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Submission to the Medicare Benefits Schedule Review Taskforce on mental health MBS items

National Mental Health Commission

May 2018

Summary

The National Mental Health Commission (NMHC) recommends that the MBS Review Taskforce consider the following recommendations in relation to mental health items:

1. For severe or complex high prevalence disorders, enable an extra six Medicare-subsidised sessions, in the Better Access initiative, of psychological therapy as clinically determined (a total of 16 in any one year).
2. The inclusion of low prevalence, severe and complex mental health disorders including personality disorders and psychotic disorders through increasing access to additional sessions for more severe presentations in the Better Access initiative.
3. The addition of a rural and remote loading for health professionals under Medicare-subsidised mental health services, removal of required face-to-face sessions under telemedicine guidelines for rural and remote patients and re-application of indexation to all Medicare-subsidised mental health services.
4. Inclusion of mental health nurses under the Better Access Medicare-subsidised mental health services.
5. Increased focus on multi-disciplinary management that allows for the treatment of mental health disorders alongside co-occurring physical health conditions.
6. The expansion of current Medicare case conferencing item numbers to encourage collaborative multi-disciplinary, consumer and carer communication. The introduction of a Medicare item number for the specific purpose of consultation between health professionals and carers/support people.
7. The introduction of Medicare-subsidised mental health services for older Australians living in residential aged care facilities.

About the National Mental Health Commission

The NMHC's purpose is to provide insight, advice and evidence on ways to continuously improve Australia's mental health and suicide prevention systems and to act as a catalyst for change to achieve those improvements. This includes increasing accountability and

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transparency in mental health through the provision of independent reports and advice to the Australian Government and the community.

The NMHC seeks to engage with people with a lived experience of mental health issues, including carers and other support people, in all areas of our work. We affirm the right of all people to participate in decisions that affect their care and the conditions that enable them to live contributing lives. Diverse and genuine engagement with people with lived experience, their families and other support people adds value to decision-making by providing direct knowledge about the actual needs of the community, which results in better targeted and more responsive services and initiatives.

Overview

The NMHC considers that the MBS Review provides an ideal opportunity to consider the mental health services provided under the MBS to ensure that the items are apace with any changes to the practice of mental health care, noting that the stepped care model has implications for how all mental health professionals' work. Also, the NMHC points to the importance of engaging with consumers, their family and carers on how they should be involved and participate in decisions regarding their own recovery journey with the mental health professionals being paid under the MBS.

Over the last eight years there was a significant increase in the number of Australians accessing Medicare-subsidised mental-health specific services.

- The total number of Medicare-subsidised mental-health specific services increased from 6.2 million in 2008–09 by 4.1 per cent to 11.1 million in 2016–17 by 9.8 per cent (2.4 million) of Australians.
- The increase in the rate of services was mostly due to increases in services provided by GPs followed by clinical psychologists and registered psychologists, noting new MBS items facilitated this increase.
- Of 11.1 million Medicare-subsidised mental health-specific services provided,
    - 8.1 per cent were from a GP,
    - 2.7 per cent from a psychologist,
    - 2.0 per cent from a clinical psychologist,
    - 1.6 per cent from a psychiatrist, and
    - 0.4 per cent from an allied health professional (AHP)

  (noting that people commonly receive more than one service).[i]

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Despite these positive results, this population does not match prevalence rates of the mental health disorders the system was designed to treat. Prevalence rates for anxiety disorders sits at 14.4 per cent of the population, 6.2 per cent for affective disorders, and a total twelve-month prevalence rate for affective, anxiety and substance use disorders of 20 per cent[ii]. Therefore, there are still improvements to be made to the system in order to increase accessibility of mental health services in Australia.

1. Increased access for people with severe high prevalence mental health disorders.

The Better Access initiative was implemented by the Australian Government in 2006 to improve treatment and management of mental illness within the community, providing an affordable option for people with high prevalence disorders such as depression and anxiety to access mental health services, specifically evidence-based psychological therapy. The success of the Better Access scheme in increasing access to psychological services in Australia is evidenced in the high utilisation of Medicare-subsidised mental health services by Australians. Nevertheless, the NMHC considers that the MBS Review provides an important opportunity to make some much needed changes to the scheme.

