

Dear Professor Robinson

Re: Medicare Benefits Schedule (MBS) Taskforce: draft report from the Psychiatry Clinical Committee

Thank you for inviting the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to provide a response to the draft report from the Medicare Benefits Schedule (MBS) Review Taskforce ('Taskforce') Psychiatry Clinical Committee.

The RANZCP welcomes the draft report, and believes that many of the recommendations included within it will contribute to a more modern MBS that reflects contemporary psychiatric practice. The RANZCP thanks the Psychiatry Clinical Committee for its review of the RANZCP’s previous submissions to the Taskforce and recognises that a number of suggestions made are reflected in the draft report.

The RANZCP is broadly supportive of many of the recommendations, however, we believe that there is scope to develop and refine many of these further to better support psychiatrists to provide an optimal service to people with mental illness. Whilst the RANZCP supports ongoing review of the MBS to ensure functionality of item numbers to reflect evolving practice, we believe that the Taskforce presents a unique opportunity to deliver an MBS that is structured to provide the best possible psychiatric care. We strongly urge consideration of the suggestions within this submission to realise this opportunity.

It is acknowledged that many of the suggestions raised by the RANZCP will require further consideration by the Psychiatry Clinical Committee and the Taskforce, as well as further work to support implementation. The RANZCP would be pleased to discuss any aspect of this submission with the Taskforce to assist with these considerations.

For any queries on the points raised, please contact Rosie Forster, Executive Manager, Practice, Policy and Partnerships Department via rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Yours sincerely

Associate Professor John Allan
President

Ref: 1625
Submission to the Medicare Benefits Review (MBS) Review Taskforce

RE: Draft report from the Psychiatry Clinical Committee

December 2019

advocating for equitable access to services
About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care. The RANZCP is accredited by the Australian Medical Council to deliver specialist medical education and training, and professional development programs.

Psychiatrists are clinical leaders in the provision of mental health care and use a range of evidence-based treatments to support a person in their journey to recovery.

The RANZCP is the peak body representing over 6,700 psychiatrists in Australia and New Zealand.

Executive Summary

The RANZCP welcomes the draft report from the Medicare Benefits Schedule (MBS) Review Taskforce (‘the Taskforce’) Psychiatry Clinical Committee, and believes that many of the recommendations included within it will contribute to a more modern MBS that reflects contemporary psychiatric practice. The RANZCP thanks the Psychiatry Clinical Committee for its review of the RANZCP’s previous submissions to the Taskforce (Submission to the MBS Review Taskforce, 2015 and RANZCP supplementary submission to the Taskforce, 2018) and recognises that a number of suggestions made in these are reflected in the draft report.

Whilst broadly supportive of many of the recommendations, the RANZCP believes that there is scope to develop and refine many of these further to better support psychiatrists to provide an optimal service to people with mental illness, particularly those who are currently disadvantaged in their ability to access to services based on geographical location and/or socio-economic disadvantage. The RANZCP further supports ongoing review of the MBS to ensure functionality of item numbers to reflect evolving practice.

The RANZCP has developed the table below that summarises its response to each of the recommendations. Further information and evidence to support the position that the RANZCP has taken is listed thereafter. The RANZCP has also suggested additional recommendations that it believes would further improve psychiatry services under the MBS. These recommendations are supported by the Productivity Commission Inquiry into Mental Health Draft Report, released on 31 October 2019.

In addition to responding to the recommendations, many RANZCP members have raised that MBS rebates for psychiatry services are too low and do not meet the costs associated with delivering services. Despite the reversal of the MBS indexation freeze, many psychiatrists are struggling to provide affordable services to their patients. Whilst the RANZCP recognises that this issue is broader than psychiatry and the MBS, the RANZCP believes the following recommendations, proposed in previous submissions to the Taskforce, would help improve access and affordability of psychiatry services:

- Medicare bulk billing rate for psychiatry services be increased to 100% of the schedule fee from the current 85%.
- Advanced psychiatry trainees be given access to the same MBS items as consultant psychiatrists, at 65% of the rebate available to consultants to improve patient access and support the provision of accredited training posts in the private sector.
## Summary of responses to recommendations

<table>
<thead>
<tr>
<th>Summary of recommendation</th>
<th>Summary of RANZCP response</th>
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<tr>
<td><strong>Recommendation 1:</strong></td>
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<tr>
<td>Continue arrangements for items 291 and 293 - development of GP-requested management plans.</td>
<td>The RANZCP supports that arrangements continue for items 291 and 293 with some amendments to the item descriptors. The RANZCP supports that there is scope to improve how these items are utilised to deliver improved services to patients. In particular, the RANZCP supports that methods to increase uptake by psychiatrists may be necessary and has proposed changes to the item descriptors or associated notes to achieve this.</td>
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<td><strong>Recommendation 2:</strong></td>
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<tr>
<td>Reform arrangements for item 288 - delivering telehealth consultations to regional and remote patients.</td>
<td>The RANZCP does not support any changes to item 288 without first agreeing clearly defined equivalent alternatives as it risks disrupting services to rural and remote areas. The RANZCP agrees that a new suite of telehealth items could be implemented to allow for improved monitoring of the use of these items. However these items would still require MBS loading to cover costs associated with telehealth delivery. This loading should also apply for face-to-face consultations to promote improved service delivery and workforce development in rural areas more generally.</td>
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<td><strong>Recommendation 3:</strong></td>
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<tr>
<td>New items to provide telehealth consultations to patients in major cities of Australia.</td>
<td>The RANZCP supports that this initiative will provide for telehealth consultations to patients in major cities with severe disabilities, mental health disorders or psychosocial stress that prevent them from attending face-to-face sessions. The RANZCP questions whether the session limit of 12 is appropriate and suggests removal of this limit.</td>
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<td><strong>Recommendation 4:</strong></td>
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<td>Continue arrangements for items 353 to 370 - consultations with psychiatrists via the phone in regional and remote areas.</td>
<td>The RANZCP supports that telephone consultations may be a useful addition to practice, particularly for patients in very rural or remote areas where internet access could be a limiting factor. The RANZCP suggests incorporating these into the telehealth item numbers with clear guidelines as to when telephone use is appropriate.</td>
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<td><strong>Recommendation 5:</strong></td>
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| Remove the stigma associated with item 319 – complex and severe mental health disorders | The RANZCP supports amending the item descriptor to remove the references to specific mental health disorders and the requirement for patients to be assessed and meet a certain threshold on the Global Assessment of Functioning (GAF) scale. The RANZCP recommends however that there is scope to further refine this item number to ensure that vulnerable patients receive the treatment they need, in a non-stigmatising manner. This includes removal of the reference to ‘complex and severe'
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<tr>
<th>Recommendation 6:</th>
<th>Revise the schedule fee for item 14224 - electroconvulsive therapy (ECT)</th>
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<tr>
<td>The RANZCP does not support that the proposed increase to the schedule fee for ECT to $98.35 is sufficient to cover the complexity of the procedure, including dose titration and management of physical health complexities suffered by those with severe mental illness. The RANZCP suggests the fee should be at least comparable with the proposed new fee for rTMS recently recommended by the Medical Services Advisory Committee ($160-180). The RANZCP further recommends that a same-day separate consultation for assessment and monitoring is allowable to be claimed under the MBS.</td>
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<th>Recommendation 7:</th>
<th>Greater flexibility of arrangements for items 348, 350 and 352 - non-patient interviews.</th>
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<td>The RANZCP supports the increased need to consult with people close to patients (usually families) to aid in the assessment and ongoing management. The RANZCP supports the move to introduce new time-tiered items and increase the number of services available to 15. The RANZCP raises some potential issues with the utility of the revised item number in practice and supports ongoing review of the functionality of these items with view to future refinements as necessary.</td>
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<th>Recommendation 8:</th>
<th>Clarify arrangements for item 346 - mother-infant group therapy</th>
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<td>The RANZCP supports inclusion of an introductory note to clarify that item 346 (psychotherapy for a group of two patients) can be used for mother-infant group therapy however suggests that appropriate gender terminology be used. The RANZCP further supports the recommendation for GP and Nurse Practitioner education on referral to the group therapy process and would be pleased to assist or provide further advice, including to ensure that the referrals of infants does not lead to any long-term impacts and stigma.</td>
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<th>Recommendation 9:</th>
<th>Aligning item 289 with best practice - management plans for children and adolescents with complex disorders</th>
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<td>The RANZCP supports removing the term ‘pervasive development disorders’ (PDD) from the MBS and replacing it with developmental disorders. The RANZCP questions whether the age limit for use of this item should be increased from under 13 in line with recommendations from the Allied Health Reference Group.</td>
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### Recommendation 10:
Aligning items 855 to 866 with best practice - case conferencing

