Orygen
The National Centre of Excellence in Youth Mental Health

Submission

Medicare Benefits Schedule Review Taskforce

7 June 2019

Orygen, The National Centre of Excellence in Youth Mental Health (Orygen) welcomes the opportunity to provide a submission to the Medical Benefits Schedule (MBS) Review Taskforce. Orygen supports the aim of improving how the MBS funds services to be better aligned with contemporary clinical evidence, practice and service delivery to improve health outcomes for young people.

About Orygen

Orygen is the world's leading research and knowledge translation organisation focusing on mental ill-health in young people.

At Orygen, our leadership and staff work to deliver cutting-edge research, policy development, innovative clinical services, and evidence-based training to ensure that there is continuous improvement in the treatments and care provided to young people experiencing mental ill-health.

Introduction

The MBS plays an influential role in Australian health care provision and its review presents an opportunity to rebalance Australia's mental health system to better include early intervention and evidence-based care.

This submission addresses selected recommendations from both the Mental Health Reference Group and Allied Health Reference Group. The submission recognises how these recommendations will improve the MBS as it relates to youth mental health, as well as highlighting opportunities for further clarification, development or reform.

Mental Health Reference Group

Recommendation 1 – Expand the Better Access program to at-risk patients

The Reference Group's recommendation to expand the Better Access program to at-risk patients aligns with Orygen's organisational objective to increase the access and provision of early intervention for young people with emerging symptoms or experiencing mental ill-health. There is significant value in preventing deterioration in mental health for those who experience early,

subdiagnostic symptoms, and for those who have recovered from a previous mental health disorder but remain at-risk of relapse without adequate maintenance of care. Reducing the minimum threshold to access support removes a significant barrier to help-seeking and could enable greater preventative behaviours in the broader community.

Nevertheless, there are a number of considerations that must be taken into account when expanding the criteria for at-risk patients to access medical therapies. These include:

- Defining the "at-risk" category. The definition must be clearly articulated and should not include those who would be better suited to accessing nonmedical interventions, such as supportive or community counselling services provided via alternate funding streams or agencies.
- Considering potential perverse outcomes. There is an existing under-supply of experienced, specialist mental health practitioners in Australia. Expanding the criteria for Better Access to include at-risk patients may result in parts of this workforce reorientating their service provision to treat a majority of lower risk clients.

While Orygen recognises the merit in expanding access to at-risk young people, the focus of MBS reforms should prioritise access to early interventions for those with a diagnosed mental illness and for those presenting with increasing severity through the provision of evidence-based treatments.

Recommendation 2 – Increase the maximum number of sessions per referral

Increasing the maximum number of sessions per referral, from six to 10, is an important step in helping to simplify and streamline access to support. Requiring a second referral to access additional sessions can create a barrier for young people.

Transferring the responsibility for communicating with general practitioners (GPs) to a mental health provider removes this burden for young people and ensures that the referral loop is closed, without the need for young people to repeat their story to multiple service providers.

In addition to items providing access to *more* sessions, there should be items that allow for *longer* consultations. There may be particular indications for the provision of an item number to be used for longer consultations, particularly where the young person may be presenting in crisis, with a deteriorating mental state that requires referral and/or transfer of care to a specialist provider and/or setting, or other presentations that require a more lengthy consultation.

More details are required on how increasing the number of sessions will incorporate team-based treatment, care and integration with community agencies and support systems. The Reference Group should:

- consider requiring a clearly defined central clinical governance structure and an expected minimum level of communication between practitioners. For example, any communication between the GP and mental health practitioner should involve sharing assessment and diagnosis, treatment plan and estimated treatment timeline.
- ensure standardised communication by developing a template that outlines required information. The current quality and standard of communication between providers warrants review.
- stipulate that communication between service providers should occur after the first treatment session, rather than the fourth session, to ensure the referred patient has accessed the referral and the GP is immediately appraised of the proposed treatment plan. As the GP is responsible for the overall provision of clinical care, there should be an

additional check-in point after several sessions to review; the implementation and currency of the original treatment plan and a patient's response to treatment.

