

Mental Health Treatment Plans

A guide for health professionals
working in general or private practice



How to Prepare a Mental Health Treatment Plan

Patients with a mental health condition, including those with a chronic or non-chronic diagnosis, benefit from structured management of their treatment needs and referral to appropriate services.

A Mental Health Treatment Plan (also known as a Mental Health Care Plan) must be completed when referring a patient to a psychiatrist, psychologist, eligible social workers or occupational therapists (providing focused psychological strategies) through the Medicare Benefits Schedule (MBS).

Referrals made under the Better Access initiative or the Access to Allied Psychological Services (ATAPS) program both require a Mental Health Treatment Plan. (For more information about these programs go to page 4).

This guide provides useful information on how to complete the Mental Health Treatment Plan.

Assess, Plan, Refer

Preparing a Mental Health Treatment Plan for your patients will involve both assessing the patient and preparing the Mental Health Treatment Plan document.

Assess

An assessment of a patient must include:

- recording the patient's consent for the Mental Health Treatment Plan
- taking relevant history (biological, psychological, social) including the presenting complaint
- conducting a mental state examination (MSE) - see page 3 for more information
- assessing associated risks and any co-morbidity
- making a diagnosis
- administering an outcome measurement tool - see page 3 for more information

Plan

Preparing a Mental Health Treatment Plan must include:

- discussing the assessment with the patient, including the diagnosis and recording of this diagnosis in the Plan
- identifying and discussing referral and treatment options with the patient, including appropriate support services
- developing goals with the patient - what should be achieved by the treatment - and any actions the patient will take
- provision of psycho-education - see page 4 for more information
- a plan for crisis intervention and/or for relapse prevention (if required)
- making arrangements for required referrals, treatment, appropriate support services, review and follow-up
- documenting the assessment and plan in the patient's Mental Health Treatment Plan - see page 5 for more information

Referral

Depending on your patients' needs you can make a referral direct to a psychologist, psychiatrist, counselling service or occupational therapist - through the Better Access Program, or through the Access to Allied Psychological Services (ATAPS) CAREinMIND™ program.

Medicare Benefits Schedule (MBS)

Medicare items for Mental Health Treatment Plans, Reviews and Consultations are available for patients living in the community (or privately funded residents of aged care facilities).

MBS items 2700, 2701, 2715 or 2717 can be claimed. MBS item 2712 is used when reviewing the GP Mental Health Treatment Plan.

Please note: The assessment can be part of the same consultation in which the Mental Health Treatment Plan is developed, or they can be undertaken in different visits.

For more information about the MBS items go to Appendix 1.

Mental Health Treatment Plan

Does your patient already have a Mental Health Treatment Plan (MHTP) ?



If no, complete a new Mental Health Treatment Plan

Use MBS items: 2700, 2701, 2715, 2717



Assess the Patient

- Record consent
- Take relevant history
- Conduct mental state examination
- Assess the associated risk and any comorbidity
- Make diagnosis or formulation
- Administer outcome measurement tool



Plan

- Discuss assessment with the patient
- Identify and discuss referral and treatment options with the patient
- Agree on goals with the patient
- Document the above steps in the MHTP
- GP and patient sign and date the plan



Referral

Refer patient to an appropriate service/clinician as agreed with the patient. Include:

- Referral Data Form (if referring to ATAPS)
- MHTP
- number of sessions required.



Review

(Use MBS item 2712)

After the initial course of treatment (usually 6 sessions) a review of the patient's progress against the goals outlined in the MHTP is required.

- Discuss progress with the patient
- Assess need for further treatment
- Re-administer the outcome measurement tool
- Offer a copy of the reviewed plan to the patient
 - Add to patient's records
 - Send a copy of the reviewed plan to service

To find out if your patient has had a MHTP in the past 12 months call **Medicare Australia on 132 150**

Exceptional Circumstances

A new MHTP may be required within a 12 month period if your patient has had a:

- Significant change to their mental health
- Change of clinical service and you are unable to obtain a copy of the MHTP.
- (Use MBS items: 2700, 2701, 2715, 2717 + 'exceptional circumstances')
- More information:
www.mbsonline.gov.au