The RANZCP supports aligning case conference items to the specialist and consultant physician items as a way of ensuring as little impediment as possible to health professionals forming multidisciplinary teams.

The RANZCP supports review of these items after a period of 1–2 years to assess functionality.

### Other issues: rTMS

The Committee was supportive of an application to MSAC was pending for the listing of transcranial magnetic stimulation on the MBS.

The RANZCP supports the implementation of the item numbers for rTMS for the treatment of depression on the MBS in line with the public summary report from the Medical Services Advisory Committee (MSAC).

### Other issues: Psychiatric advice to GPs

Productivity Commission Report: Draft recommendation 5.1 - Psychiatric advice to GPs

The RANZCP supports introducing new MBS items for a psychiatrist to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP.

### Other issues: longer consultation times for group therapy

Productivity Commission Report: Draft recommendation 5.5 - Encourage more group psychological therapy

The RANZCP supports that the MBS be amended to allow for psychiatry group therapy sessions to run for 'at least 90 minutes' and 'at least 120 minutes'.
Detailed responses

Recommendation 1: Continue arrangement for items 291 and 293 – development of GP-requested management plans

The RANZCP strongly supports items 291 and 293 as a way of supporting general practitioners (GPs) to provide ongoing support for people with mental disorders. The RANZCP is aware of many successful collaborative practice models between psychiatrists and GPs that are facilitated by the ability to use items 291 and 293.

Although fundamentally items 291 and 293 are working as intended, the RANZCP believes that there is scope to improve how these are utilised to deliver improved and more accessible services to patients. Whilst the RANZCP did not propose any changes to these items in its original submission to the Taskforce, the draft report consultation process has led to a range of frustrations being identified by psychiatrists and GPs that may be having an impact on service availability. To help address these, the RANZCP supports that initiatives to increase uptake by psychiatrists may be necessary.

Whilst many of the initiatives that are required to improve the use of items 291 and 293 will sit outside the MBS, the RANZCP believes that making some amendments to the item descriptors or the associated notes will improve the utility of items 291 and 293 for psychiatrists.

In seeking feedback from the membership in regard to these items, the following themes emerged that suggest areas where improvements are required:

*Issues for patients:*

- Misunderstanding from patients as to the purpose of the referral e.g. patients anticipate receiving ongoing care from the psychiatrist rather than GP management, or the patient already having been referred that year by a different GP meaning that the 291 cannot be charged a second time.

- Long waiting lists to see a psychiatrist, acknowledging that some psychiatrist services (e.g. child and adolescent psychiatry) have particularly long waiting lists.

- Out-of-pocket costs, acknowledging that whilst 77% of 291 and 87% of 293 consultations were bulk-billed in 2018-19, there remain a proportion of patients who will still need to meet costs privately. In addition, in some cases, patients may be asked to pay for the service upfront and claim a rebate from Medicare, which can be unaffordable in many cases and consequently prevent patients from accessing the service they require. It is however noted that bulk-billing rates for 291 and 293 are significantly higher than for other psychiatry consultations (e.g. 296 = 24%, 304 = 33%, 306 = 31%) suggesting that the higher fee for items 291 and 293 is promoting bulk-billing as intended.

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1 Data accessed from the Department of Human Services, unpublished.
**Issues for psychiatrists:**

- Timeframe for reporting (currently within 2 weeks), which can be challenging given the complexities and details required for the 291 report. This includes accounting for the need for the report to be written in a way that is both professional and accessible to the person and their carers. It further needs to take account of the biopsychosocial cultural spiritual formulation that helps the GP and others understand the person’s situation in context. It is recognised that time delays in developing these reports can potentially cause a delay to the patient’s treatment and management by the GP, and frustration for the patients.

- Lack of clarity about how to engage with family members, carers and other relevant people providing care (e.g. social care, education) in developing the management plan under item 291, as well as unclear provision within the MBS for undertaking this work (e.g. in the case of item 291 it is not clear whether items 348, 350 and 352 can also be used as part of the 291 assessment).

- Challenges in formulating an assessment and plan within one session, requiring the need for greater acknowledgement that more than one consultation may often be necessary to formulate a management plan, and that this is in line with good clinical practice and acceptable under the MBS.

- Apparent lack of awareness as to the value of item 293, with many patients and GPs not utilising these review items; in 2018-19 there were only 2,881 consultations under item 293 compared to 42,145 consultations under item 291. There is further need to acknowledge that the patient may need to return to see the psychiatrist for review several times within a 12 month period, and that GPs value ongoing consultation (e.g. via telephone) to consult with the psychiatrists in their ongoing management of the patient.

- Limited opportunities to allow RANZCP trainees to effectively manage and understand how to use 291 items.

