



Primary Care Reference Groups Consultation - Medicare Benefits Schedule (MBS) Review

Beyond Blue's response to the Report from the Mental Health Reference Group to the Medicare Benefits Schedule Review Taskforce

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Summary of our submission

Beyond Blue welcomes the opportunity to respond to the *Report from the Mental Health Reference Group* of the Medicare Benefits Schedule (MBS) Review ('the Report'). We congratulate the Reference Group on their work and Report.

The first point we make is that the introduction of mental health items on the MBS was world-leading. Australia is envied the world over for a scheme that provides universal access to subsidised psychological services and that places GPs at the heart of mental health care. Every day the mental health and lives of people and families in Australia are improved because of their access to Better Access and other MBS items that support treatment of and recovery from mental health conditions. Every day skilled and committed mental health professionals – from psychiatrists to psychologists, social workers and occupational therapists – support people back to better mental health and prevent suicide.

As numerous studies and national data have shown, the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* ('Better Access') initiative has significantly increased utilisation of psychological services and treatment. This is a significant achievement and Australia's MBS has made this possible: a policy approach, structure and funding mechanism – linked to professional training and calibrated by various policy and funding incentives – that achieved an increase in the estimated population treatment rate from 37 per cent to 46 per cent in its first three years.¹

However, more than a decade later, numerous studies and data also show that:

- costs have far exceeded projections, with some arguing that funding should be redistributed or balanced with other investments. We should remember this was hardly surprising given Better Access is a universal access, demand-driven scheme with essentially a capped budget allocation.
- there is no unequivocal evidence that Better Access has improved the psychological health of Australians – at a population level or at an individual level. This is not to say that improvements have not occurred; rather that readily available outcomes data is not available^{2,3}
- inherently, the current design of the MBS – while unquestionably enabling high volume access at scale – cannot and will never be able to address issues of equity and distribution of access nor in itself facilitate integrated treatment and support for people; and
- it is provider-led, rather than being person-led, which is a key tenet of national mental health policy.

In a sense Better Access has become a big target because of its very success, in a reality where big dollars stand out and attract commentary and criticism in comparison to other under-resourced or missing parts of the system.

Despite bipartisanship and significant political, sector and community attention, goodwill and effort, increased investment and several national strategies and plans, as a nation we are yet to successfully plan, implement and continuously measure a truly balanced mental health system for the long term. Such a system would be funded for the long term, using a social determinants, person-centred, integrated stepped care approach – from promotion, prevention and early intervention to treatment, services and support embedded in the community, to acute and crisis support and interventions.

We are optimistic the current Productivity Inquiry into Mental Health will build on the findings and recommendations of other reviews and inquiries, including *Contributing Lives, Thriving Communities*, the National Mental Health Commission's 2014 review of Australia's mental health programmes and services and make structural recommendations that are implemented over time.⁴

The comments and recommendations we make in this submission are made in this broader context. Our response takes the approach that addressing the existing weaknesses in the MBS requires action both within and outside it. We make five recommendations for priority action, each of which respond to the recommendations proposed by the Reference Group and envisage the broader structural changes needed to get the best outcome. Our recommendations have been informed by the views of our Blue Voices community of people who have lived experience of depression, anxiety and/or suicide, interviews with 30 other expert stakeholders, and academic literature reviews undertaken by the Sax Institute.

In summary, our response to the Report is:

1. We can't build the integrated mental health system our population needs through a single policy mechanism alone

- The combined effect of the recommendations to expand Better Access have been estimated to cost up to \$2 billion, based on a 30 per cent increase in demand, over four years.⁵ As a demand-driven program, expenditure under Better Access exceeded its expected budget by three fold in the first five years.⁶ Any changes should be realistically costed and considered in a broader 'balance of new investment' approach.

Most of the population affected by poor mental health would benefit from low intensity supports and services

- Reform of the mental health system needs to be planned to deliver an increase in the supply of a range of affordable and accessible services and supports tailored to population needs and distribution.
- Most mental health issues can be dealt with effectively if the right supports are received early. Ninety-seven per cent of the population are either mentally well (60 per cent), at risk of poor mental health/mental illness (23 per cent) or experience mild to moderate symptoms of a mental health condition (14 per cent).⁷
- Low intensity non-clinical ('LINC') services are proven to be effective in addressing earlier the impacts and recovery from mild to moderate mental ill health,⁸ yet most of this part of the stepped care service system is yet to be recognised and built.
- LINC services deliver highly accessible, safe, evidence-based, Cognitive Behavioural Therapy, through a non-clinical workforce (with clinical oversight and supervision); can be designed to produce real-time outcomes data; overcome workforce supply and distribution challenges; and can be effectively delivered by phone, using Skype or face to face.

At a population level, Better Access is inequitable in its distribution

- Better Access generally favours people in major cities, where the majority of private practitioners work, and those who can pay out of pocket costs. Those who can access face-to-face treatment receive good psychological care, while those with fewer options, due to cost or geography, miss out.⁹
- At present, mental health-related prescriptions and fee-for-service consultations make up the bulk of the mental health system.¹⁰ It has been argued this has led to 'over-medicalising' of some consumers and underservicing of others.¹¹
- Simply expanding clinical access will also not overcome the gender and cultural imbalances perpetuated by fee for service mental health care.