Services

Access to Allied Psychological Services (ATAPS) CAREinMIND

- Referrals to centralised intake system at North Western Melbourne PHN
- Eligible patients: health care card, low income.
- Free service

Better Access

- Referral direct to a psychologist, psychiatrist, counselling service or occupational therapist.
- Medicare rebates available

Further information:

- North Western Melbourne PHN:
www.nwmpnhn.org.au or 9347 1188
- Medicare (claims and item enquiries):
www.mbsonline.gov.au

Mental Health Treatment Plan- step by step

Review

After the initial course of treatment (usually 6 sessions) a formal review (MBS item 2712) of the patient's progress against their Mental Health Treatment Plan and their need for further treatment is required. The mental health service provider will usually make a request for a review at this time.

Please note: You **do not** have to complete another Mental Health Treatment Plan.

The review must be completed in person with the patient and include:

- recording the patient's agreement for the service
- review of the patient's progress against the goals outlined in the Mental Health Treatment Plan
- modifying the Plan (if required)
- checking, reinforcing and expanding education
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided
- re-administration of the outcome measurement tool used in the assessment stage

A copy of the reviewed Plan must be offered to the patient (or carer, if appropriate) and a copy of the reviewed Plan added to the patient's records.

A copy of the review must be sent to the CAREinMIND team at NWMPHN if the patient is accessing ATAPS. Sessions 7-12 will continue after the review has been received and processed by NWMPHN.

Department of Health and Human Services, 2016, GP Mental Health Treatment Medicare Items, www.health.gov.au/internet/main/publishing.nsf/content/pacd-gp-mental-health-care-pdf-qa

Mental State Examination (MSE)

It is recommended that all components of the MSE should be considered at each assessment:

- Appearance
- Behaviour
- Speech
- Content of speech
- Mood and affect
- Thought
- Perception
- Cognition
- Insight

For more detail about conducting the MSE go to appendix 2.

Outcome Measurement Tools

Outcome Measurement Tools include:

- Depression, Anxiety and Stress Scale (DASS21)
- Kessler Psychological Distress Scale (K10)
- Short Form Health Survey (SF12)
- Health of the Nation Outcome Scales (HoNOS)

It is at the discretion of the practitioner as to which outcome tool is used.

If you are not familiar with the Outcome Measurement Tools or would like more information, training and education is available through the General Practice Mental Health Standards Collaboration, www.racgp.org.au/education/gpmhsc/.

Psycho-education

Psycho-education occurs in a range of contexts and may be conducted by a variety of professionals, each with a different emphasis. In general, however, four broad goals direct most psycho-education efforts:

1. Information transfer (as when clients/patients and their families and carers learn about symptoms, causes, and treatment concepts).
2. Emotional discharge (a goal served as the patient/client or family ventilates frustrations during the sessions, or exchanges with similar others their experiences of the problem).
3. Support of a medication or other treatment, as cooperation grows between professional and client/patient and adherence and compliance issues diminish.
4. Assistance toward self-help (that is, training in aspects such as prompt recognition of crisis situations and knowledge of steps to be taken).

Australian Institute of Professional Counsellors, 2014, Psychoeducation: Definition, Goals and Methods, www.aipc.net.au/articles/psychoeducation-definition-goals-and-methods/

Mental Health Treatment Plan - Templates

To ensure all relevant information is provided and to support the most appropriate referral for your patient it is recommended to use a Mental Health Treatment Plan template. Templates are available from:

- North Western Melbourne PHN: www.nwmphn.org.au/careinmind
- The Royal Australian College of General Practitioners (RACGP): www.racgp.org.au/education/gpmhsc/gps/gp-mental-health-treatment-plan-templates/

Please note: It is not mandatory to use any particular form when preparing and claiming for a Mental Health Treatment Plan, but it is mandatory to document all of the Medicare requirements (as outlined in Appendix 3).

Better Access and ATAPS

To determine whether Better Access or ATAPS is the most appropriate referral option for your patient, refer to appendix 4.

ATAPS CAREinMIND

Access to ATAPS is a free, short term service assisting people to a range of mental health issues including:

- anxiety (e.g. sleep difficulties, panic attacks and general stress)
- depression (e.g. low mood, poor motivation, low self-esteem)
- perinatal depression
- drug and/or alcohol misuse
- relationship and family difficulties (e.g. conflict, separation, parenting difficulties)
- life transition, and
- bereavement.