**General service issues:**

- The need for more focused education about 291 items in rural communities, particularly as a significant percentage of GPs working in rural communities are international medical graduates who may lack information as to the purpose of these items.

- Encouraging public mental health services, particularly in rural areas, to access private psychiatrists via 291 and 293 assessments, including use via telehealth.

- Confusion as to clinical responsibility when patients are under the primary care of a specialist and consultant physician but require a mental health assessment and management plan (e.g. a paediatrician working with a patient with autism, or pain specialist working with a patient with chronic pain). As specialist and consultant physicians cannot refer directly to psychiatrists under a 291, this requires a separate referral back to the GP to seek a 291 referral, even though the ultimate management will be by the specialist. This can cause a delay to the patient in receiving assessments and management plans.
In the Productivity Commission Inquiry into Mental Health Draft Report (‘Productivity Commission’) released on 31 October 2019, the value of items 291 and 293 was also acknowledged together with the need for initiatives to improve access and collaboration. Draft recommendation 7.2 suggested that item 291 and 293 take place via telehealth regardless of patient location, which could assist in reducing waiting lists in some areas. Recommendation 5.1 recommended introducing a new MBS item for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP. The RANZCP also made this recommendation in its 2018 supplementary submission to the Taskforce.

Recommendations:

To promote improvements to the items 291 and 293 within the MBS, the RANZCP recommends that the following be clarified within the relevant item descriptors or associated notes as appropriate:

- Make more explicit that case history is required for a 291 and that this can take place over 2-3 sessions rather than 1 appointment.

- Focus on 291 and 293 being a way to facilitate access to psychiatrist opinion, and acknowledge that alternative methods may be acceptable instead of completion of a full report within the current two week time frame (e.g. a briefer report supported by a telephone call with GP, or an initial assessment explanatory note stating that the full report will be available within an additional two weeks).

- Make clear provision for and advise how psychiatrists can consult family members and others involved in the patients’ care separately when undertaking 291 and 293 (e.g. explicit acknowledgement of the use of items 348, 350, 352 or equivalent).

- Introduce flexibility to charge item 293 on more than one occasion, as well as flexibility for the GP or nurse practitioner to re-refer the patient back to the psychiatrist within the 12 months period if there are ongoing concerns about diagnosis and/or management.

- Acknowledge that item 291 and 293 can take place via telehealth regardless of patient location.

- Allow ongoing provision for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP [acknowledging that this may require separate and additional MBS items].

The RANZCP further recommends that consideration be given to referrals to 291 being allowed directly from specialist and consultant physicians where the patient has been referred to the physician by their GP, and with the requirement that the psychiatrist’s report is also provided to the GP. The RANZCP strongly supports the role of GPs as gatekeepers in providing ongoing care and accepts that this issue will require further consideration collaboratively from psychiatrists, GPs and specialist and consultant physicians before any determinations can be made.

The RANZCP is further looking at ways in which it can continue to educate psychiatrists to ensure that item numbers 291 and 293 are used in the most effective manner, and would be pleased to engage with GP organisations, such as the Royal Australian College of General Practitioners, to improve utility of these items.
Recommendation 2: Reform arrangements for item 288 – delivering telehealth consultations to regional and remote patients

The RANZCP supports the ongoing provision of telehealth for the wellbeing of people for whom psychiatry services are difficult to access (e.g. people in rural areas, residential aged care facilities (RACFs), and under the care of Aboriginal and Torres Strait Islander Health services as currently defined). Telehealth enables psychiatrists to be able to reach individuals who are otherwise isolated and without psychiatrist support in their areas, and is an effective mechanism of delivering services.

Telehealth services in psychiatry under the MBS provide patient assessments, management plans and ongoing support for patients, families, multidisciplinary teams and GPs. This provides much needed support for GPs and the local community. In addition, ongoing support of patients through both regular psychotherapy and medical management makes a real difference in the life of many people who have accessed telehealth services.

Delivery of telehealth services can be complex and time consuming as psychiatrists spend additional time understanding, liaising, and building relationships with local health services and communities with which they may not be familiar. The provision of additional funding via MBS item 288 allows psychiatrists to partially meet these additional costs.

Rural communities, GPs and psychiatrists are concerned about the suggested potential phasing out of MBS item number 288, without clearly defined equivalent alternatives. The suggestion that item 288 may be removed has been a cause of significant alarm among RANZCP members who provide telehealth services, as well as those who are working or residing in rural areas. Any cut to this currently available funding will severely disrupt services, as many psychiatrists will no longer be able to afford to provide these services and will therefore stop doing so. The RANZCP considers this to be major threat to the stability of mental health services currently greatly valued by psychiatrists, GPs and rural communities.

The RANZCP is aware that the current provision for item 288 provides many advantages in the delivery of services to isolated communities including:

- Providing much needed psychiatry services to people in rural and remote areas, in residential care facilities, or under the care of an Aboriginal Medical Service. In 2018-19, 66,205 psychiatry telehealth services were delivered to populations who would alternatively receive no care, or have waited for face-to-face care, which they typically would have had to travel significant distances to receive. Telehealth is a crucial part of improving access to psychiatry in rural and remote areas.

- Populations using telehealth are underserviced and frequently high risk. Psychiatry workforce shortage in rural and remote areas is well documented with data reporting that in 2017 psychiatry workforce distribution was 16.2 FTE per 100,000 population in major cities, 6.4 in inner regional, 4.9 in outer regional, 6.2 in remote areas and 2.1 in very remote areas; this distribution was different from the overall medical practitioner workforce, with the location of psychiatrists more

skewed towards less remote locations than all medical practitioners. Further the growing number of people in RACFs being prescribed psychotropic medication is demanding increased access to the psychiatry workforce. This demand is likely to increase in view of the ongoing Royal Commission into Aged Care, which released its interim report on 31 October 2019 highlighting the need for significant change in medical and operational practice in residential aged care to address the issue of unsafe and substandard care regime in regard to prescription of psychotropic medications.

- Many people who currently access services under item 288 are severely socio-economically disadvantaged by virtue of living in rural areas, being under the care of an Aboriginal Health Service or in a RACF. The additional funding helps ensure that, in the vast majority of cases, psychiatrists are able to bulk-bill patients for these services meaning that services are provided to people who would otherwise be unable to afford them. In 2018-19, 99.4% of 288 items were bulk billed. In addition, 100% of 291 undertaken via telehealth are items are bulk-billed.

- The 288 loading provides for additional costs in setting up a telehealth consultation, including psychiatrist technology set-up and ensuring that the patient has the necessary technology. Additional time is also required for liaison with local GPs and other health services supporting the patient, including Indigenous health services where relevant.