- outline how the My Health Record system can be used to manage and coordinate communication between GPs, allied health practitioners and treatment teams, in order to provide more holistic team-based care.
- explore potential enablers to encourage patients, particularly young people, to receive their treatment and health care from one primary health care practitioner; and to strengthen practitioner capacity and confidence to provide holistic care. Many young people speak about using multiple GPs for various health concerns, including their mental, physical and sexual health needs, resulting in practitioners having less awareness of their overall health risks and comorbid conditions.

Recommendation 3 – Introduce a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness

This recommendation aligns with the progression of mental illness outlined in the clinical staging model. The clinical staging model creates more opportunities for practitioners to pre-empt, delay or avert progression from earlier stages of mental ill-health.

The Better Access model is already capable of providing assistance to those with mild symptoms and low-level needs. The recommendation to introduce a tiered system of care would enable appropriate levels of care for young people with moderate levels of mental ill-health and diagnosed disorders. Generally, these young people are too unwell to be provided effective services through the primary mental health system, but are not acutely unwell enough to access state/territory based care. The provision of tiered levels of care will enable better support for this 'missing middle'.

More detail is required on the mechanism through which the need for additional sessions, due to increasing severity, would be assessed and activated. The Reference Group outlines that this should be completed by a GP. However, for patients with severe or complex needs, especially with physical and mental health comorbidities, a GP may not be able to provide the specialist knowledge necessary to develop a holistic treatment plan. The Reference Group should consider whether a practitioner with more advance practice skills, such as a psychiatrist, would be better placed to provide this kind of assessment. The specialist opinion would then inform a GPs continued care provision and decision-making regarding access to a higher tier of care. Orygen recognises that within different workforces there are competing interests over MBS items, but the Reference Group must look at which disciplines can operate effectively, safely and skilfully within the *appropriate scope of practice* necessary to provide the patient with a holistic, evidence-based treatment within a team setting as the key driver in decision-making on this issue.

The Reference Group could better outline how it will guarantee a patient's access to greater team-based care and integrated care models, such as those operating within headspace centres, as part of the expanded 3-tiered system. They should also outline how this recommendation augments the current 'more of the same' available to patients with complex needs.

Simply expanding access to a greater number of sessions will not address the workforce or service shortfalls that currently see this group missing out on the support and care they need. Consideration is also required in how mental health providers deliver clear messaging around the number of sessions patients will be able to access at the start of the referral. This is particularly important for

young people who are inclined to spread out or reserve their available sessions to ensure they have access to services when they need them most.

Recommendation 4 – Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups

Orygen supports the creation of a new working group made up of independent individuals with subject matter expertise who can provide routine in-depth analysis of the risks, issues and opportunities necessary for reviewing MBS items. A skills matrix approach should be applied to the make-up of this group and it should be assured that all members can demonstrate relevant skills and an understanding of the health system, particularly regarding primary care.

The group would primarily be dealing with issues relating to the government's funding and investment in various rebates. Therefore, all members would have to be able to demonstrate relevant skills and an understanding of:

- the nature of the evidence-based clinical interventions to be delivered (and the associated base costs of these)
- an awareness of the scope of practice and regulatory and accreditation frameworks that dictate who can deliver these, and contemporary business practices and models in primary health care
- financial analysis skills.

It is essential that each member of the new working group is independent and does not represent the interests of any particular professional group. The group should also include consumer representation membership, particularly young people with lived experience of mental ill-health.

Recommendation 5 – Reduce the minimum number of participants in group sessions

The recommendation to reduce the minimum number of participants in group sessions may help create safer environments for group therapy, including those facilitated for young people. Young people in these group sessions may be at-risk due to lower representation, for example due to cultural, language, sexuality and other forms of diversity. Reducing requirements on group sizes would also increase the opportunity to provide group sessions in rural and remote areas with a smaller population base.

Simply reducing the number of people required to claim a group session rebate will not deliver value for money. The Reference Group should investigate the feasibility of linking this item to geographical locations or safety of young people to ensure it is being used by practitioners for these reasons. The Reference Group should also further interrogate the evidence to determine what the optimal size of groups are in group based interventions. In some circumstances the reduction of group size may impact on the efficacy of the intervention.

Clarification is required as to whether this item refers to the minimum number of attendees per group, or refers to the minimum number of participants registered to attend the group. This is an important distinction, particularly for services with MBS based funding models that can be negatively impacted by how many participants attend a group session.