Visibility of outcomes for funders and the community

- The Government has no systematic mechanisms to ascertain whether its substantial and uncapped financial investment in the MBS is having any effect on the prevalence of mental ill health in Australia.
- Under Better Access, demand driven funding is channelled through mental health treatment plans ('MHTPs') into the individual therapy room, without any consistent way of determining if and what works.
- The absence of reliably collected and stored pre- and post- outcome data stymies the ability to monitor the effectiveness of psychological interventions and the effectiveness of investment.
- Where outcomes are not consistently measured and readily available, people may not know if they are getting better.

Holistic support for people with complex mental ill health

- Around a third of people in Australia living with severe and persistent mental illness also need some sort of psychosocial support to deal with chronic physical comorbidities and/or non-physical complications and social and environmental factors.¹² This can include substance abuse, homelessness and unemployment.

- Fragmentation in care, role confusion and duplication, and lack of incentives for multidisciplinary care are especially problematic for people with complex mental health issues, who often have to navigate multiple agencies without continuity in approach or represent the ‘missing middle’.¹³
- Enabling people to coordinate their MBS subsidised services for physical and mental health – by linking general practitioner management plans (GPMPs) and MHTPs – is a start, but it does not provide holistic care that accounts for the social determinants of severe mental ill health.

2. To meet the mental health needs of the population, we need system-level change, with reforms designed to connect services and rolled out concurrently:

Build the low intensity system

- Building the LINC service system, while addressing current equity issues in access to MBS-funded clinical services, would be an effective and efficient way to undertake early intervention at scale for those at risk of mental disorder. The Report defines those at risk as either:

*(i) those with early, sub-syndromal symptoms of the disorders referenced above, who have a high likelihood of developing such a disorder in the next 12 months without timely and appropriate treatment; or (ii) those who have recovered from a previously diagnosed disorder as referenced above and require treatment to maintain their mental health and prevent relapse.*¹⁴
- The task of building a LINC service system could be catalysed through a national plan to establish the architecture needed to underpin the LINC workforce, the sector and outcomes measurement, supported by clear funding mechanisms.

Fix the design flaws in Better Access to address outcome measurement, inequity and fragmentation

- To improve consistency in measurement, we need robust pre- and post-outcome data, stored in a reliable repository, such as a minimum dataset.
- To improve equity, we need a national strategy that focuses on generating uptake of services in disadvantaged areas, rural and regional locations, and amongst hard to reach groups with less mental health literacy.
- To achieve less fragmentation, we need GPs and multidisciplinary teams to be the all-important ‘medical homes’ for people with complex needs, where case management, triaging and patient records can be centralised and coordinated.¹⁵

Expand access and improve visibility of outcomes in key ways the Report suggests

The Mental Health Reference Group makes 14 recommendations. We make comment on several below.

Report recommendation 1: Expand the Better Access Program to at-risk patients

We support strongly the need to restructure the system and rebalance/recalibrate investment to match population needs, from keeping people mentally healthy; to intervening early to support those at risk of mental ill health from deteriorating to the point they need more specialised services and supports; to providing adequate clinical treatment and psychosocial supports to those living with mental ill health, especially severely affected and who have complex needs. However, we believe proper reform of the mental health system needs to be planned in an holistic way to deliver an increase in the supply of a range of affordable and accessible services and supports tailored to population needs and distribution.

As such, we do not believe that the MBS as currently designed is the best or the only mechanism to provide earlier intervention and person-centred support for people who are at risk of developing a mental health condition. We strongly urge consideration of LINC service models that use new, local workforces, harness technology and have been designed to produce measurable and visible recovery outcomes for funders and people.

In any case, any changes should be realistically costed and considered in a broader 'balance of new investment' approach which plans and sequences the structural and financial changes necessary to match population needs. These choices are hard and complex, but necessary.

Report recommendations 2 and 3: Increase the maximum number of sessions per referral; Introduce a tiered system for access to Better Access sessions for patients with a diagnosed mental illness

We support the recommendation that the number of sessions available under a Better Access MHTP should be increased to match the clinical needs of the person and their diagnosis and functional needs, including the introduction of tiered packages. This has already happened for eating disorders; and would be a much-needed improvement in supporting the needs of people who live with other more severe and complex conditions such as borderline personality disorder and chronic depression.

We also agree that the referring practitioner should exercise discretion in setting the number of sessions in a treatment course in the referral and that this should be done in discussion with the person and the receiving provider.

Reviews of session numbers are needed but also need to add value to everyone, including the taxpayer. We also believe that the current design of Better Access, specifically the lack of real-time outcomes data, will make the intended improvements of these recommendations difficult to genuinely achieve.

Report recommendation 8: Measure Better Access outcomes

We believe this recommendation is the most important and should be prioritised, for the reasons outlined above. We support strongly the Reference Group's recommendation to introduce consistent, comprehensive and carefully implemented outcomes measurement and monitoring.