- Telehealth as a method of delivering psychiatry services is increasing year on year indicating practitioner engagement and patient confidence in using this as a method of service delivery. Psychiatry is a specialty that lends itself particularly well to telehealth, and this is reflected in the increased use of item 288.

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<tr>
<th>Year</th>
<th>Total psychiatry telehealth services (288)</th>
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<tr>
<td>2015-16</td>
<td>40,860</td>
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<tr>
<td>2016-17</td>
<td>44,098</td>
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<tr>
<td>2017-18</td>
<td>51,246</td>
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<tr>
<td>2018-19</td>
<td>66,205</td>
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The RANZCP refutes that the item number 288 was ever intended to provide incentive payments for uptake. The incentives payments that originally existed to promote uptake for telehealth were removed in 2013-14. The RANZCP notes that the draft report from the MBS Review Taskforce Specialist and Consultant Physician Clinical Committee also recommended removing the telehealth loading (equivalent to 288) across all specialties. The RANZCP is concerned that this decision has been presented for implementation to the Psychiatry Clinical Committee without due consideration of the unique importance

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4 Data accessed from Department of Human Services and Call to Mind, unpublished. The RANZCP is continuing to work with the Department of Human Services to refine these data and will provide updated data analysis in due course.
of telehealth in psychiatry, in terms of high service demand and delivery. The RANZCP suggests therefore that telehealth use in psychiatry cannot be compared to telehealth use by other specialities.

Whilst the benefits of telehealth are recognised by the RANZCP, concerns regarding its long-term impact on the rural and regional workforce and the potential for workforce displacement are acknowledged. This is particularly relevant as funding for telehealth currently exceeds that for face-to-face consultations, and patients in rural areas frequently have additional costs associated with attending consultations face-to-face (e.g. petrol or other travel costs). Furthermore, rural psychiatrists who supplement their face-to-face practice by offering telehealth to patients in their regions are not eligible to receive the 288 loading. However the RANZCP does not accept this as a reasonable justification for removing the loading for telehealth – particularly as many of the areas where such services are provided to do not currently have access to any face-to-face psychiatry. Instead the RANZCP strongly recommends that telehealth should complement targeted measures to increase local face-to-face services.

The RANZCP is further aware of potential concerns raised in regard to the potential corporatisation of telehealth, where coordinating organisations have been established to deliver telehealth services, based on a model of taking a percentage fee. The RANZCP acknowledges that the additional funding for 288 may have allowed such business models to evolve, but believes that the overall intention of all telehealth services is to meet an unmet need. The RANZCP strongly promotes the need for professional practice models to ensure that the establishment of such services that are in the best interests of patients (for example, the RANZCP supports financial transparency whereby patients understand the costs involved of any service). The RANZCP acknowledges that any concerns with any corporate models may need to be reviewed outside of the context of MBS developments, potentially through the development of clear guidelines. Increased awareness among GPs to ensure that services they refer to are acting in patients’ best interests in also important. The RANZCP further supports initiatives that would encourage metropolitan-based telehealth organisations to support locally based practitioners, e.g. through assistance with recruitment to rural areas or by providing training and administration support.

Taking into account the above, the RANZCP suggests that there is scope for the development of a new suite of telehealth items to allow for improved monitoring of the use of these items. However these items would still require MBS loading to cover costs and time associated with telehealth delivery. It is imperative that this loading also applies to face-to-face consultations and telehealth consultations in regional and rural areas, based on both the location of the practitioner and the patient, to promote improved service delivery and workforce development in rural areas more generally.

**Recommendations:**

Given the severe and significant disadvantage that rural communities, Aboriginal and Torres Strait Islander peoples, and people in RACFs face in regard to the availability and accessibility of psychiatry services, the RANZCP strongly supports measure that promote the delivery of psychiatry services to these group. Overarchign recommended principles to support this are:

- There should be no funding cuts to any psychiatry services that are currently provided to rural communities via telehealth. Any cut of funding to rural psychiatry services is incongruous at a time when it is a key government priority to improve access to care for these populations.

- A loading should continue to be applied to the MBS that is accessible by psychiatrists who see patients in rural areas via telehealth or face-to-face, as well as see people under the care of Aboriginal Medical Services or in RACFs via telehealth (as current defined under item 288). This
loading will deliver funding to reflect the greater time and complexity costs associated with delivering services to these populations, and further promote bulk-billing of such psychiatry services to patients.

The RANZCP recommends that consideration be given to implementation of all of the following:

- Development of new suite of items to be used in all circumstances of telehealth for psychiatry which, as suggested by the draft report, could mirror the relevant face-to-face consultation items and rebated at the same rate. The items should cover all items currently available for use by telehealth when using item 288, with the addition of further items for group therapy (items 344 and 346).

- These items would also be used for telehealth in metropolitan areas and those areas in which connections are poor and telephone consultations are required instead (see recommendations 3 and 4). This proposal will ensure that there is only one suite of telehealth items, which may assist in preventing any confusion.

- Apply a percentage loading that forms part of the MBS (equivalent item 288) for relevant patients. Patients for whom a loading applies should reside in regional, rural and remote areas, be under the care of an Aboriginal Medical Services, or in RACFs. The percentage loading should also be accessible by psychiatrists undertaking face-to-face consultations or telehealth consultations in rural areas to promote face-to-face and locally-based services in these communities, and to reflect the complexities and socio-economic status of many patients in these areas.

The RANZCP encourages consideration of, as part of the implementation phase, location based incentives that would apply differential indexing of the MBS item loading for telehealth based on, for example, geographical location of the patient and the practitioner to attract and build a specialist workforce in areas of need. However, this should be under the premise that there is no reduction to currently available overall funding. It is further acknowledged that further consideration of this is required given such needs may be difficult to define (as some patients’ needs will vary regardless of location or situation). Until such indexing of MBS items for telehealth can be agreed, the current loading of 50% to all consultations should continue to apply.

To develop this proposal the RANZCP suggests that further discussions be held between the RANZCP and the Taskforce as part of the implementation of this report. In progressing any changes to the MBS schedule the RANZCP recommends that:

- Psychiatrists with expertise and experience in delivering rural psychiatry under the MBS be engaged in the implementation group.

- There is a need to ensure data is collected that will allow monitoring of the impact of any changes implemented.
Recommendation 3: New items to provide telehealth consultations to patients in major cities of Australia

The RANZCP strongly supports this initiative that will provide for telehealth consultations to patients in major cities with severe disabilities, mental health disorders or psychosocial stress that prevent them from attending face-to-face sessions. The RANZCP advocated for this in its submission to the Taskforce.

The RANZCP accepts that there will be no loading for these items. They will be paid at the same rate as face-to-face consultations, and that eligibility will be clearly defined.

