18h September 2025

Department of Health, Disability and Ageing

Consultation: Post-Implementation Review of MBS Psychiatry Inpatient Telehealth Items

Submitted to:

mbsclinicalpolicy@health.gov.au

Contact Persons for this Consultation:

MBS Clinical Policy Section
MBS Policy & Reviews Branch
Medicare Benefits & Digital Health Division
Australian Government, Department of Health, Disability and Ageing
E: mbsclinicalpolicy@health.gov.au
GPO Box 9848, Canberra ACT 2601, Australia

Lived Experience Australia Ltd
Contact: Sharon Lawn
Executive Director
slawn@livedexperienceaustralia.com.au
PO Box 98, Brighton SA 5048
Phone 1300 620 042
ABN: 44 613 210 889

Contents

Introduction 3
Background & Purpose of this Consultation 3
Our Response 3
LEA 'Friends' Feedback for this Consultation 4
Our Response to the Analysis of the Department's data on utilisation of the temporary telehealth inpatient items 7
LEA Support for Submission by the Australian Private Hospitals Association (APHA) 7
Recommendations 8
Contact 9
Appendix 1: Information about these MBS Items & Usage (1 Nov 2024 – 31 July 2025) 10
Appendix 2: Early Insights from Current Research on Telemental Health for Rural, Remote Areas and Underserved Communities 12

Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002. Our 'friends' include more than 12,000 people with lived experience of mental health concerns across Australia. This includes lived experiences with all parts of the mental health care system, NDIS, psychosocial disability support outside the NDIS, PHN commissioned services, public and private service options, and service provision across urban, regional, rural and remote Australia. All members of our Board and staff have mental health lived experience as either a consumer, family/carer/kin/supporter, or both.

Lived Experience is core to our advocacy, recognising that the impacts of policy and practice are felt not only by individuals, but also by families and whole communities. Our core business is to advocate for effective policies and systemic change to improve mental health care and psychosocial disability support services and support across the lifespan, across the whole Australian health and social care system, including within State and Territory jurisdictions.

We are recognised as the lived experience Peak representing the perspectives of people with mental health challenges and their family/carers/kin who use Private Mental Health Services (i.e. within General Practice, private psychiatry and psychology services, and pharmacy).

Please note: Following confirmation of our contributions, we make our submissions to consultations like this available to our 'friends' network via our website and e-news communications, as part of our commitment to keep them informed, raise awareness, and acknowledge their lived experience contributions. Your advice on any aspects that you would prefer to remain confidential (e.g. MBS item usage in Appendix 1) is welcome and respected.

We welcome the opportunity to provide our feedback to this consultation, particularly as it relates directly to the needs and experiences of people who rely on access and availability of private hospital inpatient care and psychiatrists who provide mental health services to that setting.

Background & Purpose of this Consultation

This submission is provided in response to the Department of Health, Disability and Ageing's (the Department's) invitation to contribute to the Post Implementation Review of six temporary Medicare Benefits Schedule (MBS) psychiatry inpatient telehealth items (92478, 92479, 92480, 92481, 92482, and 92483 – each reflecting length of contact between the psychiatrist and consumer, or context for the contact between them (see **Appendix 1** for detail). These items were introduced on 1 November 2024 to facilitate video consultations for private hospital inpatients by psychiatrists. The review aims to assess the clinical effectiveness of these items in supporting appropriate admission and access to inpatient care. The outcomes of this review will inform a decision by government on the future of these temporary items.

Our Response

Our submission is based on consultations with our LEA 'friends' in relation to their lived experiences of being recipients of services by psychiatrists using these MBS item numbers, their views on use of telehealth generally, and LEA's lived experience knowledge of the private mental health sector.

LEA 'Friends' Feedback for this Consultation

We sent out an open invitation to our 'friends' network, seeking their views. We asked - What feedback would you like Lived Experience Australia to consider in our submission?

We received responses from 24 individuals – 17 who had accessed mental health services, and 7 who had both accessed and support another person to access mental health services. Of these 24 individuals, 14 had accessed a private hospital for mental health at some time between November 2024 and now.