Recommendation 7 – Enable family and carers to access therapy

Orygen has interpreted this recommendation to be about the inclusion of support people to inform treatment provision through review of therapeutic progress and outcomes.

A broader definition of support person is required that includes groups such as siblings, partners, housemates and extended family, ensuring those involved in the patient's care are their preferred option. This is especially important for young people for whom a family member and/or carer may not be their preferred or ideal representative. Involving preferred support people in a young person's therapy is seen as a positive option by many young people, and practitioners and service providers recognise the superior outcomes that involvement can provide. Further, the Reference Group should give greater consideration for those young people aged between 14 and 18 years, who have the right to control their health records and health care decisions, but who are not the legal point of contact due to their age. Consideration also needs to be given to young people who have been assessed to be "mature minors". Their right to select preferred support people should be respected, but also outlined in the claim guidelines.

The Reference Group has not identified a maximum number of support people who can be present, nor defined whether the number of participants would effect the rebate payment.

Recommendation 8 – Measure Better Access outcomes

The Reference Group's recommendation to develop standardised, comprehensive outcome measures will better ensure that the Australian Government's investment in mental health results in improved outcomes. However, the Reference Group does not provide a clear explanation of where this information will be stored, how a central information depository will be kept secure, or how it will manage and share access among key stakeholders.

Currently, there is no overarching system to allow this recommendation to be implemented nor guidelines as to how and for what purpose data will be collected and when and by whom this would be accessible. Further, for youth-specific outcomes, there is still no nationally agreed upon standardised age range, with existing data sets measuring 12-18 years, 14-24 years and 18-24 years.

The inclusion of outcome measures in the MBS should be developed within the context of existing policies, practices and databases. If new measures are to be developed, the Reference Group should investigate ways to use existing compulsory reporting mechanisms and databases (i.e. referrals, mental health treatment plans). The new working group or committee identified in recommendation 4 should be consulted in the development and/or implementation of outcome measures in MBS items for mental health services.

Any outcome measures developed and/or implemented must recognise that patient-assessed outcomes can create a potential barrier in therapeutic practice, as these can be an additional burden and take time away from therapy. For young people, outcome evaluation processes should be relevant and include measures they deem beneficial.

Recommendation 9 – Update treatment options

There is an opportunity to expand current treatment options through packages of care to support a more holistic response to an individual's mental health needs. These treatment options should include exercise physiology, dietetics, speech pathology and neuropsychologists (for the purpose of

receiving neurological assessments) to help inform the selection of more targeted treatment approaches for an individual. Implementing packages of care, coordinated by a GP in consultation with specialists, would ensure an appropriate level of care is provided and that treatment is in concordance with available evidence.

In addition to adding therapies with National Health and Medical Research Council Level I and Level II evidence to the list of approved therapies under Better Access; existing therapies on this list should be reviewed for concordance with National Health and Medical Research Council Level I and Level II evidence requirements.

Recommendation 10 – Unlink GP focused psychological strategy (FPS) items from M6 and M7 items

Orygen interprets the intention of this recommendation as being; to increase access to psychological treatment through general practice as an enabler of treatment provision to young people "at-risk" of mental ill-health (Recommendation 1). Access to these MBS items would still be through a Mental Health Treatment Plan (MHTP).

In relation to Recommendation 3, the increase in sessions for young people with an increased severity of mental disorder requires a corresponding increase in treatment specialisation. An increase in the number of sessions available through items 2721–2727 would not provide this level of care and, therefore, does not need to be increased.

As the Reference Group outlines, GPs are well placed to offer lower-intensity interventions for less severe, high-prevalence conditions like depression and anxiety, freeing up other resources to be offered to patients where the potential benefit is much greater. Increased uptake of these items would also enable improved patient access to psychological interventions, where specialist service options are limited, such as in rural and remote areas.

This recommendation highlights an opportunity to further modify MBS items relating to provision of GP services in youth mental health service platforms, such as headspace, to encourage increased GP participation in multidisciplinary, holistic, early intervention care settings.

The Reference Group should take the opportunity to further develop or create additional items that address the current lack of incentives for GPs working with young people with mental health issues, as this creates a significant service gap and puts additional pressure on the existing workforce.