The Better Access initiative is increasing community access to mental health professionals and team-based mental health care, with GPs encouraged to work more closely and collaboratively with psychiatrists, clinical psychologists, registered psychologists and appropriately trained social workers and occupational therapists.

After being in operation for about five years, the decision to reduce the number of available Medicare sessions from 18 to 10 had significant impact as the Better Access scheme is no longer sufficiently funded to treat more severe presentations of high prevalence disorders. The change was based on the average number of sessions utilised being substantially lower than 18, with the aim to reduce overall cost. This change, however, was not in line with clinical evidence.

While administrative data is available on Medicare in Australia, the Australian Psychological Society (APS) researched further to better understand what conditions the services were being provided for – the data indicates that 81 per cent of Medicare-subsidised services provided by psychologists were for 'high prevalence disorders' such as anxiety and depression, and only small percentages for 'low prevalence' disorders such as schizophrenia, or bipolar disorders.[iii] Additionally, data suggest that of those who needed more than 10 sessions, the majority were high prevalence disorders, exactly those that Better Access was designed to treat.

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Therefore, in line with these observations, the NMHC suggest consistent with recommendations made in 2014[iv] that the Australian government consider re-instating an additional six Medicare-subsidised sessions, available to people experiencing mental health disorders of higher severity, at the discretion of the clinician. However, an approach that is more like a chronic disease plan with a higher number of sessions (or multiple plans per year) is seen as preferable.

Recommendation 1: For severe or complex disorders, enable an extra six Medicare-subsidised sessions, in the Better Access initiative, of psychological therapy as clinically determined (a total of 16 in any one year).

2. Proposed inclusion of people with severe high prevalence mental health disorders

As mentioned prior, the Better Access initiative was originally implemented to provide an affordable option for people with high prevalence disorders including depression and anxiety to access mental health services, specifically psychological therapy. Currently, the majority of services under MBS are utilised by people with such presentations.

Consistent with Priority Area Three: *Coordinating treatment and supports for people with severe and complex mental Illness* in the *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) the NMHC recommend that expansion of Better Access to effectively treat low prevalence, severe mental health disorders such as personality disorders and psychotic disorders be considered. Frequently, allied health providers in private practice receive referrals from local public mental health team, community mental health and hospitals. This may be to provide additional support or to continue care following an admission. Thus, having an MBS system that accommodates their needs would assist in achieving more effective treatment, continuity of care and minimising risk of additional hospital admissions.

It is noted, that research indicates a least 20, in many cases 30 or more sessions of evidence-based therapy are required for treatment of complex disorders such as eating disorders, psychotic disorders and personality disorders. The current MBS system does not allow for evidence-based therapy to be completed, due to insufficient coverage of sessions, often resulting in the referral of people experiencing complex mental health disorders back to mental health teams or psychiatrists for ongoing care. The NMHC believe for the sake of continuity of care it would be more beneficial for these individuals to be able to access

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sufficient care with their private allied health provider, reducing the burden on the public mental health system.

It is acknowledged that significant changes such as this to the MBS scheme would result in significant additional cost, however ideally where such provisions are made future hospitalisations and referrals to the over-burdened public mental health teams will be prevented, and the overall cost the mental health system reduced through provision of consistent ongoing care in the community.

For example, recent media attention has seen significant lobbying for increasing the number of Medicare sessions for eating disorders. This has been drawn from the findings of recent research by Deakin University, funded by the National Health Medical Research Council, that indicate evidence based treatment for eating disorders involving 20 to 30 sessions per year were found to be cost effective in health gains and treatment costs[v]. Thus an expansion of the 10 sessions currently available is warranted.

Recommendation 2: The inclusion of low prevalence, severe and complex mental health disorders including personality disorders and psychotic disorders through increasing access to additional sessions for more severe presentations in the Better Access initiative.