We also received information on early findings on consumer perspectives from a study of telemental health in rural and regional areas, by Dr David Lim, which we have included as **Appendix 2.**

Below is the range of direct feedback provided, from highly supportive experiences of use of the temporary MBS item numbers, to mixed experiences and concerns, generally, about the use of telehealth.

Supportive Feedback:

Its value in supporting continuity and consistency of connections and treatments with a known and trusted psychiatrist was noted:

> "*Having access to telehealth with my Psychiatrist both prior to & during my hospital admission was very useful. It gave me the opportunity to express my concerns (fear) about the admission & allowed me to remain in contact with my Psychiatrist throughout my stay*."
>
> *"Telehealth consults were beneficial to keep connections and treatments current and consistent, please keep this option available to support and maintain wellness."*
>
> *"One of my admissions I did not see the psychiatrist often enough. Telehealth may have been good for more contact."*
>
> *"Accessing psychiatrist services via telehealth has had a very positive impact on me as a consumer. It has allowed me to carry out my consultation even though the psychiatrist could not be in the office. That meant I didn't have to postpone my appointment by one or two weeks but keep to our schedule."*

Its value in supporting admission to hospital, not only due to Psychiatrist's potential offsite location, but also when the person was highly distressed, was noted:

> "*When I was severely depressed (and eventually admitted to a private psychiatric hospital), I was very scared to drive. The psychiatrist I had been referred to was over 30 minutes away and public transport there was not straightforward. (I doubt I would have been able to navigate multiple bus connections, anyway."*

Its value in overcoming transport and geographical access challenges was noted:

> *"Telehealth is fantastic for those of us who have difficulty, due to lack of transport and required travel distance, accessing appropriate mental health support and treatment."*

Its value for some in helping them to connect with mental health services, given trust and other concerns with engaging with services, was noted:

"Telehealth consultations with psychiatrists - Consultations were as an inpatient. However, I note my 32-year-old son has had telehealth consultations with his psychiatrist. My son was under an order, was with the community team and had had a number of face-to-face consultations previously. The online consult was helpful as my son was reluctant to attend the appointment physically, plus he actually was more forthcoming with the psychiatrist as my son found it easier to discuss over the computer than in person."

Its value in improving access to psychiatrists for people located in regional and rural locations was noted:

"I have had many many private hospital admissions, none where the psychiatrist has used Telehealth. Living in a regional area at times I think it would have been really valuable to have had access to a psychiatrist more frequently, or someone who had a special interest and skill in complex trauma using Telehealth to facilitate admission to our local private facility."

Its value in facilitating smoother, more timely admission and avoiding consequent harm and trauma from delayed admission was noted:

"My experience with hospital admission processes has been mixed. Planned admissions were relatively easy to arrange and went smoothly. However, crisis admissions were very stressful, with long waits just for referral assessments before even knowing if I would be admitted. In moments of acute distress, these delays felt overwhelming and added to the pressure of an already difficult situation."

Its value in supporting autonomy and self-determination for the person as part of the admission and hospital stay, and reducing potential burden on family, was noted:

"The importance of having someone to talk to other the friends or family about the struggles you are facing. At times I did not want to burden my family anymore."

Feedback Reflecting Mixed Concerns:

Feedback from some individuals reflected concerns, more broadly, with access, workforce, and other concerns across the mental health system, including private services.

"I contacted a private hospital for admission, and it still took 3 weeks to get a bed. This is not a good scenario if the person is immediately distressed and needs immediate attention. I have also had a scenario where an ambulance was called, was taken to hospital where there were no facilities for mental health then transferred to a regional hospital in public system. This was useless. It was supposed to have groups and various appointments but had nothing. There was also no follow up after discharge."

Whilst the telehealth MBS items have value, in-person contact must continue as the preferred mode of contact:

"In an environment where isolation was a big issue for me, face to face is what was more therapeutic. That human contact, feeling a person's presence in the room. I really struggle to build rapport over telehealth. For me someone showing up, in person, portrays care and commitment to me."