We support the remaining recommendations, acknowledging the extensive review work and expertise of the Reference Group. The implementation design of responses to the recommended changes will be absolutely critical to success.

In particular, we note the value of:

- **Report recommendation 7: Enable family and carers to access therapy.** Families and other support people have repeatedly raised the need for information – with the appropriate checks and balances as outlined in the Report – to assist them in their support roles and to protect their own mental health and wellbeing. This recommendation would enhance collaboration, increase engagement and recognise the valuable contribution of carers/support people.
- **Report recommendation 11: Encourage coordinated support for patients with chronic illness and patients with mental illness.** Taking into account the well-established link between physical and mental health, this recommendation focuses on ensuring flexible access to and coordinated care for people with chronic health conditions. However, it misses the opportunity to expand coordinated approaches to treatment and address a wider set of contributors to adverse physical and mental health conditions.
- **Report recommendation 13: Support access to mental health services in residential aged care.** We need to continue to monitor the new mental health funding to residents of aged care facilities, but also act to ensure people in residential aged care facilities receive mental health screening and access to MBS services.

Summary: recommendations for improving mental health outcomes through the Medicare Benefits Schedule

1. Build early intervention both within and beyond the MBS	2. Make Better Access more accountable	3. Coordinate care for complex mental health issues	4. Improve equity of access
<p>Build – outside the MBS – the LINC service system Australia needs to support a genuine stepped care model of mental health care. This could include developing a national strategy, investing in the necessary infrastructure to scale up the most promising services that produce measurable outcomes</p>	<p>Prioritise the collection of pre- and post- treatment outcomes data to ensure visibility of impact and effectiveness for Government and the community (recommendation 8 of the Report)</p>	<p>Create the mechanism proposed under recommendation 11 of the Report as a priority, <u>and</u> include a capacity to coordinate access to treatments and services for non-physical comorbidities (such as alcohol and drug addiction, homelessness and unemployment services)</p>	<p>Establish and invest in the roll out of a strategy to improve equity of access, which could include loadings or other financial incentives for MBS items that deliver services to patients in low SES postcodes, and in regional and rural areas</p>
<p>Introduce early intervention into the MBS via complementary mechanisms that 1) enable ‘at-risk’ people to access a mental health treatment plan, 2) require GPs and clinicians to utilise LINC as part of a stepped care approach</p>	<p>Establish a national minimum dataset for GPs and mental health professionals, similar to those that operate in other parts of the health system, to track outcomes, progress and uncover what works</p>	<p>Support a system of ‘medical homes’ – coordinated care that wraps around services – for people with complex and severe mental health issues and link it to psychosocial support</p>	<p>Scale up across the country LINC services, which are effective in improving mental health literacy, help-seeking and outcomes for harder to reach groups</p>
<p>5. While we believe the above should be a priority, we also support other reforms recommended by the Mental Health Reference Group:</p>			
<ul style="list-style-type: none"> • Increase the number of MBS sessions available under a single referral to 10, at the discretion of the referring practitioner (recommendation 2 of the Report) but ensure the referred number of sessions is the result of an assessment of need and discussion with the person and the provider. A system of assessment and review that provides oversight of treatment outcomes is essential. • Introduce three tiers of sessions available under a MHTP, for people with a diagnosed mental health condition (recommendation 3 of the Report). Ensure the tier is the result of an assessment of need and discussion with the person and the provider. A system of assessment and review that provides oversight of treatment outcomes is essential. • Enable family and carers to access subsidised therapy services under the MBS (recommendation 7 of the Report). • Monitor new mental health funding for people in residential aged care facilities (recommendation 13 of the Report) but take action to ensure they receive mental health screening and access to MBS services as a matter of priority. 			

Recommendation 1: Build low intensity early intervention pathways within and beyond the MBS

The Commonwealth Government should take immediate steps to develop prevention and early intervention mechanisms in Australia’s mental health system. It should:

- 1. Build – outside the MBS – the LINC service system needed to realise a genuine stepped care model of mental health, by**
 - committing to, and funding, the development of a National Strategy to support the continued growth and maturation of early intervention supports that underpin the stepped model of care, and
 - funding a national expansion of proven early intervention services, to ensure that many more Australians at-risk or with mild to moderate mental health conditions have access to services, without the need for a referral or out of pocket costs.
- 2. Enable the MBS to deliver early intervention, by**
 - introducing the mechanism recommended by the Reference Group for enabling patients deemed ‘at-risk’ to access MHTPs (recommendation 1 of the Report), and
 - requiring GPs and clinicians to utilise LINC referral as part of a stepped care approach. This could be achieved by inserting into the MHTP item descriptor, a requirement that GPs refer ‘at-risk’ patients to appropriate LINC solutions before referring them to clinical sessions.