3. Increased focus on equity of Access

Rural and remote

The disparity in provision of mental health services in rural and remote contexts when compared to major cities in Australia is well established. Indeed, the lack of rural incentives under Medicare-subsidised mental health services appears to be an anomaly when compared with other programmes where there is a rural loading—for example, for GPs, practice nurses and mental health nurses.

In 2014 the NMHC made recommendations in order to address this issue of inequitable distribution of services. The NMHC have reported that if rural Australia is to receive its fair share of services, it needs to receive a fair share of funding. This includes examining incentives for AHP's to work in regional, rural and remote areas specifically the introduction of a Medicare-subsidised mental health services rural loading.

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Telemedicine

In 2017, the Australian Government improved access to telehealth delivered mental health services for those living in rural and remote Australia through allowing video consultations for those with difficulties accessing face-to-face services.

Despite this being a significant improvement, the initiative requires that three of the ten sessions, specifically including one of the first four sessions, be completed face-to-face. While such recommendations are intended to promote positive therapeutic alliance and rapport, these requirements also pose a high cost for the consumer in attending the face-to-face session. There is strong resistance from practitioners and consumers as it is seen to add an unnecessary burden.

These requirements limit consumers still to accessing health professionals only from their local towns if they cannot afford to travel to see health professionals further away and thus excludes access to professionals in major cities, where more specialised services may be available. Therefore the NMHC recommend these requirements be reconsidered as compulsory components of the initiative, but rather a decision made at the discretion of the clinicians to assume responsibility for establishing a positive therapeutic rapport and utilising face-to-face sessions at the frequency they deem clinically most appropriate.

Affordability

In the 2013-14 Federal Budget, government announced the pausing of indexation of Medicare Benefits Schedule Fees resulting in Medicare rebates failing to increase with Cost Price Index (CPI). As a result, many health professionals were forced to charge/increase co-payments to cover increasing costs of service provision. The freeze has created a further barrier for many people with mental health concerns to access treatment as practice costs increasing with CPI were likely passed on to the consumer.

Combined with the reduction in the number of psychological therapy sessions as mentioned above, this has resulted in limiting access to mental health services due to affordability. As a result, many consumers are unable to afford the ongoing support that they require through the Medicare-subsidised mental health services system, resulting in accessing services less frequently than clinically required, which may result in deterioration of their mental health and the continued over-burdening of the public mental health services.

<u>Recommendation 3:</u> i) The addition of a rural and remote loading for health professionals

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under Medicare-subsidised mental health services, ii) removal of required face-to-face sessions under telemedicine guidelines for rural and remote patients and iii) re-application of indexation to all Medicare-subsidised mental health services.

4. Increased implementation of Stepped Care approaches

While it is true that Medicare-subsidised mental health services engage a range of providers, there are limitations within the scheme in maximising the distribution of services across disciplines. Currently, under the Medicare-subsidised mental health services scheme, the majority of psychotherapy services are offered by psychologists and clinical psychologists. While occupational therapists, social workers, mental health workers and Indigenous Australians' mental health workers can also access the scheme, the vast majority of psychotherapy services are provided by psychologists.

In the 2014 review[vi] the Commission recommended that Medicare-subsidised mental health services be more effectively broadened to other disciplines, such as mental health nurses. Mental health nurses argue for their remuneration under Medicare-subsidised mental health services, given that a range of other professionals, with arguably less specialist training in mental health, are remunerated. For example, mental health nurses holding post-graduate qualifications in mental health are not currently able to access the MBS yet their training may exceed that of a GP delivering focused psychological strategies that are remunerated under the MBS.

For example, the inclusion of mental health nurses in the MBS could enhance opportunities to achieve, a stepped-care model, for example, psychological services delivered by mental health nurses co-located in the general practice for mild to moderate mental health disorders. This kind of intermediate step does not exist currently, due to restrictions placed on the current Mental Health Nurse Incentive Program (MHNIP) program. Mental health nurses could provide an alternative or replace the provision of GP focused psychological strategies and provide a first-line intervention for mild to moderate mental health disorders. It is acknowledged that should mental health nurses be included under the MBS there may be unintended implications for staff movement from tertiary to primary care, however such changes could exist for any discipline, and mental health nurses should not be penalised for this.