Recommendation 11 – Encourage coordinated support for patients with chronic illness and patients with mental illness

Mental ill-health can be comorbid with chronic physical illness. The recommendation is concerned with the interaction of GP Management Plans (GPMPs) and MHTPs to remove the risk of duplication or the inclusion of mental health care taking up sessions for physical health care under a GPMP.

The larger issue is how to coordinate communication between specialists to enable a treatment plan that takes into account all perspectives and options. Case conferences are intended to enable communication between health practitioners to ensure patient's multidisciplinary care needs are met through a planned and coordinated approach. However, current MBS items only provide a rebate to medical practitioners coordinating a conference.

Current MBS items also only provide a rebate for coordination, not for participation. Other participating health practitioners cannot claim payment for time spent preparing for and

participating in a case conference. This is a barrier to participation for private providers and can mean the requisite three health practitioners is not achieved, voiding the coordination rebate claim. MBS items for case conferencing need to be reviewed to better enable communication between specialists to ensure treatment through a GPMP and/or MHTP is coordinated.

Recommendation 12 – Promote the use of digital mental health and other low-intensity treatment options

The rationale provided for promoting the use of digital mental health and other low-intensity treatment options were cost-effectiveness and access advantages, with the conclusion that 'effective digital solutions exist'. The recommendation groups together digital mental health and low-intensity treatment. The two need to be considered separately as the respective evidence-bases differ.

While there has been a rapid expansion in digital mental health treatment options, there has not been a matching expansion in available evidence. The evaluation of digital treatment options and development of an evidence-base is a more involved process. Digital technologies have the potential to drive a revolution in mental health care by enhancing the accessibility, impact and cost-effectiveness of youth mental health services, but implementation and delivery must be evidence-based. The development of evidence-informed guidelines and an ongoing process of reviewing emerging options is required before digital mental health treatment options can be promoted.

The evidence-base for low-intensity treatment options is more advanced. Where effectiveness is proven brief, low-intensity treatment options can be promoted.

Recommendation 13 – Support access to mental health services in residential aged care

The Australian Government acknowledges that a small number of young people with a disability who have high or complex health needs reside in residential aged care due to a lack of suitable housing. While the government has an action plan to address this issue, it is important that these young people have access to appropriate mental health services.

The recommendations for supporting access to mental health services in residential aged care should be equally applied in all forms of supported accommodation.

A lived experience of mental ill-health can make an individual aware of others mental health needs and many young people support increased access to mental health services for residential aged care. Providing young people, who may have grandparents and other relatives in aged care, with an assurance that they too will have access to mental health care, is important.

Recommendation 14 – Increase access to telehealth services

Orygen supports the Reference Group's recommendation for a review into the recently announced expansion of mental health telehealth services in rural and remote areas.

This review should assess whether the expansion has delivered intended outcomes, as well as highlight how it plans on addressing barriers to accessing telehealth services. These barriers include: practical infrastructure solutions and connectivity issues, training opportunities to develop their capacity to use new and emerging telehealth technologies, and more support to integrate telehealth with existing community services.

Barriers to access exist for young people in urban centres as well. For example, service availability, transport options and time requirements can be barriers to access for young people living in under serviced suburbs and in growth corridors. Service choice should not be a privilege based on where a person lives or the service they can afford.

Preferences for treatment delivery is also an issue in evaluating policies to increase access to telehealth services. The acceptance and response to face-to-face and telehealth therapy by young people will vary, necessitating that both options must be available. Many telehealth services cost consumers the same as a traditional face-to-face services, which some feel does not represent value for money.

The appropriateness of telehealth for different stages of treatment also needs to be considered within the review. The original telehealth policy required a minimum number of face-to-face appointments and stipulated when they needed to be implemented. This approach recognised the benefits of face-to-face delivery for (1) establishing a therapeutic relationship, and (2) clinical assessments.

There is an opportunity for the review to explore additional options for providing mental health services to those in rural and remote regions, particularly young people. These include increasing access to mobile clinics, delivering training and formal opportunities to develop skills and competencies in mental health and crisis support to build capacity at a local level, and better incentivising of mental health providers to deliver services in these areas.

Finally, telehealth supports must be relevant and culturally responsive, in order to facilitate rapport in patient-practitioner relationships. A requirement that patients and practitioners meet in person, at a minimum biannually, would assist this rapport building and may increase both access and acceptability of telehealth.