Further to this concern, some believed that telehealth could miss important assessment communication when compared with face-to-face contact:

"I think when I was admitted to a private hospital, having Telehealth appointments with a psychiatrist honestly would have really negatively impacted me. I needed someone to see me face-to-face. I had physical body language cues you cannot see on a video and I would have felt like if it was on video that I wasn't getting the full access to private health services for what I was paying. I think this will really negatively impact people. In my case I wouldn't have opened up which would have impacted my overall treatment. I also think that if my family therapy appointment with the psychiatrist was on video that it would have made the situation worse due to basic communication skills and language which constantly informs treatment and communication through internal and external feedback mechanisms."

"Psychiatrists can be very intimidating in hospital whether on telehealth or in-person face-to-face, I don't think it makes a difference. I think the psychiatrist should be in-person to make correct judgement on the individual's state of mind."

"Some people … struggle with telehealth … because I don't take in that much information on telehealth when I am mentally unwell."

Use of these MBS telehealth item may not be suitable for use with some people; however, it could be suitable and acceptable during a crisis, in some circumstances:

"Some individuals may I don't feel that telehealth would suit me. Personally, I do not feel that a Psychiatrist appointment can be as therapeutic if not held in person. I did have some sessions online during Covid and found it to be just a token session. We didn't really do proper work on my issues. It was more of just a hello and deciding when we would next catch up. For me, I don't feel comfortable using video to talk to someone and having to look at myself while I speak. It is off-putting. A phone call would be more comfortable than telehealth. I guess it depends on the acuity of the patient. Telehealth could be very helpful in a crisis for a remote patient."

A number of people highlighted inherent challenges that exist within the mental health system that could make the use of these MBS items challenging:

"I find this very hard because within our Private Mental Health Facility in Tasmania there is a six-week waiting period to get in even when your Psychiatrist tries to get you in."

One LEA 'friend' (Stephen Lake) who wished to be named, spoke to a range of system concerns:

"We have a national shortage of them in the public system, which means that many people have little or no access to any psychiatric care whatsoever…I can notionally understand that it is not financially advantageous or sustainable for psychiatrists to continue working, insofar as this is not an issue limited to them but is also a factor in the closure of GP practices (which are also viewed as being a front line in mental health care) and also in national shortages of teachers, nurses and other professional and trades groups as well. That then does indeed point to far deeper and more systemic issues that governments are going to have to radically improve upon if these shortages and their effects are ever going to be resolved. At the same time, and perhaps it also plays out against the same problem, there are reports of psychiatrists over-charging for consultations, both at unaffordable hourly rates and also for hourly sessions that may have only run for 10 minutes.

I appreciate that these trialled Medicare Telehealth services can be useful for some people, e.g. as a means of triage or assessment preliminary to an in-patient admission, assuming that such facilities are available, but I have several concerns about this. There are no in-patient mental health facilities available across much of Australia, not even within reach of metropolitan centres but certainly

across much of regional, rural and remote Australia, and those facilities that do exist cannot appropriately meet the full needs of their catchment areas and demographics, and they therefore remain seriously deficient. There are no local mental health services near where I live in regional NSW, and my local hospital has no capacity for mental health admissions. I would not be able to go directly to any private mental health service and would only access one via the public system. There are almost no identifiable private mental health clinics or hospitals in regional and rural NSW.

Effective therapeutic relationships need to be conducted with the patient and the clinician in the same room, face to face, and not via a screen. Telehealth cannot be viewed as a replacement for such relationships.
I think that governments need to find the means to recruit and employ more psychiatrists across regional and rural areas, who relocate and remain permanently employed in those centres. Any in-patient mental health unit should have at least two resident staff psychiatrists (or registrars), and ideally, more.

Therefore, while I can acknowledge some limited benefit in these Medicare rebate options, I do not consider any of them as adequate permanent solutions to the numerous failures of government in delivering adequate and appropriate, universally accessible and affordable mental health services across the entire country."