In addition, the current Medicare-subsidised mental health services scheme holds GPs as gate keepers, such that people are required to have a GP Mental Health Treatment Plan and

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a new referral following six sessions to access psychological services. However, the role of the GP as gatekeeper has been contested. The Australian Psychological Society (APS) have argued there are well trained allied health professionals, clinical psychologists, psychologists, and appropriately trained occupational therapists and social workers are able to provide thorough assessments and mental health treatment, and conduct their own assessments in their first session already. Therefore, they suggest that the allied health workforce could be better utilised if direct access under Medicare-subsidised mental health services was allowed, noting that all assessments and treatment plans should still be provided to the GP to maintain their co-ordination role.[vii]

Similarly, the Commission made the recommendations in their 2014 review that Medicare-subsidised mental health services be amended to enable the option of a simple referral from a GP to an AHP (as is now possible with psychiatrists and paediatricians), but only on the basis that at the initial session the AHP undertakes an assessment and develops a care plan with the person, which is then provided to the GP for review and endorsement or amendment. These suggestions are additionally in line with reducing excess expenditure, given 29 per cent[viii] of expenditure under Medicare-subsidised mental health services goes to GPs, the majority of which is for conducting Mental Health Treatment Plans and Mental Health Treatment Plan Reviews.

These recommendations, shifting greater responsibility to AHP's and freeing up GPs to maintain an oversight and case management role, will help to encourage the promotion of current clinical practice guidelines and pathways where the prescribing of medications is not a regular first line response to mild and moderate depression and anxiety.

Recommendation 4: Inclusion of mental health nurses under Medicare-subsidised mental health services.

5. Improving the integration of physical health and mental health

The NMHC is committed to improving holistic, person-centred care that includes the physical health of those living with mental ill health. Evidence suggests overall, that people living with mental ill health have poorer physical health, due to a range of factors outlined in our Equally Well Consensus Statement.

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The NMHC believes it is important that the MBS promotes a holistic approach to the needs of individuals, taking into account both their physical health and mental health. This is particularly important given the significant problems of late diagnosis of physical illness and subsequent clinical deterioration of people with a mental illness.

In the context of mental health, this could include management of physical health conditions independent of the person's mental health, as well as management of physical health that in inherently linked to their mental ill health.

An example of this would be Eating Disorders, a mental health disorder that poses significant risk to the physical as well as mental health of the individual. While eating disorders remain low prevalence disorders, they pose the highest mortality rate of all mental health disorders due to high rates of suicide along with the life threatening medical complications experienced within the disorder.[ix] Common medical complications exist with eating disorders including cardiac abnormalities, electrolyte disturbances, osteoporosis and amenorrhea. Due to the potentially life threatening nature of such conditions eating disorders have been singled out to be in high need of an appropriate management plan that is multi-disciplinary, including quality mental health and physical health care. This could involve input from a psychologist, a dietician, a medical practitioner and psychiatrist.

It is the role of the MBS to ensure quality holistic health care is provided, given that when insufficient management is available within the community, consumers are more likely to require an inpatient admission of greater cost to the already over-burdened hospital system.

Recommendation 5: Increased focus on multi-disciplinary management that allows for the treatment of mental health disorders alongside co-occurring physical health conditions.

6. Enhanced inter-disciplinary, consumer and carer collaboration

An additional aspect to ensuring collaborative multidisciplinary care of both the physical as well as the mental health of consumers is the importance of clear communication between health professionals, consumer and carers along with any appropriate additional third parties [for example, school counsellors or National Disability Insurance Scheme (NDIS) planners] that may be involved in their care.

Currently case conferencing is available to GPs and psychiatrists, however, the NMHC recommend the expansion of current MBS item numbers to allow for case conferencing between AHP's, consumers and carers and appropriate third parties with the removal of the restriction around the required presence of a medical professional. This would allow for

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greater coordination and collaboration between all parties involved in the consumer's care. In addition, removal of restricted access would allow for the consumer themselves to request case conferencing between the parties they feel most relevant, providing an appropriate registered MBS provider is present. A common complaint from consumers is the lack of integrated care and poor communication between third parties, health professionals and service providers and the expansion of case conferencing could assist in addressing such limitations.