Specialist services are also available to support children and young people, and people at risk of suicide or self-harm.

Referring to ATAPS CAREinMIND

Referring GPs must provide both a completed referral data form and mental health treatment plan when referring to ATAPS CAREinMIND™ (**NB:** An exception is the ATAPS Suicide Prevention Service, which does not require a mental health treatment plan).

Referral forms and the mental health treatment plan template are available on our website: www.nwmphn.org.au

For further information about referring to ATAPS CAREinMIND

Contact: ATAPS CAREinMIND Coordinator

Phone: (03) 9088 4277

Secure Fax: (03) 9348 0750

Email: careinmind@mpcn.org.au

Mental Health Treatment Plan Example

Below is a good example of a patient's Mental Health Treatment Plan. It includes all of the Medicare requirements to ensure the patient receives the best possible treatment for their mental health condition.

GP MENTAL HEALTH TREATMENT PLAN PATIENT ASSESSMENT			
Patient's Name	Sophie	Date of Birth	01/01/1975
Address	Sophie's address	Phone	9999 9999
Carer details and/or emergency contact(s)		Other care plan Eg GPMP / TCA	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
GP Name / Practice	#####		
AHP or nurse currently involved in patient care	N/A	Medical Records No.	#####
PRESENTING ISSUE(S) What are the patient's current mental health issues	<p>Sophie is a 39 year old female presenting with depressive symptoms in the context of ongoing relationship difficulties with her husband.</p> <p>Sophie reports low mood 3/10, lack of motivation and no longer enjoying certain activities that she used to. She reports having these symptoms for the last 6 months.</p> <p>Sophie lives with her husband and 5 year old daughter. Sophie is a stay at home mum and finances are tight.</p>		
PATIENT HISTORY Record relevant biological psychological and social history including any family history of mental disorders and any relevant substance abuse or physical health problems	<p>Sophie can recall last feeling like this in her teenage years however didn't access treatment at this point. This episode seemed to pass when she finished secondary school.</p> <p>Sophie has not accessed counselling before.</p> <p>Sophie's mother and grandmother had depression. She cannot recall whether they accessed treatment for this.</p> <p>Sophie doesn't report any issues with her daughter, however is concerned about how her mood and the conflict between her and her husband impacts on her daughter.</p>		
MEDICATIONS (attach information if required)			
ALLERGIES	None		
ANY OTHER RELEVANT INFORMATION			
RESULTS OF MENTAL STATE EXAMINATION Record after patient has been examined	<p>It appears Sophie hasn't attended to her self-care. She is wearing dirty clothing.</p> <p>She presents as restless.</p> <p>Sophie is quietly spoken, normal rate and flow of speech.</p> <p>Sophie is worried about always feeling tired and depressed. She reports her mood as 3/10.</p> <p>Her affect is flat and she was tearful throughout the consultation.</p> <p>No thought disorder noted.</p> <p>She expressed hopelessness and occasional suicidal thoughts with no plan or intent.</p> <p>Sophie reports negative voices in her head. It was identified this is negative self-talk. Nil perceptual disturbances.</p> <p>She is oriented to time, place and person.</p> <p>Sophie is aware that the way she is feeling is not healthy. She identifies her relationship with her husband as contributing factor to the problem. She is unsure how to resolve this problem however and says she will never consider ending the relationship because that's not the right thing to do.</p> <p>She is agreeable to counselling and the commencement of antidepressant.</p>		

RISKS AND CO-MORBIDITIES Note any associated risks and co-morbidities including risks of self harm &/or harm to others	Sophie reports an occasional thought of suicide however does not have a plan. She reports that her daughter is a protective factor. Sophie has a supportive friend that she feels comfortable confiding in. Sophie denies the misuse of substances and use of illicit substances. She wants help and identifies that things need to change.
OUTCOME TOOL USED DASS21	RESULTS D = 11 A = 6 S = 6
DIAGNOSIS	Depression