Our Response to the Analysis of the Department's data on utilisation of the temporary telehealth inpatient items

The usage data for these items (see **Appendix 1** below), as provided in Attachment A of the consultation information, highlights significant variability in their use across Australia's States and Territories. The data shows that psychiatrists in NSW, VIC, and QLD were more likely to have used them during this trial period (1 Nov 2024-31 July 2025). We urge the Department to examine the reasons for his variability, given this usage does not necessarily reflect community mental health needs across the jurisdictions. Whilst it is clear that there are more private psychiatric units in these 3 States, we are concerned about the potential inequity that could be created in the longer-term if these items are made permanent without also understanding this variability and addressing it so that people in other jurisdictions can also benefit from their use.

We note that item 92480 (30–45 min attendance) appears to be the most frequently used across all states, suggesting that mid-length consultations are the most commonly required for inpatient psychiatry telehealth services. We also note the relatively low usage of items 92482 (>75 min) and 92483 (Admission, >45 min) may reflect either limited demand for extended consultations or barriers to accessing these services. We particularly raise the need for a clear communication and awareness raising process for people who may access private psychiatric hospital services. This could be done through easy-read information sent out by the person's private health insurer, through consumer and carer advocacy organisations, or to private psychiatrists (e.g. via the RANZCP regular communication to their fellows).

In preparing this submission, I asked a psychiatrist from one jurisdiction with very low use of the MBS items during the pilot period about the potential reasons for that. Their response was that it would take time for telehealth for this purpose to become 'routine in their field of awareness'.

LEA Support for Submission by the Australian Private Hospitals Association (APHA)

We wish to affirm the views of APHA that continuation of these MBS items will have a positive impact on clinician engagement and workforce sustainability. That is:

- Inpatient telehealth has been critical in supporting private psychiatrists to sustain inpatient practice. For instance, it has provided psychiatrists with flexibility that was not previously available other than during the COVID-19 pandemic.
- Clinicians believe that these items will positively impact workforce retention within private hospital settings, over the long term.
- Given the significant challenges that psychiatric hospitals are currently facing in relation to permanent workforce recruitment, inpatient telehealth has proven to be invaluable.

The APHA has highlighted several key principles for the Department to consider in their review and decisions about the future of these MBS items. These principles are mirrored in the feedback from LEA's 'friends'. They include the value the MBS items have provided to:

- Ensuring timely and effective care via enabling continuity of care with known and trusted providers.
- Improving access to care particularly in bridging geographical gaps and improving access to psychiatric services for underserved populations.
- Supporting least restrictive care and the potential harms that arise from delayed admission and then needing to resort to alternative public system Emergency Departments when in crisis, the potential harms and stress caused for the person and family, carers and supporters (where applicable), and the pressures then put on the public system.

Recommendations

Based on the feedback from LEA 'friends', and aligned with APHA recommendations, we propose the following recommendations:

- Make psychiatry inpatient telehealth items (92478–92483) permanent beyond the initial 2-year period.
- Expand the permitted frequency of telehealth inpatient consultations to reflect patient demand and clinical need; though ensure there are sufficient guardrails so that this does not take away the primacy and importance of face—to-face contact between the person and the psychiatrist.
- Prioritise support for the implementation of electronic medication charts in private hospitals to enable full utilisation of the consultation items.
- Investigate barriers to the use of longer consultation item (92482) and particularly the Admission item (92483) and provide targeted support to increase their uptake.
- Investigate reasons for the disparities in usage across States and Territories in order to address current inequity and ensure this inequity doesn't widen over time.

- Ensure ongoing consultation with and inclusion of consumers and family, carers and supporters in any further review and refinement of the telehealth model.

- Consider a further incentive to encourage psychiatrists to embed telehealth into inpatient care models, similar to that which has occurred in general practice.

- Build more awareness among consumers, families, carers, supporters, psychiatrists, and the wider mental health service system about these MBS items.

Contact

We thank you for the opportunity to put our views forward. We wish you well with the next steps and would be pleased to contribute our Lived Experience perspectives to any future discussions about this important topic.