Beyond Blue commends the Reference Group for seeking to expand Better Access to a large new cohort considered ‘at-risk’ of developing a mental health condition (recommendation 1 of the Report). However, undertaking early intervention through the MBS alone is likely to increase the level of service to the same population rather than dealing with the existing problems in Better Access: its outcome blindness, maldistribution, and lack of nuance to deliver stepped care. **An alternative is to concurrently build up the LINC service system** – such as digital support, coaching and self-guided interventions – with complementary workforces that enable GPs to refer to more early step options in a stepped care approach to early intervention. Broadening clinical access while also developing the low intensity system architecture is our best chance at achieving effective and sustainable early intervention for improving mental health outcomes at a population level across Australia.

The case for action

1. Low intensity prevention and early intervention services are what the great majority of our population needs to protect their mental health.

- Ninety-seven per cent of the population are either mentally well (60 per cent), at risk (23 per cent) or have a mild to moderate mental health condition (14 per cent) – see Figure 1.¹⁶

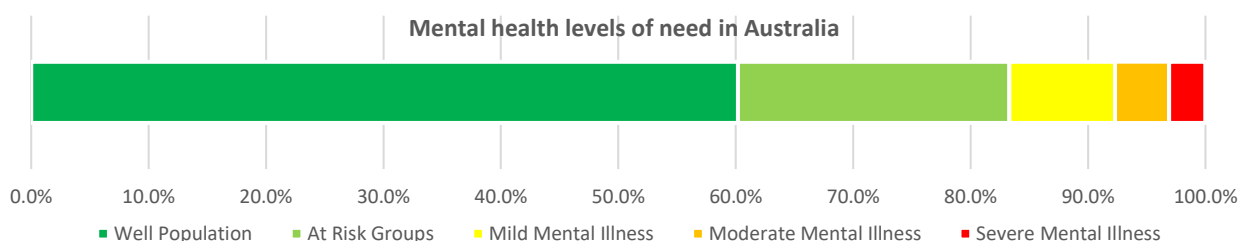


Figure 1: At risk, mild and moderate mental health conditions represent the vast majority of need

- The support they need is low intensity prevention and early intervention, as detailed in the stepped care model being promoted by Primary Health Networks. Services consistent with the UK National Institute for Health and Care Excellence (NICE) Guidelines,¹⁷ such as coaching, digital support and self-guided interventions, can match the level and complexity of needs with the right service type and level.

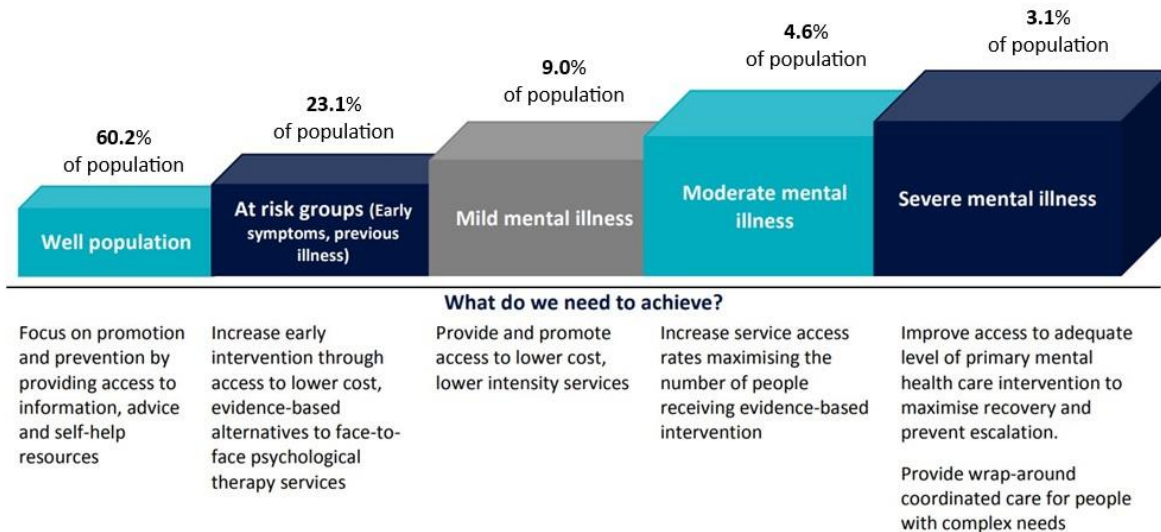


Figure 2: The stepped care model¹⁸

2. Most mental health issues can be dealt with effectively if the right supports are received early.

- Prevention initiatives can help the well population and those at risk to avoid mental health conditions and assist people with conditions to recover.
- Early intervention services can also make a huge difference in mental health. Many people never seek treatment or spend years suffering before they do. For those at risk or with mild to moderate conditions, early intervention can often help people to restore good mental health relatively quickly.

3. Most of the LINC system we need is yet to be built.

- The merits of LINC services filling gaps in the mental health system were acknowledged long ago. The National Mental Health Commission's landmark 2014 review of mental health programs and services¹⁹ found that not only is our mental health system disjointed, but some essential parts of the system are just beginning. The Commission noted that most funding goes to high cost acute care after people have developed severe conditions, rather than providing prevention and early intervention through stepped care, including LINC supports. The primary mechanism for overcoming this was to establish a stepped care model, facilitated by primary care.
- Five years on, data from the Australian Institute of Health and Welfare shows that mental health prescriptions and fee-for-service consultations make up the bulk of the mental health system (Figure 3).