GP MENTAL HEALTH TREATMENT PLAN PATIENT PLAN			
PATIENT NEEDS / MAIN ISSUES	GOALS Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take	TREATMENTS Treatments, actions and support services to achieve patient goals	REFERRALS Note: Referrals to be provided by GP, as required, in up to two groups of six sessions. The need for the second group of sessions to be reviewed after the initial six sessions.
Depression	Sophie wants to feel happy and content. She would like her self-esteem and confidence to improve. She wants to have more energy to look after her daughter. She wants to get along better with her husband and spend more time together as a family.	Commence antidepressant today. Provide patient with Psych triage and Lifeline number.	Refer patient to ATAPS.
CRISIS / RELAPSE If required, note the arrangements for crisis intervention and/or relapse prevention	Sophie has been given the Psych triage and Lifeline numbers. She has identified a good friend who she feels comfortable contacting for support. We discussed the importance of Sophie attending regular appointments with GP and psychologist. Informed Sophie of beyondblue resources.		
APPROPRIATE PSYCHO-EDUCATION PROVIDED	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	PLAN ADDED TO THE PATIENT'S RECORDS	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
COMPLETING THE PLAN On completion of the plan, the GP is to record that s/he has discussed with the patient: <ul style="list-style-type: none"> - the assessment; - all aspects of the plan and the agreed date for review; and - offered a copy of the plan to the patient and/or their carer (if agreed by patient) 		COPY (OR PARTS) OF THE PLAN OFFERED TO OTHER PROVIDERS	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> NOT REQ'D <input type="checkbox"/>			
DATE PLAN COMPLETED 25 May 2016		REVIEW DATE (initial review 4 weeks to 6 months after completion of plan)	
REVIEW COMMENTS (Progress on actions and tasks) Note: If required, a separate form may be used for the Review.			OUTCOME TOOL RESULTS ON REVIEW

Case Study Example

Provided below is a case study of a patient presenting with a mental health disorder. The case study demonstrates a good example of the presenting issue, patient history, risks and co-morbidities and the patient plan (requirements of the Mental Health Treatment Plan).

Case study - Jack

Presenting problem:

Jack is a 55 year old male presenting with depression and anxiety. Jack lost his job two years ago following his position being made redundant and reports worsening of symptoms since this time.

Jack lives on his own. He has two adult children.

History:

Jack reports experiencing depression and anxiety for most of his adult life. He has been on antidepressants in the past (many years ago) however ceased them due to unwanted side effects of nausea. Jack accessed counselling around the time he separated from his wife (5 years ago). He reports that he found it helpful.

Jack reports no family history of mental illness, however said that his brother has had issues with illicit substance use in the past.

Risk:

Jack reports ongoing suicidal thoughts with no plan or intent. He said he couldn't do that to his children. He has not made any attempts in the past.

Jack reports frequent alcohol consumption, 2-3 drinks per day. He said he enjoys drinking in the evening as he finds it relaxing.

He identifies one good friend who he has known since he was a teenager that is a good support for him.

Jack wants help however reluctant to commence antidepressants. He is keen to commence counselling.

Plan:

- Commence antidepressant
- Refer to ATAPS
- Review in a weeks' time
- Provide patient with phone numbers to Psych Triage and Lifeline

Appendix 1 – MBS Item Numbers

GP Mental Health Treatment Better Access to Mental Health initiative



Patients with a mental health condition, including those with chronic or non-chronic diagnosis, benefit from structured management of their treatment needs and referral to appropriate services. Medicare items for GP Mental Health Treatment Plans (GPMHTP), Reviews and consultations are available for patients living in the community (or privately funded residents of aged care facilities). [Dementia, delirium, tobacco use and mental retardation are not included in criteria for these services.]