Your sincerely

Sharon Lawn

Professor Sharon Lawn, Executive Director
Lived Experience Australia Ltd
Email: slawn@livedexperienceaustralia.com.au
Mobile: 0459 098 772

Appendix 1: Information about these MBS Items & Usage (1 Nov 2024 – 31 July 2025)

The following information is sourced from the Department's MBS Online website, where you can search by item number: As example - https://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=92478&qt=ItemID

The intention of this suite of items is to provide for one video consultation on admission and one subsequent video consultation per week of admission with the remaining consultations to be provided face to face using existing in-hospital subsequent consultation items. Psychiatrists are able to use items 92478 to 92482 for initial video consultations (which may be admission consultations) for patients who are not new to the psychiatrist).

MBS video items provide Medicare benefits for services provided by video conferencing. Video MBS items cannot be used for phone or email consultations.

Considerations for appropriate care

In claiming the items, the practitioner must ensure that the video appointment is safe, clinically appropriate and suitable for the patient. Psychiatric practice using this suite of items should be guided by the RANZCP Professional Practice Guideline 19 Telehealth in Psychiatry, the AHPRA guidance in relation to video consultations with patients and the National Safety and Quality Digital Mental Health Standards.

Particularly, psychiatrists should consider:

- the suitability of using video in the inpatient setting for a consultation in partnership with hospital staff, the referrer, patient and, where appropriate, their carer(s) or guardians. Further, the psychiatrist using the items must provide continuity of care and keep other practitioners informed of the treatment they are providing when sharing the care of the patient;
- that any practitioner using video services is expected to continuously assess the appropriateness and safety of using video for the consultation and make arrangements for the patient to be seen in-person, if necessary;
- that the use of digital services in the mental health setting must be safe. To ensure this, there must be a model of care that includes clear roles and responsibilities and determines how the private psychiatrist works with the staff on the unit to provide safe care for the person. There is also a need to have clear mechanisms for assessing and responding to risk, and communicating for safety;
- that it is expected that the psychiatrist would consult with the patient face to face within 48 hours of a video admission. 48 hours is considered a maximum and the clinician should consult with the patient face to face sooner, if necessary; and
- that the items are expected to be used for emergency and acute admissions and are not intended for elective admissions.

List of temporary MBS item numbers that are the subject of the Department's current consultation and review:

- Item 92478 - available for a subsequent video consultation in hospital of less than 15 minutes.

- Item 92479 - available for a subsequent video consultation in hospital of at least 15 minutes and not more than 30 minutes.
- Item 92480 - available for a subsequent video consultation in hospital of at least 30 minutes and not more than 45 minutes.
- Item 92481 - available for a subsequent video consultation in hospital of at least 45 minutes and not more than 75 minutes.
- Item 92482 - available for a subsequent video consultation in hospital of more than 75 minutes.
- Item 92483 - available for new patient video consultations in hospital of more than 45 minutes.

Usage of MBS psychiatry inpatient telehealth items by patient state/territory 1 Nov 2024 – 31 July 2025

Item	**92478**	**92479**	**92480**	**92481**	**92482**	**92483**
Item description	Attendance on admitted patient (<15min)	Attendance on admitted patient (15-30min)	Attendance on admitted patient (30-45min)	Attendance on admitted patient (45-75min)	Attendance on admitted patient (>75min)	Admission - attendance on new patient (>45min)
Number of services - NSW	22	73	206	40	<6	17
Number of services - VIC	6	46	164	56	11	<6
Number of services - QLD	18	70	46	12	<6	6
Number of services - SA	-	-	<6	-	-	<6
Number of services - WA	<6	<6	10	<6	-	-
Number of services - TAS	<6	-	<6	-	-	-
Number of services - NT	-	<6	-	-	-	-
Number of services - ACT	-	<6	<6	-	-	-

Appendix 2: Early Insights from Current Research on Telemental Health for Rural, Remote Areas and Underserved Communities

A Comment on Telemental Health Care based on recent findings within the project 'A user-centred design and development of a telemental health virtual clinic for rural, remote areas and underserved communities' [ETH24-9607]

Ashleigh Heath[a], David Lim[a,b]

aCollege of Medicine and Public Health, Flinders University, Bedford Park, Australia

bIMPACCT: Improving Palliative, Aged and Chronic Care through Clinical Research and Translation, Faculty of Health, University of Technology Sydney, Ultimo, Australia

Ongoing qualitative research within the project titled 'A user-centred design and development of a Telemental health virtual clinic for rural, remote areas and underserved communities' [ETH24-9607] affiliated with the World University Network has sort consumer, and service provider perspectives of Telemental health care. The following findings are synthesized from eight interviews with individuals with lived experience of mental illness and receiving mental health care in rural and remote Australia.