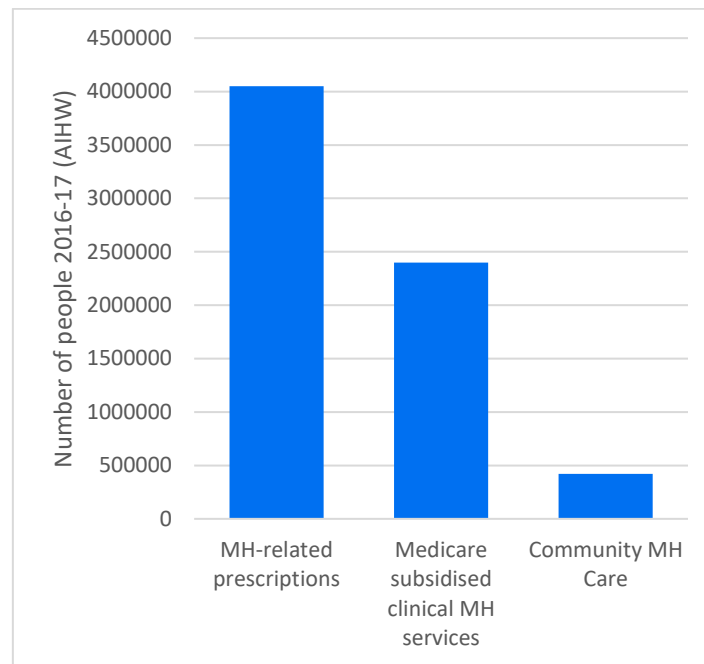


Figure 3: Top mental health services in Australia 2016-17.²⁰

4. LINC services are proven to be effective.

- The UK NICE Guidelines recommends low-intensity interventions as a first-line treatment for people with mild/moderate mental health conditions. The Improving Access to Psychological Therapies (IAPT) program in England currently treats over 560,000 people a year, with 48 per cent of people receiving LINC cognitive behavioural therapy.
- An evidence review check commissioned by Beyond Blue in 2018 revealed that internet and mobile-app delivered interventions were effective for managing mild to moderate depression and anxiety.²¹
- New Access, an early intervention CBT coaching service developed by Beyond Blue and now in 17 sites around Australia (commissioned by PHNs under free licence by Beyond Blue and delivered by local service providers), is producing sustained, promising results. Data shows significant improvements in post intervention scores compared to preintervention, with almost 70 per cent surpassing the threshold for clinical recovery, after just six sessions.²²
- Evidence-based LINC services have in-built safeguards that ensure people with more severe mental illnesses are promptly identified and referred into appropriate care. For example, under New Access, a clinical supervisor evaluates every person's assessment for risk and refers to higher intensity services if needed. People can be stepped up into these services at any stage thereafter. Coaches receive weekly supervision and supervisors are on-call during service hours.

5. LINC provides the affordable and cost effective care our mental health system lacks.

- A community survey undertaken by Beyond Blue indicated that many people still struggle to access services or find their cost prohibitive. Our mental health system needs a plan for structural change to match the supply of affordable services and supports tailored to population needs, that embrace new workforces and new ways of working.
- Neither goal can be achieved by simply expanding access to one part of the system, such as the MBS.

6. Expanding access to clinical MBS services while building the LINC service system is the only effective and efficient way of undertaking early intervention.

- Modelling suggests the combined effect of the recommendations to expand Better Access could cost the budget up to \$2 billion, based on a 30 per cent increase in demand over four years.²³ This additional demand would increase the already high and increasing expense of the program, which exceeded its budget by three fold in the first five years.²⁴ A small fraction of the budget allocated to meet the

demand driven costs of the MBS could be devoted to scaling up LINC services that are proven to be effective and that demonstrate measurable outcomes (see Appendix 1).

- A combined approach would begin to rectify the design flaws in the MBS. It is both feasible and necessary to ensure the scheme provides access to services across the spectrum of mental health, rather than the one-size-fits-all approach that favours some at the expense of others.
- For example, expanding clinical access alone would do nothing to rectify the gender imbalance that has resulted over twelve years of Better Access. Men attend their GP in high numbers, yet represent just 40 per cent of consumers of MBS mental health services.^{25,26}
- GPs will be critical in facilitating early intervention under the MBS, but also need an evolved and valued LINC system to support their efforts. When faced with a person experiencing mental ill-health, GPs currently have very few options other than to prescribe medication, admit to hospital or refer to Better Access. In developing the stepped care model, the National Mental Health Commission envisaged a central role for primary care. It recommended GPs be actively encouraged to limit access to face-to-face psychological services to those for whom a self-help or LINC service are not clinically appropriate.²⁷ Without a range of proven and accessible services to refer to, GPs cannot use a stepped care approach.
- A system of LINC supports would enable GPs to undertake equitable and cost-effective early intervention, as opposed to perpetuating the limitations of the MBS on a new patient population.
- Digital solutions that are flexible, cost effective and person-driven should be embraced within Better Access. GPs can and should be incentivised to refer into online services that can be guided or self-administered, such as Mindspot (see Appendix 1).
- Before that can occur effectively, however, the Government needs to develop and support a system of services into which clinicians can refer, as a form of consistent and effective early intervention.