Allied Health Reference Group

Recommendations from the Allied Health Reference Group amend existing items and create new items with the intention of ensuring the MBS aligns with current clinical guidelines. Not all recommendations pertain to mental health disorders or professional disciplines and have not been addressed.

Recommendation 1 – Introduce initial assessment appointments of more than 40 minutes for allied health professionals

Orygen supports the introduction of a minimum 40 minutes initial assessment appointment under a GPMP. This recommendation recognises the need for allied health professionals to undertake initial assessments and the time required to conduct these.

GPMP assessment conclusions should be communicated with other specialists and the referring medical practitioner to enable a team-based approach and treatment coordination.

In addition to providing sufficient time to adequately assess a patient's therapeutic needs, this length of time enables a practitioner to begin developing patient-practitioner rapport.

Recommendation 2 – Increase the number of allied health appointments under team care arrangements (TCAs; item 721 and 723) by stratifying patients to identify those with more complex care requirements

The current level of access to only five MBS-funded allied health appointments is often insufficient for young people with chronic, and often comorbid, conditions. By increasing the number of allied health appointments available under team care arrangements, the Reference Group recognises that a young person will often benefit from treatment support in multiple domains. For example, dietetics and exercise physiology strongly support psychological therapy for young people.

Removing the need to choose one treatment type over another will optimise care design for a young person and reduce any potential for stress and confusion often involved in making this choice.

Recommendation 5 – Conduct a systematic review of the evidence for group allied health interventions to inform future models of care

Evidence-based treatment is a fundamental foundation for providing optimal health care. As a research and service provider, Orygen understands the value of evidence-based mental health care. Orygen suggests this recommendation should also include funding for the development of professional guidelines and a strategic implementation plan to enable the widest uptake of evidence-based practice.

Orygen would like to see young people experiencing mental ill-health included in the list of cohorts identified by the Allied Health Reference Group that would benefit from group interventions (e.g. exercise physiology) under the MBS item M9 (Allied Health Group Services).

Recommendation 9 – Improve access to M10 treatment items as group therapy

Orygen supports the inclusion of MBS items that specifically provide additional access and support to children and young people with significant mental health needs, such as Autism Spectrum Disorder.

Recommendation 11 – Improve access to the ASD and eligible disability assessment to people under 25

Orygen supports the inclusion of a recommendation to provide children and young people with greater access and support by increasing the age limits on the outlined items.

Recommendation 13 – Support the codifying of allied health research and evidence

Orygen supports research to enhance the available evidence-base for allied health treatments for young people.

Recommendation 15 – Pilot non-fee-for-service allied health payment models

The piloting of non-fee-for-service allied health payment models should be as part of a package of care that considers a young person's mental, physical and sexual health. Any pilot should include a trail site in a cluster of headspace centres. A cluster approach would ensure sufficient volume and enable allocation of resources as required.

A pilot non-fee-for-service allied health payment models should require:

- delivery of evidence-based treatment in concordance with available evidence and treatment fidelity
- a GP referral to enable coordination of care and assessment of health outcomes
- a team-based approach to enable the potential of a package of care to be realised.

Alternatives to fee-for-service models of service delivery are justified in the delivery of mental health services for young people. There is an ongoing concern that reliance on a fee-for-service model promotes 'high-volume' work over 'high-quality' work. Furthermore, there are instances when the time required to provide mental health care for young people exceeds that which can be viably funded through MBS rebates.

Recommendation 16 – Enhance communication between patients, allied health professionals and general practitioners (GPs)

Orygen supports the Reference Group's recommendation on enhancing communication between patients, allied health professionals and GPs. This is particularly important for young people, who are often navigating the system for the first time and require enhanced support and guidance as they access treatment and services.

Improved communication will enable greater person-centred care and ensure that sufficient information is shared between a young person's referring GP and the subsequent allied health practitioner. Being able to receive congruent and accurate information from all providers, regarding what they can expect from treatment, estimated time commitment and relevant costs involved, can help young people feel more informed and empowered about their treatment. This will also reduce the burden that can often be placed on the young person to repeat their story and experiences, which they find time-consuming and seemingly unnecessary with the increasing interconnectivity that platforms like My Health Record offer to service providers.

Contact details

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