Referring to recommendation 2 above, the RANZCP suggests that only one new suite of telehealth items be created to cover all telehealth consultations. The additional loading referred to in recommendation 2 would only be applied in certain circumstances. The RANZCP would not expect this to routinely include people in this list unless their situation meets with the loading criteria once developed.

The RANZCP does have some concern about the suggested limit of 12 sessions per year. The RANZCP considers this limit to be arbitrarily restrictive and inequitable to the specified target population, which includes those with mental disorders that prevent them from leaving the house. The particular concern is that the proposed arrangement does not allow for the range of session-duration and frequency required for different disorders or patient groups. Unstable patients with complex or treatment-refractory issues, who are likely to fit into this group, may require more frequent reviews of short duration, e.g. while commencing or switching medications. 12 sessions will be inadequate to provide this care in many cases and also raises concern for how ongoing care could be met after 12 sessions. The RANZCP suggests that, to provide equitable care, the number of sessions align with those whose disorders allow them to attend appointments in person.

In addition to these changes, the RANZCP agrees with the Productivity Commission draft recommendation 7.2 which recommends that item 291 and 293 take place via telehealth regardless of patient or status location. The RANZCP strongly supports that, in addition to recommendation 3, this further Productivity Commission recommendation will improve access for people for whom accessing a psychiatrist face-to-face under item 291 or 293 difficult due to other reasons (e.g. psychiatrist availability, or the need to see a psychiatrist with the same language or culture).

The RANZCP further notes that this initiative could be useful in areas where there are specific workforce shortages for disorders. For example in South Australia there is well-documented dearth of psychiatrists who are available to treat Attention Deficit Hyperactivity Disorder (ADHD) meaning that patients with this disorder are woefully underserviced. It would be beneficial to allow psychiatrists from other states to utilise telehealth to meet this need.

Recommendations:

- That the proposed limit of 12 sessions per year be removed.
- That data monitoring be undertaken to review impact of these changes with view to potentially expanding this to a broader definition of patients in future.
- That Productivity Commission draft recommendation 7.2 be implemented that allows for item 291 and 293 to be conducted via telehealth regardless of the status or location of the patient.
Recommendation 4: Continue arrangements for items 353 to 370 – consultations with psychiatrists via the phone in regional and remote areas

The RANZCP supports that telephone consultations may be a useful addition to practice, particularly for patients in very rural or remote areas where internet access could be a limiting factor. There may also have an appropriate use in crisis situations.

In its submission to the MBS Review Taskforce, the RANZCP recommended removal of these items as it was thought they were obsolete, with item 288 having been introduced. However, it is accepted that current item 288 requires the use of telehealth using video and therefore using these items for telephone consultations may be non-compliant. The RANZCP therefore supports the retention of provision for psychiatrist consultations with patients via phone.

Referring to recommendation 2 above, the RANZCP suggests that only one new suite of telehealth items be created that cover all telehealth consultations. The RANZCP recommends that, for ease of implementation, items 353 to 370 be removed and that people utilising phone consultations use the new suite of telehealth items. The RANZCP does not support that telephone consultations should be utilised where video telehealth consultations or face-to-face consultations are available. However, the RANZCP does acknowledge that phone consultations do form an important part of communication when these services are unavailable. The RANZCP therefore suggests that, within the item descriptor for the new suite of telehealth items, it is clearly stated that phone consultations are only to be used in circumstances of poor connection.

Recommendation:

- That items 353 to 370 be removed and that people utilising phone consultations use the new suite of telehealth items, with the item descriptor clearly stating that phone consultations only be used in circumstances of poor connectivity.

Recommendation 5: Remove the stigma associated with item 319 – complex and severe mental health disorders

The RANZCP supports the recommended amendment the item descriptor to remove references to specific mental health disorders, and the requirement for patients to be assessed under and meet a certain threshold on the Global Assessment of Functioning (GAF) scale. The RANZCP strongly advocated for this in its submission, suggesting it was limiting and discriminatory, and commends the Psychiatry Clinical Committee for enacting this change.

However whilst this change is welcome, the RANZCP has concerns that some people who would be eligible to receive treatment under the 319 item number may still be restricted in their ability to access the services they need within the proposed changes.

It remains the RANZCP’s preferred position that item 319 be removed completely, with consequent removal on the limits on the number of items that can be claimed under 300-308. It is noted that the RANZCP has made this recommendation in the past, and it has not been taken on board. It is further acknowledged that the proposed changes to item 319 are a significant improvement on the current item.
Accordingly the RANZCP has made suggestions below to further enhance the functionality of the proposed revisions to item 319. In developing these suggestions, the RANZCP submits that MBS item 319 is the only means by which patients can access longer-term intensive psychotherapy. This treatment is not available within the public mental health system despite it having a significant evidence base and, for some patients, it being the recommended treatment (especially those with the sequelae of complex trauma, abuse and childhood neglect/deprivation, personality disorders, comorbidity, failed trials of shorter psychological interventions etc.). Despite this, the service annual average five-year growth for item number 319 is continuously decreasing (-3.6 % noted in the draft report) and its use constitutes only a miniscule aspect of health and mental health expenditure.

As item 319 is the only point of access for patients across the entire public and private health care systems to receive intensive specialist psychiatrist-provided psychotherapeutic treatment, any changes to the defining criteria warrant significant scrutiny. This is important not just so patients can access medically necessary treatment, but to protect the human rights of a vulnerable cohort of patients. Three specific human rights, enshrined within law, are relevant to the review of MBS item number 319. Firstly, the right to recognition and equality (that everyone is entitled to equal and effective protection against discrimination), secondly the right to privacy and reputation (that everyone has the right to keep their lives private) and thirdly, the right to dignity/the right to protection from 'degrading treatment'.

The RANZCP has the following concerns about the new proposed new item number as follows:

- How ‘complex and severe mental health disorder’ will be defined
- What constitutes an ‘evidence-base to support intensive psychotherapy as an effective treatment’ and how this will be defined
- The limit of 160 sessions that can be claimed under this item.

Definition of complex and severe

The RANZCP welcomes the assertion in the draft report that ‘some patients may not perfectly meet the diagnostic criteria for the disorders currently outlined in the descriptor, but intensive psychotherapy is still indicated as the best modality of treatment for them’. This is a movement in line with international publications.

However, concern is expressed about the introduction of undefined criteria where there is no formally accepted definition of ‘severe and complex mental health disorder’ and where there are historical splits and difficulties in defining this term. Some define it as comprising the serious affective (mood) and psychotic disorders only, where others consider personality disorders or complex trauma to fall within the realm. It is to be noted also that while ‘severe and complex mental health disorder’ might be less pathologising and stigmatising than the current DSM diagnostic criteria legislated within MBS item number 319, it remains a term that is not well understood and that holds significant stigma and discrimination.