For example, psychiatrists and psychologists who may be more intensely involved in the consumer's care could case conference with the consumer and/or carer without requiring the GP to be present. In addition, psychologists or psychiatrists may case conference with the consumer and/or carer, their NDIS planner and any additional service providers to ensure additional supports are implemented. The NMHC considers that a more flexible approach to case conferencing will enhance care.

This may consist of an item number, available to all providers, that allows the consumer to request any of the participating Medicare approved health professional providers to initiate a session, with payment linked to the amount of time spent face-to-face or via teleconferencing.

Additionally, to ensure clear communication and support, the NMHC recommends the introduction of an item number for the specific purpose of consultation between health professionals and carers/support people. It is believed that greater collaboration with carers and support people without taking from the treatment of the consumer would be of long-term benefit.

Recommendation 6: The expansion of current Medicare case conferencing item numbers to encourage collaborative multi-disciplinary, consumer and carer communication. The introduction of a Medicare item number for the specific purpose of consultation between health professionals and carers/support people.

7. Access to psychological interventions under the MBS for people older people

Access to mental health care for older people has been raised as an ongoing concern. Increasingly, government attention is being drawn to the aging population in Australia and the numbers of older people who will require Residential Aged Care Facilities (RACFs). Specifically, it is those Australians with poorer physical and mental health that are most likely to be living within these arrangements.[x] The prevalence of clinically significant

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depression in older people living within RACFs is believed to be significantly higher than those living independently within the community, and therefore believed to be a group with poorer mental health. The NMHC highlighted in its 2014 Review that residents in aged care facilities often are poorly diagnosed, treated and supported. Their frailty and comorbidity often masks their mental health conditions, and there are poor incentives for many mental health providers to visit and practice in aged care homes.

The Australian Institute of Health and Welfare's most recent study on depression within aged care indicated 52 per cent of permanent residents of RACFs reported symptoms of depression.[xi] Despite this, access and utilisation of mental health treatments in RACFs is low.

Factors contributing to this include: lack of education among aged care workers on mental health thus impairing their ability to detect mental health conditions, common held beliefs that depression in older people is not treatable, lack of health professionals trained with an aged care specialisation, and lack of access to mental health services in RACFs.[xii] RACFs are currently excluded from Medicare-subsided mental health services as the facilities are asked to cover the cost, but fail to be sufficiently funded to do so.

Further education and training in mental health first aid is required in the aged care sector as well as increased access to mental health services. Given the exclusion of people over the age of 65 in the National Disability Insurance Scheme (NDIS) it is essential that the aging population be offered appropriate supports through other services. Within mental health, Medicare-subsidised mental health services are best placed to meet this need.

The NMHC recommends that Medicare-subsidised mental health services be made available to older Australians living in RACFs. It is important that specific item numbers are developed for aged care, including additional loading for health professionals to travel to consumers where needed, and similarly, multi-disciplinary collaborative care plans that allow for the management of physical and mental health concurrently, given their inherent link within the aging population should be considered.

<u>Recommendation 7:</u> The introduction of Medicare-subsidised mental health services for older Australians, specifically living in residential aged care facilities.

8. The National Disability Insurance Scheme (NDIS)

Finally, the NMHC notes that concerns have been raised surrounding existing gaps between Medicare-subsidised mental health services and the NDIS. Currently, health professionals may be involved in educating consumers on access to the NDIS, completion of access request forms and/or assessments that are currently uncovered under both schemes. There

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are concerns that GPs and psychiatrists and others cannot claim for doing a plan for the NDIS. This can be quite time consuming and is currently not remunerated.

Expanding health professionals' knowledge surrounding the NDIS, eligibility and entitlements for consumers, the application process and ongoing assessments that may be required are activities that require further clarification as to whether they are NDIS and Medicare-subsidised services. The suggested expansion of case conferencing mentioned above may be one avenue to address some of these activities, however, if future collaboration is not achieved then consumers will continue to fall through the gaps and fail to be able to access the supports they are entitled to receive.

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