MBS item	Fee	GP training	Time requirement	Service description	Frequency
2700 *	\$71.70	no	at least 20 mins	Preparation of a GP Mental Health Treatment Plan * Involves: an assessment (agreement, history, examination, risks, diagnosis, measurement tool) and preparation of a plan (discuss the assessment and referral options, agree goals, provide psycho-education, plan prevention, make support arrangements). Document the assessment, plan and review date.	Not within 12 months [†] of a claim for 2700, 2701, 2715 or 2717 (a new plan should not be prepared unless clinically required). Not within 3 months [†] of a claim for item 2712.
2701 *	\$105.55	no	at least 40 mins		
2715 **	\$91.05	yes	at least 20 mins		
2717 **	\$134.10	yes	at least 40 mins		
2712	\$71.70	-	-	Review of GP Mental Health Treatment Plan or Psychiatrist Assessment and Management Plan * Involves: recording patient agreement, reviewing progress against goals, modifying plan as required, reinforcing education, developing a relapse prevention strategy and re-administration of the measurement tool (unless clinically inappropriate).	Review 1-6 months from preparing the GPMHTP. Further review 3 months after first, if required. [†]
2713 **	\$71.70	-	at least 20 mins	GP consultation in relation to a mental disorder ** Involves: taking relevant history, identifying presenting problem(s), providing treatment and advice, providing referral for other services or treatments and documenting the outcomes of the consultation.	No restriction.
<p>★ To use these items recognised GP mental health skills training is required. It is strongly recommended that GPs preparing mental health treatment plans have appropriate training. Contact GPMHSC re training options: Tel 03 8699 0554 or email gpmhsc@racgp.org.au</p> <p>* Service not associated with a service to which item 2713 or 735 to 758 applies.</p> <p>** Service not associated with a service to which item 2700, 2701, 2715, 2717 or 2712 applies.</p> <p>† Except where there has been a significant change in the patient's clinical or care circumstances that requires the preparation of a new GPMHTP / Review.</p>					

- Treatment options include psychiatrist, psychologist, trained GP or allied mental health professional; pharmacological and/or community services.
- **Referral:** patients with GPMHTP prepared within last 12 months eligible for up to ten Medicare services per calendar year, from clinical psychologists, trained social workers or occupational therapists providing focused psychological strategies. Maximum of six visits in any one referral. Following feedback from the service, make a further referral if indicated (up to the total of 10 per calendar year). Additionally, up to ten group sessions can be claimed.
- Before making a claim read the item descriptors & explanatory notes at: www.mbsonline.gov.au
- For fact sheets, Q&A, and templates see: www.health.gov.au/mentalhealth-betteraccess
- See also ATAPS CAREinMIND™ information: www.nwmpn.org.au/careinmind

Appendix 2 – Mental State Examination (MSE)

All components of the MSE (listed below) should be considered when assessing the patient.

Appearance

- All aspects of the person's appearance including facial appearance, clothing, grooming and self-care are observed.

Rapport

- The attitude of the person to the examination, and any counter transference experienced by the examiner (e.g. a sense of threat or discomfort) can also be noted at this point.

Behaviour

- The person's posture and level of activity are important and may give clues about their mood, for instance psychomotor retardation in depression.
- Some disorders and side effects are also associated with particular movement disorders, e.g. tremor and bradykinesia (abnormally slow movement) with Parkinson's disease or the extrapyramidal side-effects of antipsychotic medication.
- Specific movement patterns such as echopraxia (involuntary imitation of the movements of others) may indicate catatonia.
- The person's composure and distractibility during the interview should be noted.

Speech

- The spontaneity of speech is important. Some people with depression or the negative symptoms of schizophrenia display little or no spontaneity, and a lack may also be observable in catatonia.
- The volume of voice and rate of speech may be raised in anxiety, mania or anger, and lowered in depression. Similarly, these conditions may affect the quantity of speech.
- The flow and interruptibility of speech may also be affected, for instance in mania the speech may be pressured and it may be impossible to redirect the person from their topic of choice.

- The form of speech may indicate a disorder of thought form. In persons who have a neurological or specific speech disorder (e.g. stuttering) this may not be the case.

Content of speech

- The overarching and characteristic themes of the person's conversation, including the positivity or negativity of these themes, the normality of content and any evident preoccupations should be noted here.

Mood and affect

- Mood is a person's prevailing emotional state, and affect is the observed responsiveness of their emotional state. A person may have a predominantly elevated mood and a highly reactive and labile affect, veering rapidly from enthusiasm to anxiety to irritability to laughter.
- If the person's mood appears depressed, questions probing suicidal ideation should be asked.