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There are many documents that detail and intend to refute commonly held sociocultural myths regarding patients with ‘severe’ and/or ‘complex’ ‘mental health disorder(s)’ or ‘mental illness’⁷. These documents exist because negative stereotypes and myths associated with ‘severe and complex mental health disorders’ and/or ‘illness’ continue to exist and not uncommonly. This was evidenced in the recent interim report from the Victorian Royal Commission into Mental Health Services and remains a focus for significant ongoing advocacy.

Given the number of different clinical and non-clinical professionals (within psychiatry, medicine and public service etc.) who now have access to the patient’s electronic health record and Medicare data, the RANZCP remains concerned that amending MBS 319 descriptor to flag that a person has a ‘severe and complex mental health disorder’ is also stigmatising and not in keeping with the human rights to privacy and reputation, dignity and protection from discrimination – reasons for which the currently existing diagnostic descriptor is being removed. The RANZCP suggests that there is a need, in redefining item 319, to move away not just from DSM diagnostic descriptors but also from a ‘mental health disorder’ descriptors and labels, including ‘severe and complex mental health disorder’.

Two alternatives to consider include:

1) Moving to a descriptor that references clinical need, such as: ‘An attendance of more than 45 minutes duration at consulting rooms “where the patient’s condition clinically requires intensive treatment” (or psychotherapeutic psychiatric treatment)’

Or

2) Moving to a descriptor in keeping with contemporary recommendations from the Superior Health Council, 2019, that focuses on formulation and away from DSM and disorder-based language: ‘An attendance of more than 45 minutes duration at consulting rooms “where the formulation of the patient’s clinical presentation indicates intensive psychotherapy is indicated”’.

These definitions are more in keeping with the principles and practice of psychotherapy and psychotherapeutically-informed holistic psychiatry. Revising the item number as per the second suggestion above, which requires the formulation of the patient’s clinical condition, will provide an implicit clinical requirement for clinicians to be trauma-informed and trauma-competent. Further, these do not identify any clinical information regarding the patient and as such do not contribute to stigma, breach privacy and erode dignity.

The inclusion of the proposed criterion ‘for which there is an evidence-base to support intensive psychotherapy as an effective treatment’

Whilst accepting that the intention of this was to include helpful and reasonable criterion, the RANZCP has concerns regarding the definition of the relevant evidence-base, how and which organisations or groups define the evidence base, and the potential for restriction or erosion of patient access to dynamic and analytic intensive psychotherapies (which are typically the psychotherapies in which patients are seen 2 - 5 times each week).

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⁷ See SANE Australia factsheets and guides: https://www.sane.org/information-stories/facts-and-guides/
These concerns exist in the context of the current evidence-base being heavily cognitive behavioural therapy (CBT) focused. For example the one and only reference citing the ‘evidence-base’ for psychotherapy noted in the draft report does not include any reference to the psychodynamic or psychoanalytic evidence base and the definition of long-term treatment in the article is unclear.

Whilst the RANZCP could provide details of an evidence-base that is more inclusive, and there is a significant amount of research evidence that supports the provision of psychotherapy\(^8\), it is noted that every treatment provided within psychiatry and medicine as such should be provided based on a clinical evidence base, and this criterion should not be required to be legislated into the MBS. Restrictions therefore should form part of the gatekeeping role that falls within professional, clinical and ethical competence, which includes the professional (medical) and ethical responsibilities of not commencing a treatment which is either not indicated or from which risks might clearly outweigh potential benefits.

The RANZCP accepts that there is also a need to ensure that the treatment being provided under item 319 is by a psychiatrist who is suitably qualified to provide ongoing trauma-informed care. The RANZCP is aware of its responsibility to continually improve training and practice in this area.

*The limit of 160 consultations per year*

Evidence was provided in the RANZCP supplementary submission to the Taskforce that very few patients are receiving more than the limit of 160 sessions per year (only 25 patients in 2015-16 received more than 150 consultations per year under 319, and no patients received more than 200 sessions). However, those who do require more than 160 sessions are mostly likely to have histories of abuse and severe trauma, and be socio-economically disadvantaged. Often these patients require intensive treatment, four or five times each week, to remain out from hospital, and to prevent suicide. There is a cost benefit relating to this intensive treatment beyond prevention of medical and psychiatric admissions, also in terms of reduction in medication usage and costs to the PBS, as well as the potential for gains in returning to the workforce.

Currently the only option available to such patients after they have received 160 sessions is to use items 310-318 that attract a lower rebate. Often psychiatrists reduce fees significantly to facilitate these patients accessing necessary treatment, however this is not ideal and can be experienced by patients as humiliating or degrading and/or prevent their accepting treatment.

Accordingly the RANZCP suggests that consideration be given to raising the limit for number of sessions to be accessed under MBS 319 to 245. The RANZCP suggests that only a tiny proportion of patients will require this increased limit but, for those who do, it will be a critical to their ongoing recovery.

It is noted that the Department has recommended reviewing any amendments to item 319 in 12 months. The RANZCP supports this review to ensure that treatment is being received is clinically appropriate, and being received by those who need it most.

\(^8\) Research available at: [https://www.psychoanalysis.asn.au/all-resources](https://www.psychoanalysis.asn.au/all-resources)
Recommendations:

- That item 319 be removed, with a consequent removal on the limits on the number of items that be claimed under 300-308.

- That if the above recommendation is NOT implemented, then the following amendments be made to the proposed changes to item 319:
  - That the item descriptor be amended to remove reference to ‘complex and severe disorders’ and the evidence-base requirement be removed.
  - That the limit on the number of sessions that can be claimed under item 319 be increased to 245.

- The RANZCP supports that any amendments to 319 are reviewed in 12 months to ensure that they align with best practice and are fit for purpose, and that this review involves psychiatrists engaged in long-term psychotherapy.

Recommendation 6: Revise the schedule for item 14224 – electroconvulsive therapy

The RANZCP supports that the fee for electroconvulsive therapy needs to be revised to better account for the time and complexity associated with delivering this service. The RANZCP has recently published professional practice guidelines for the administration of electroconvulsive therapy (April 2019) that highlights the complexity of the procedure, including the need for pre- and post-treatment review, as well as a range of further considerations.

Whilst recognition within the draft report that the need for a schedule fee increase is welcome, the RANZCP does not support that the proposed schedule fee increase to $98.35 (85% benefit = $83.60) is sufficient to cover all the associated complexity, including dose titration and management of physical health complexities suffered by those with severe mental illness.

In particular the RANZCP raises the following:

- In its submission, the RANZCP suggested a fee comparable to $396.00. The justification for this is provided in the RANZCP submission to the Taskforce in 2015, as well as in the ECT professional practice guidelines referred to above. For ECT to be delivered in a manner that promotes maximum benefit whilst minimising harm requires additional time and funding to support practice improvements.