7. A national strategy and a mechanism to fund promising LINC services are needed now

- The task of building a LINC service system could be catalysed through a national strategy to build the architecture needed to underpin the sector, underpinned by clear funding mechanisms. As with any nascent sector, there are structural impediments that must be addressed if the LINC sector is to grow to provide comprehensive and effective support for people. For instance:
 - **Consumer awareness and trust:** Awareness of emerging new models of early intervention services is limited. Many people either simply aren't aware of services that could help them, or don't know whether they can trust what's on offer.
 - **Inability to 'go national':** PHNs play a seminal role, but their funding (an average of around \$12 million a year) – does not enable investment in the national infrastructure, including workforce development and training, that will enable true scale, economies of scale and local and regional implementation.
 - **Integration and referrals from the clinical system:** Some clinicians lack awareness of low intensity services, or are slow to recognise their utility, so do not refer patients to alternative services that could meet their needs.
 - **Demand and cost-effectiveness:** The above factors challenge the ability for LINC services to be widely and effectively promoted, and demand for services is lower than it would otherwise be. Without economies of scale and with services being used at lower than full capacity, unit costs are higher than they could be.
 - **A national workforce, with career structures, and structured education and training pathways:** The workforce to underpin this sector is still emerging. The structured education and training pathways and career structures that would build a new, large, high quality workforce to run the low intensity system are yet to be built.
 - **Accreditation of services:** While work has commenced on accreditation, a system of accreditation that would give consumers and clinicians confidence in the effectiveness of particular services, appears to be years away from being established.
- Consideration could be given to funding effective services to achieve national reach through contractual arrangements with providers. Additionally, requiring GPs to refer 'at-risk' patients to LINC services as a first step, where appropriate, would support the development of the LINC sector by enabling effective services to receive demand driven funding.

Recommendation 2: Make Better Access more accountable

The Commonwealth Government should:

- **Prioritise the collection of pre- and post- treatment outcomes data** to ensure visibility of impact and effectiveness for Government and the community (recommendation 8 of the Report)
- **Establish a national minimum dataset for GPs and mental health professionals**, similar to those that operate in other parts of the health system, to track outcomes, progress and uncover what works.

Beyond Blue commends the Reference Group for recommending outcome measures be built into the MBS so that the MBS provides for consistent, comprehensive, carefully implemented and flexible measurement of Better Access services (recommendation 8). While this is a good starting point, it should go further. We need to ensure measurement is consistent, which will only be enabled by the collection of robust pre- and post-outcome data, stored in a reliable repository, both hallmarks of Better Outcomes. This could be achieved by requiring or incentivising GPs to enforce the review consultation component of the MHTP descriptor, and by establishing a specialist minimum dataset into which the assessment data can be stored and analysed.

The case for bolder mechanisms of accountability within the MBS

- Under Better Access, demand driven funding is channelled through MHTPs into the individual therapy room, without any consistent way of determining if and what works. An evaluation was unable to conclude with certainty whether Better Access had increased treatment rates of people with mental disorders.²⁸
- More consistent outcome measurement would enable people to know whether the treatment they are often in part paying for, and investing themselves in, is working.
- The Reference Group identified two reasons for inconsistency in outcomes measurement in the MBS: *“inadequate infrastructure to develop and implement quality measures and the lack of a cohesive strategy to apply mental health quality measurement across different settings”*.²⁹ These issues could be resolved by ensuring that the existing review mechanisms built into MHTPs are utilised, and building a central repository for outcome data.
- Though the Reference Group notes that many clinicians carry out patient assessments, the lack of review consultations undermines the ability to track progress before and after the MHTP is issued. In analysis of MBS item data, it was found that for every MHTP written in 2016-17, just 37 per cent were reviewed.³⁰
- Under Better Outcomes, GPs who referred to Access to Allied Psychological Services (ATAPS) were required to administer psychological assessment, such as the Kessler Psychological Distress Scale 10 (‘K10’), at the initial review and at the final review. The pre-and post-outcome data was stored in minimum data sets maintained by (then) Divisions of General Practice that allowed for efficient and broad outcome measurement.
- Pre-and post-outcome data enables objective and systematic measurement. For instance, an evaluation of pre-and post-outcome data showed 86 per cent of patients treated through ATAPS had a medium to large improvement in symptoms, compared to control.³¹ The measurement data was aggregated from a range of instruments, suggesting it is the pre-and post- collection that is a more important factor for consistent measurement than achieving uniform assessment techniques.