Thought

- Thought is not directly observable, it is inferred from observing speech and behaviour. The quantity of thought should be noted: poverty of thought may occur in depression, dementia or schizophrenia. The rate of thought is affected in a similar manner to the rate of speech for the most part: many people with mania have pressure of thought and some people with depression have bradyphrenia (slowed thought stream).
- The form of thought may indicate specific problems. Several types of thought disorder, such as tangentiality, derailment and neologisms may indicate psychosis. Clanging or punning associations are often indicative of mania and thought blocking and echolalia (automatic repetition of another's words) may indicate the presence of catatonia. Thought disorder may be so severe that no sense can be made of the person's conversation ('word salad').
- The content of thought may include delusional thinking: a fixed false belief that is not normal for the person's background. The nature of the delusion and the degree of conviction with which it is held may be very important in determining risk.

Appendix 2 – Mental State Examination (MSE) continued

Suicidal and homicidal ideas, and the presence and nature of any obsessions, are also considered in thought content.

Perception

- Hallucinations (a perception in the absence of sensory stimulus) may affect any sense (auditory, tactile, olfactory, visual and gustatory).
- The most common type of hallucination in mental illness is auditory.
- It is particularly important to enquire about command hallucinations, where individuals hear and sometimes obey voices that command them to perform certain acts - especially if that may influence them to engage in behaviour that is dangerous to themselves or others.
- Illusions are similar to hallucinations, but involve misperception of a real stimulus.
- Depersonalisation and derealisation are odd experiences where the person feels as though either they themselves or the world around them are unreal. Both are often associated with anxiety.

Cognition

- This involves assessing the person's orientation in time, place and person.
- If this appears in any way impaired, then a subtest called the Mini Mental State Examination (MMSE) may be performed. MMSE may reveal underlying cognitive impairment for further investigation and diagnostic clarification.

Insight

- A complex and highly individualised concept. It includes an account of the person's perception of the nature of the problem, the cause of the problem, why it continues to be a problem and what might be done to help resolve the problem.

Mental Health Professional Online Development (MHPD), 2004, Mental State Examination (MSE), www.mhpod.gov.au/assets/sample_topics/combined/Mental_health_histories_and_MSE/3MHMM_objective2/index.html

Appendix 3 - Mental Health Treatment Plan – Medicare Requirements

- Patient's name
- Date of birth
- Address
- Phone
- Carer details and/or emergency contact(s)
- GP name/practice
- Other care plan e.g. GPMP/TCA (yes/no)
- AHP or nurse currently involved in patient care
- Medical records no.
- Presenting issue(s) - what are the patient's current mental health issues
- Patient history - record relevant biological, psychological and social history including any family history of mental disorders and any relevant substance abuse or physical health problems
- Medications (attach information if required)
- Allergies
- Any other relevant information
- Results of mental state examination - record after patient has been examined
- Risks and co-morbidities - note any associated risks and co-morbidities including risks of self-harm and/or harm to others
- Outcome tool used and results
- Diagnosis

Department of Health and Human Services, 2016, GP mental health treatment plan sample template - Better Access program, www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-gpsamp

Appendix 4 – CAREinMIND™ ATAPS and Better Access

	CAREinMIND ATAPS	Better Access
Sessions per calendar year	Up to 12 sessions	Up to 10 sessions
Mental Health Treatment Plan	Required	Required
Eligibility	Clinically-diagnosed mental disorder and a holder of a Health Care Card (or those in genuine financial hardship – i.e. not able to afford gap payments under the Better Access (Medicare) scheme)	Clinically-diagnosed mental disorder
Cost to patient	Free (no cost)	Medicare rebates available
Who is not eligible?	Acute/crisis referrals <ul style="list-style-type: none"> • People who require long-term treatment (with chronic, severe or long-term (persistent) mental illness) • Individuals who have already utilised Better Access (Medicare) funding in the same calendar year 	
Review after 6 sessions	Required	Required
Referral process	Referrals are made to a centralised intake system at North Western Melbourne PHN - CAREinMIND	Referrals are made directly from the GP to the appropriate clinician
Providers	Patients are allocated to the most appropriate ATAPS provider by the centralised intake team Please note: If the patient or GP knows an ATAPS provider, they may select their preferred provider. This must be included on the referral form	Medicare rebates available

