Preparing a GP Mental Health Treatment Plan	Preparation of a GP Management Plan	Level C & D consultation
What is involved – Assess and Plan A rebate can be claimed once the GP has undertaken an assessment and prepared a GP Mental Health Treatment Plan by completing the steps from Assessment to the point where patients do not require a new plan after their initial plan has been prepared, and meeting the relevant requirements listed under 'Additional Claiming Information'. This item covers both the assessment and preparation of the GP Mental Health Treatment Plan. Where the patient has a carer, the practitioner may find it useful to consider having the carer present for the assessment and preparation of the GP Mental Health Treatment Plan or components thereof (subject to patient agreement). Assessment **An assessment of a patient must include:** ○ recording the patient's agreement for the GP Mental Health Treatment Plan service; ○ taking relevant history (biological, psychological, social) including the presenting complaint; ○ conducting a mental state examination; ○ assessing associated risk and any co-morbidity; ○ making a diagnosis and/or formulation; and ○ administering an outcome measurement tool, except where it is considered clinically inappropriate. The assessment can be part of the same consultation in which the GP Mental Health Treatment Plan is developed, or can be undertaken in different visits. Where separate visits are undertaken for the purpose of assessing the patient and developing the GP Mental Health Treatment Plan, they are part of the GP Mental Health Treatment Plan service and are included in item 2710. In order to facilitate ongoing patient focussed management, an outcome measurement tool should be utilised during the assessment and the review of the GP Mental Health Treatment Plan, except where it is considered clinically inappropriate. The choice of outcome measurement tools to be used is at the clinical discretion of the practitioner. GPs using such tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training. **Preparation of a GP Mental Health Treatment Plan** ○ In addition to assessment of the patient, preparation of a GP Mental Health Treatment Plan must include: ○ discussing the assessment with the patient, including the mental health formulation and diagnosis or provisional diagnosis; ○ identifying and discussing referral and treatment options with the patient, including appropriate support services; ○ agreeing goals with the patient - what should be achieved by the treatment - and any actions the patient will take; ○ provision of psycho-education; ○ a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;	**A comprehensive written plan must be prepared describing:** (a) the patient's health care needs, health problems and relevant conditions; (b) management goals with which the patient agrees; (c) actions to be taken by the patient; (d) treatment and services the patient is likely to need; (e) arrangements for providing this treatment and these services; and (f) arrangements to review the plan by a date specified in the plan. **In preparing the plan, the provider must:** (a) explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and (b) record the plan; and (c) record the patient's agreement to the preparation of the plan; and (d) offer a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and (e) add a copy of the plan to the patient's medical records.	**Level C** Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. **Level D** Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation;

○ making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and ○ documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Treatment Plan. Treatment options can include referral to a psychiatrist; referral to a clinical psychologist for psychological therapies, or to an appropriately trained GP or allied mental health professional for provision of focussed psychological strategy services; pharmacological treatments; and coordination with community support and rehabilitation agencies, mental health services and other health professionals. Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare either through item 2702 or 2710, a patient is eligible to be referred for up to twelve Medicare rebateable allied mental health services per calendar year for psychological therapy or focussed psychological strategy services (with provision for exceptional circumstances. Patients will also be eligible to claim up to 12 separate services for the provision of group therapy (either as part of psychological therapy or focussed psychological strategies). When referring patients GPs should provide similar information as per normal GP referral arrangements. This could include providing a copy of the patient's GP Mental Health Treatment Plan, where appropriate and with the patient's agreement. The necessary referrals should be made after the steps above have been addressed and the patient's GP Mental Health Treatment Plan has been completed. It should be noted that the patient's mental health treatment plan should be treated as a living document for updating as required. In particular, the plan can be updated at any time to incorporate relevant information, such as feedback or advice from other health professionals on the diagnosis or treatment of the patient. On completion of a course of treatment provided through Medicare rebateable services, the service provider must provide a written report on the course of treatment to the GP. For the purposes of the Medicare rebateable allied mental health items, a course of treatment consists of up to six services (but may involve less than six depending on the referral). There may be two or more courses of treatment within a patient's entitlement of up to 12 services per calendar year. The number of services that the patient is being referred for is at the discretion of the referring practitioner (eg. GP). Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan.		d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.