Recommendation 3: Coordinate care for complex mental health issues

The Commonwealth Government should:

- **Create the mechanism recommended by the Reference Group for coordinated access to MBS services for people with chronic illness and mental health issues (recommendation 11 of the Report), as an immediate priority. Included in the mechanism should be a capacity to coordinate treatments and services for non-physical comorbidities (such as alcohol and drug addiction, homelessness and unemployment services).**
- **Develop a national strategy to deliver coordinated care for people with severe and complex mental health issues, which builds off evidence from the existing work being undertaken into ‘medical homes’, which ensure case management and treatment is coordinated through GPs or multidisciplinary teams, combining mental health, physical health and other non-physical comorbidities.**

Coordination of treatment plans provides an opportunity to develop better wrap-around care for people with complex mental health conditions, whose ability to navigate our complex service system is exacerbated by physical or non-physical comorbidities. However, the mechanism should be broader in its application and aspiration: it should extend to treatment for non-physical comorbidities, like addiction, unemployment and homelessness, and include incentives to build multidisciplinary teams that can serve as ‘medical homes’, places where treatment is centralised and coordinated.

The case for coordinating treatment for complex mental health and *all* comorbidities

1. Genuine coordination must go beyond physical comorbidities

- The interaction between physical health and mental health has been long established, yet they are often treated in isolation. For people with severe mental health issues – who typically experience higher rates of medical comorbidity^{32,33} – having one component of their problem addressed while other elements are neglected can reduce the impact of any treatment provided³⁴ and be potentially life threatening.
- For instance, around 30 per cent of the 690,000 Australians living with severe mental illness in 2014 also had chronic illness, with most needing some sort of social support, ranging from low intensity or group-based activities through to extensive disability support.³⁵ Without treatment for all aspects of a person’s health, we will continue to perpetuate a fragmented mental health system.
- Severe mental health conditions are often compounded by accompanying complications, like substance abuse, homelessness, and unemployment. Including these comorbidities in any coordinated care mechanism is essential if we are to address the systemic barriers faced by the ‘missing middle’: people whose needs are too complex for standard treatment but who do not qualify for publicly funded acute care or NDIS psychosocial support.³⁶
- Social workers and occupational therapists provide just four per cent of mental health services under the MBS.³⁷ These professionals can be a lynchpin in the provision of affordable and holistic care for people with complex needs and could be incentivised under the MBS to play a coordination role in the delivery of services, individually or as part of multidisciplinary teams.

2. People with severe and complex mental health issues benefit from 'medical homes' to help overcome system fragmentation.

- Fee for service mechanisms alone do not incentivise multidisciplinary care. Fragmentation in care, role confusion and duplication are especially problematic for people with complex mental health issues, who often have to navigate multiple agencies without continuity in approach.³⁸ It is common for people to repeat their story to different providers or the same provider. This is demoralising and means people with some of the highest needs receive sub-optimal care unless they have the resources and support to self-advocate effectively.³⁹
- GPs, in conjunction with multidisciplinary teams, can provide all-important 'medical homes' for people with complex needs, in which case management, triaging and patients records are centralised and coordinated.⁴⁰ Medical Homes were a key recommendation of the seminal 2014 report of the National Mental Health Commission, *Contributing Lives, Thriving Communities*.⁴¹ They already have the support of both the AMA⁴² and RACGP.⁴³
- Achieving this requires more than tweaking MBS items descriptors. We need to build on the evidence collected through the Health Care Home Trial and 'Link-me', the randomised control trial of a systematic model of stepped mental health care in general practice, to develop a system of medical homes that can service people nationally. Subject to the findings from the above work, elements should include, at minimum:
 - incentivising GPs through MBS payments to take on responsibility for the coordination of care for people with more severe mental illness.
 - patients voluntarily enrolling with a GP, having a single care plan linked to a single patient electronic health record, like 'My Health Record', which all providers need to sign up to, and being assigned to a care coordinator or multidisciplinary team who would support them to navigate the system.
 - An initial focus on mental and physical health, with the potential to extend in time to housing, justice, education and employment.

Recommendation 4: Improve equity of access

The Commonwealth Government should:

- **Establish a strategy to improve equity of access**, which could include loadings or other financial incentives for MBS items that deliver services to patients in disadvantaged postcodes, and in regional and rural areas.
- **Scale up across the country LINC services**, which are effective in improving mental health literacy and help-seeking amongst **harder to reach groups**.

As part of macro system redesign, we also need a plan to tackle the problems of maldistribution and inequity inherent in Better Access. Expanding access to clinical services through a one-size-fits-all mechanism will fail to overcome the design flaws that perpetuate greater access to some, at the expense of others. Building up the LINC system – and introducing new workforces that are flexible, local and person centred – can begin to alleviate inequity. GPs have a direct role in supporting new services and must be enabled to do so.