- Repetitive transcranial magnetic stimulation (rTMS) was recently recommended for public funding under the MBS by the Medical Services Advisory Committee (MSAC) in August 2019, as outlined in the MSAC Public Summary Document Application No. 1196.2 – rTMS for the treatment of depression. The proposed fee for rTMS is $186.40 (for assessment and prescription) and $160.00 (for administration of treatment).
The RANZCP supports that the fee for ECT be increased to that recommended for rTMS, as a minimum. Cardioversion by electrical stimulation is not comparable given the additional complexities for patients with mental illness and associated monitoring.

The RANZCP further recommends that psychiatrists be allowed to claim a same-day separate consultation for assessment and monitoring. The RANZCP supports that this would reflect the additional time complexities, and could also be appropriately applied in situations where the assessing psychiatrist may be different from the psychiatrist administering ECT.

Recommendation:

- That the fee for ECT be further increased to at least $180.00, and provision made for a same-day separate consultation to be claimed for assessment and monitoring.

Recommendation 7: Greater flexibility of arrangements for items 348, 350 and 352 – non-patient interviews

The RANZCP is pleased that this recommendation recognises the need within contemporary psychiatric practice to consult with people close to patients (usually families) to aid in the assessment and ongoing management of the patient. The RANZCP supports the move to introduce new time-tiered items and increase the number of services available.

Removing items 348 and 350 and developing new time tiers and remuneration to align with items 300, 302 and 304 is a logical approach. Currently there is only one time tier for interviews with non-patients in the ongoing management of a patient. Implementing the recommendation would allow psychiatrists to bill more appropriately for the time they consult, and shorter consultations could be applied to situations where brief consultations with non-patients are required (e.g. with carers in RACFs).

The RANZCP further supports the change to the item descriptor that indicates that these items can be used for psycho-education purposes, which supports the evidence-based family therapy approach. It is noted that currently there is much misunderstanding among families, particularly where the patient is a child or adolescent, about how to engage with a patient’s psychiatric treatment. It is hoped that changes in this area will support psychiatrists in allowing this family consultative work to take place more efficiently within the MBS. For example, currently, owing to the significant restrictions on consultations with non-patients, many parents are referred as patients themselves to allow the psychiatrist to be remunerated for their time in working with the family. In many circumstances it is helpful for the psychiatrist to see the parent first (for example under item 348). It is therefore recommended that it be confirmed that this will still be allowed for within the new proposed structure. Accompanying information about the use of these items in practice would also be beneficial.

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In considering the proposed changes to these items, some issues have been raised that may impact on their utility in practice. It is acknowledged that implementation of these items may be required first before any impact can be determined. The RANZCP therefore strongly supports ongoing review of the functionality of these items, and has raised issues to be considered as part of this review.

Issues to be considered include:

- Whether the increase for the number of sessions for a psychiatrist to consult a family member, carer, or other relevant person (separately from the patient) to 15 (from 4 currently) is sufficient. Child and adolescent psychiatrists in particular have raised the potential need for more in this population group and it is noted that this remains below the maximum of 50% of sessions afforded to psychologists seeing children under ATAPS (although recognising the total number of available sessions is more).

- Removing items 348 and 352 that currently cover consultations taking place in the initial diagnosis stage over the first month will mean that now these all count as part of the 15 consultations (where as currently these are unlimited). This in effect reduces the number from 15, and review of whether this has any ongoing impact should be undertaken.

- Whether the new time tiers are appropriate and sufficient. The proposed highest tier is greater than 30 minutes but not more than 45 minutes (to align with item 304). The need for a potentially longer consultation in more complex cases may be appropriate, and the need for a further tier to align with 306 and 308 may be appropriate.

- Whether these consultations could be appropriately delivered via telehealth, including for consultations not currently eligible, given the difficulties some families or other non-patients may have in attending face-to-face appointments.

Recommendation:

- That the introduction of the proposed changes be implemented to encourage greater flexibility in arrangements for interviews with non-patients, with ongoing review to ensure optimal functionality.

Recommendation 8: Clarify arrangements for item 346 – mother-infant group therapy

The RANZCP supports inclusion of an introductory note to clarify that item 346 (psychotherapy for a group of two patients) can be used for mother-infant group therapy. The RANZCP advocated for this and is pleased that it will be clarified in the explanatory notes. This support for mother-infant therapy, which has a very strong evidence, particularly for high-risk families, is welcome.

The RANZCP further suggests appropriate gender terminology within these items, acknowledging that whilst dyads are mostly mother-infants this is not the only possibility. Further it is important to distinguish that this refers to dyadic therapy (where you have a parent/caregiver and infant) from group therapy (where you might have two dyads present). The item descriptor of this item as ‘group therapy’ may
therefore be misleading. The RANZCP suggests that these issues can be addressed adequately through careful wording of the revised item descriptor.

The RANZCP further supports the recommendation for GP and Nurse Practitioner education on referral to the group therapy process and would be pleased to assist or provide further advice. It is noted that currently many GPs refer dyads under the parent as a standard consultation items and that many private psychiatrists are more likely to use items 300-306 for dyadic work between parents and infants rather than attempting to obtain separate referrals for both parent and infant unless the infant has a diagnosable neurodevelopmental disorder. In considering referral approaches it is necessary to consider any longer term negative impacts on the infant when being referred for a psychiatric service.

The RANZCP further supports consideration of increased time tiers for group therapy more generally (as documented in additional recommendations below).

Recommendation:

- That the proposed changes to item 346 be implemented, with consideration given to appropriate gender terminology and referral practice.

Recommendation 9: Aligning item 289 with best practice – management plans for children and adolescents with complex disorders

The RANZCP supports removal of the term ‘pervasive development disorders’ (PDD) from the MBS and replacing it with the term ‘neurodevelopmental disorders’. The RANZCP has long advocated for this term to be removed, to ensure that disorders that do not currently meet the definition of PDD, e.g. Fetal Alcohol Spectrum Disorder (FASD), can be included.

The RANZCP further supports the change of the consultation to be for the ‘purposes of diagnosis’, to acknowledge that confirming diagnosis may require multiple attendances, and that a diagnosis may not always be achieved.

The RANZCP broadly supports the proposed new item descriptor as outlined at appendix D of the draft report. In terms of the list of disorders for which this item would be appropriately used, the RANZCP agrees that not limiting the list to those disorders identified is appropriate. This will ensure that people with other complex and enduring needs without one of these defined disorders, but who have a neurodevelopmental disorder that require a similar assessment and plan, are not excluded.