Telemental health care was accepted by all participants as part of the solution to address gaps in rural mental health care. One individual stating 'if there were more telehealth options, I would have utilized them', and another acknowledging 'it can improve or increase the frequency of support that you're able to get'. Research has shown rural and regional populations have similar proportions of population affected by mental health. However, due to barriers such as limited resources, distance to services, and lack of awareness, there are health disparities leading to poorer health outcomes. This is represented by increased emergency department visits, lower mental health service utilization, and more frequent psychiatric emergencies (Edwards et al., 2023; Kavanagh et al., 2023). Whilst Telemental health care was accepted as part of the solution by the eight participants, a concern is acceptance of the service across communities. One participant highlighted 'when the Covid pandemic reached Australia, we quickly learned that we could do approaches like mental health appointments or psychology counselling via telehealth, video conferencing, that kind of thing, and people seemed, I think, actually quite open to it'. As such, it seems the shift in culture through the pandemic may have also shifted attitudes towards health care.

Distance and resources are disproportionate barriers to mental health care in rural areas, compared to metropolitan. Within rural and remote areas, there is often a 'lack of after-hours service' and frequently a need to travel, if not to a city, then 'travel to another bigger town…and not everyone has the capacity to do that'. As such, Telemental health care provides a solution to these barriers. And whilst many would rather face-to-face healthcare, 'it might be preferable to have a tech-based care than no care at all, or a tech-based care where they can stay in their home and receive the appointment, then have to travel hundreds of kilometres to care'.

Stigma of mental illness is present regardless of location. However, in rural and remote towns, smaller populations limits anonymity when accessing mental health care. One participant explaining that some people won't see the local psychologist 'because they think that if anyone sees their car parked nearby, then it's a declaration that they're going to see the psychologist'. Another participant explained Telemental healthcare may 'open up a new world…because of the stigma, if they could talk to someone and no one else is going to know about it' then they could access care. Finally, Telemental health care can be seen as 'a softer entry, a less confronting entry into the world of help-seeking for many people'.

Through discussions with individuals with lived experience of mental illness in rural and remote Australia, it is clear Telemental health is a crucial addition to the limited services available. However, a major concern is the limitation of not receiving care face to face. For those who had previously received Telemental health care, they did not believe they 'missed out on anything', a participant stating 'I feel like I'm looking at you now, even though we've got a screen in front of us. I'm okay with it, and I don't feel a barrier', and another suggesting talking across devices, particularly when using video still has 'a large human element in it'.

An important thing to acknowledge is rural Australia 'is a completely different world' to the city, and this must be considered when applying Telemental healthcare in rural settings. People in rural settings acknowledge they do not have the same resources as metropolitan Australia. 'There has got to be a recognition that it is not possible, despite our best efforts to have a professional in every small town and in every small centre in the remote communities, on a continuous basis', and as such, it is important we consider solutions to these gaps in services, such as implementing Telemental health care designed for rural Australia.

Reference List:

Edwards, A. M., Hung, R., Levin, J. B., Forthun, L., Sajatovic, M., McVoy, M., & Heckman, T. G. (2023). Health Disparities Among Rural Individuals With Mental Health Conditions: A Systematic Literature Review. Journal of Rural Mental Health 47(3), 163-178. https://doi.org/10.1037/rmh0000228

Kavanagh, B. E., Corney, K. B., Beks, H., WIlliams, L. J., Quirk, S. E., & Versace, V. L. (2023). A scoping review of the barriers and facilitators to accessing and utilising mental health services across regional, rural, and remote Australia. BMC Health Services Research 23(1), 1-1060. https://doi.org/10.1186/s12913-023-10034-4