At present this item aligns with the Helping Children with Autism Program. Neurodevelopmental disorders will potentially broaden the category beyond autism spectrum disorder. It therefore needs to be made clear whether the children assessed under this item would be eligible for the 20 sessions of allied health care that is triggered when a diagnosis is made, with the RANZCP suggesting that it should be.

The RANZCP also suggests that consideration be given to whether it is appropriate to increase the age limit, which currently includes only those under the age of 13. The RANZCP suggests that it may be appropriate to increase this to 25 in line with the draft report from the MBS Review Allied Health Reference Group, which included the following recommendation:
Recommendation 11: Increase the ASD, CDD and eligible disability assessment and treatment age to 25. This involves increasing the age limits as follows:

- items 82000, 82005, 82010 and 82030 from 13 years to 25 years
- items 82015, 82020, 82025 and 82035 from 15 years to 25 years.

In its response to this report the RANZCP supported increasing the treatment ages for assessment and treatment to 'allow access to services for the number of people increasingly being diagnosed between age 13 and 25, particularly in people with mental illness and in parents with undiagnosed ASD who may seek diagnosis after a child has been diagnosed'. The RANZCP further questioned whether the age limit should in fact be higher given many parents will be older than this and a small but significant number are diagnosed in adulthood. It is acknowledged that whilst the current Helping Children with Autism Program may not align with this age group, the ability to access allied health support more generally under the item numbers outlined in recommendation 11 above would still be valuable. The RANZCP suggests that this item be considered in line with the Taskforce's review of the report from the Allied Health Reference Group.

Recommendation:

- That the proposed changes to item 289 be implemented, with consideration being given to whether it is appropriate to increase the age range to ≥13 years.

Recommendation 10: Aligning items 855 to 866 with best practice – case conference

The RANZCP supports aligning case conference items to the specialist and consultant physician items as a way of ensuring as little impediment as possible to health professionals forming multidisciplinary teams.

The RANZCP acknowledges the recommendation to introduce a new simplified framework of case conference items, featuring three types:

i. discharge planning case conferences - a case conference to facilitate better post-discharge care and communication;

ii. community case conferences - a case conference to facilitate the provision of better multidisciplinary care; and

iii. treatment planning case conferences (new) - a case conference that explores and analyses potential treatment options and their respective benefits.

In its submission to the Taskforce the RANZCP suggested that there was a need to make changes to the provisions for case conferences to make them easier for clinicians to arrange, as the current set-up was identified as a potential barrier. Based on the RANZCP’s review of the specialist and consultant physician report, it does appear that the new framework for case conference items could address some of the concerns that exist around psychiatry case conferences. For example the recommendation stipulates a minimum of 3 attendees of different disciplines at each case conference, which can include
consultant specialists, GPs, AHPs, and nurse practitioners (i.e. it does not require two medical practitioners as is current).

If the changes proposed do take place, clearer instructions in the item descriptors about what constitutes a case conference and who needs to be present would be appreciated. It would also be useful to have more clarity as to whether education providers can count as providers for the purposes of these conferences as they are often part of treatment for children and adolescent patients.

Recommendations:

- That these changes be implemented, along with clear information in the associated notes to improve understanding of how to utilise these items.

- That these items be reviewed after a period of 1 – 2 years to assess functionality.

Other issues: repetitive transcranial magnetic stimulation

The RANZCP welcomes support from the Psychiatry Clinical Committee of the application to the Medical Services Advisory Committee (MSAC) to seek public funding for rTMS.

The application to seek approval for funding for rTMS for the treatment of depression under the Medicare Benefits Schedule (MBS) was supported by the Medical Services Advisory Committee (MSAC) in August 2019 (MSAC Public Summary Document Application No. 1196.2 – rTMS for the treatment of depression).

MSAC recommended the introduction of two new item numbers under the MBS category 3 Therapeutic Procedures to fund rTMS covering:

1. Initial prescription and mapping session (undertaken by a TMS-trained psychiatrist)
2. rTMS treatment (performed by a nurse or allied health professional who has been suitably trained)

Given the significant evidence for rTMS as an effective treatment for depression, and the clearly defined standards for the delivery of rTMS\(^\text{10}\), the RANZCP supports that it should be accessible in public and private mental health services in addition to the current spectrum of treatments. It should be affordable and, where appropriate, offered as a therapeutic option for the treatment of major depression. It is noted that MSAC is considered retreatment with rTMS at its meeting on 29 November 2019 and the outcome is awaited.

\(^{10}\) RANZCP Professional Practice Guidelines for the administration of rTMS, November 2018.
Recommendation:

- That the new MBS item numbers proposed for rTMS for the treatment of depression, as recommended by MSAC, be implemented in full by the Australian Government.

Other issues: Psychiatric advice to GPs

The Productivity Commission Report: Draft recommendation 5.1 (‘psychiatric advice to GPs’) recommends introducing a new MBS item for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP. The effectiveness of the new item should be evaluated after several years. The report notes that the discontinued ‘Psyche support’ service was greatly valued GPs.

This is something that the RANZCP called for in its MBS Review supplementary submission, as a way of promoting better care coordination, but it was not included the draft Psychiatry Clinical Committee report. The RANZCP continues to support the importance of allowing GPs to access psychiatric advice and strongly supports implementation of this recommendation.

Recommendation:

- That new MBS items be introduced for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP.

Other issues: longer consultation times for group therapy

The Productivity Commission Report: Draft recommendation 5.5 (‘encourage more group psychological therapy’) notes the value of group therapy and recommends that the MBS be revised to allow for groups to take place with fewer participants and run for ‘at least 90 minutes’ and ‘at least 120 minutes’.

These refer to focused psychological therapies, predominantly run by psychologists. However, the RANZCP suggests that the recommendation for longer session times equally applies for psychiatrists who undertake group therapy. Group therapy by psychiatrists remains a relatively well-used modality of treatment and seeing considerable numbers of patients in a group can be a very efficient and cost-effective way of treating people. Many psychotherapists in Australia offer combined group therapy and individual therapy to their patients e.g. a person requiring therapy twice weekly may have one individual and one group therapy session.

Recent feedback from RANZCP members has indicated that the current time period of one hour is frequently not sufficient, particularly in regard to family therapy. Examples have been given of psychiatrists having to charge each family member a 306 item separately to allow for an adequate consultation time. The RANZCP suggests that it would be more appropriate practice to allow psychiatrists to claim for longer periods for group therapy to help prevent the need for this occurring, and to allow the MBS to more accurately monitor the use of family therapy in practice.
**Recommendation:**

- To increase consultation times for psychiatry group therapy item numbers to run for 'at least 90 minutes' and 'at least 120 minutes'.

If you would like to discuss any of the issues raised, please contact Rosie Forster, Executive Manager, Practice, Policy and Partnerships via rosie.forster@ranzcp.org or by phone on (03) 9601 4943.