The case for improving equity under Better Access

1. Better Access favours people in major cities who can pay out of pocket costs and access specialists

- The shift away from Better Outcomes/ATAPS to Better Access/fee-for-service poses a unique challenge for people in rural and remote areas. Better Access saw a substantial increase in new consumers accessing MHTPs.⁴⁴ While it is very encouraging that more people have access to psychological treatment for mental health conditions, the increase in access has not been evenly distributed.
- One study has shown that during Better Outcomes, there was no significant difference in uptake of mental health care items, or the proportion of referrals to psychologists, between people in major cities and non-major cities. Under Better Access however, item usage and referrals to psychologists have increased significantly amongst ‘advantaged’ people in major cities compared to non-urban take up.⁴⁵
- This is supported by Medicare data showing a large proportion of people outside cities who need mental health services but either do not or cannot access them. As shown in Figure 4, among people with a high K-10, 20 per cent access services in major urban areas compared with 0.5 per cent in other urban settings and virtually nil in other areas.

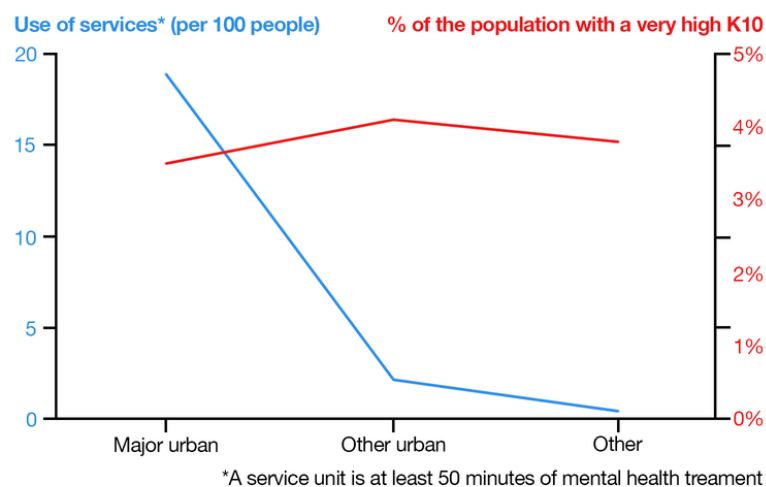


Figure 4. Mental health service use vs percentage of population with a very high K10 score, by area⁴⁶

- As depicted by Figure 5, people in higher socioeconomic areas, who live in areas of higher psychological services density and can afford out of pocket costs, access substantially more MBS subsidised services than those in lower socioeconomic areas.

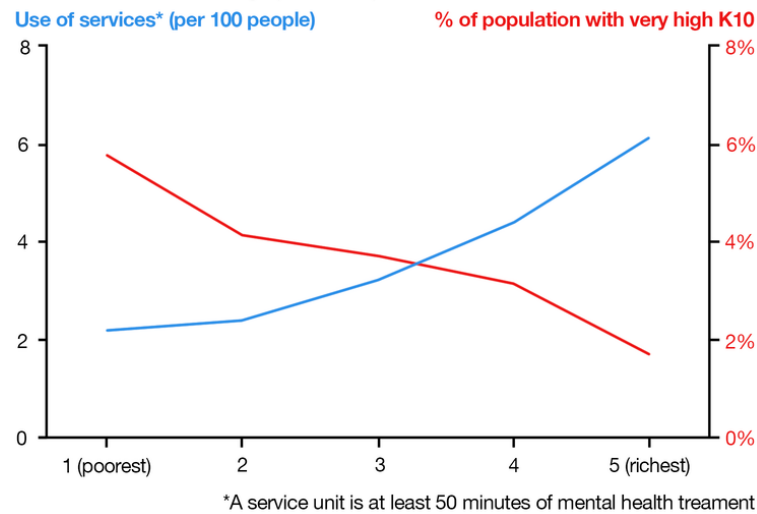


Figure 5. Mental health service use vs percentage of proportion with a very high K10 score, by area of socioeconomic disadvantage (IRSD scale).⁴⁷

- LINC solutions can be part of the solution to address these gaps in access. Complementary workforces – like coaches, support coordinators and peer workers - that are flexible and embedded in their communities can meet people where they are. These service models are designed to tailor mental health care to individual need, and the absence of out of pocket fees removes cost as a barrier to access (see Recommendation 1 of this submission).
- 2. Simply expanding clinical access will not overcome the gender imbalance perpetuated by fee for service mental health care**
- As discussed in recommendation 1 of this submission, around 60 per cent of consumers of subsidised services under the MBS are women. This is not because fewer men attend their GP – 80 per cent did 2016-17.⁴⁸ More likely, men feel less comfortable disclosing their mental health challenges. Fewer than one in five of men over 45 who attended their GP in 2014-15 talked about their emotional and psychological health, and just one in ten received mental health care from a professional other than their GP.⁴⁹
 - Patterns of health seeking are complex, yet socio-cultural factors – attitudinal and behavioural factors and entrenched masculine norms – can act as barriers to health service utilisation by men.^{50,51} New research suggests this reluctance starts early, with young males representing only one in five callers to the Kidshep helpline.⁵²
 - LINC solutions have a role in improving men’s mental health literacy and help-seeking. Evidence from NewAccess shows that its practical approach, ease and directness of access (e.g. no referral), and lack of costs were attractive to men.⁵³

Final recommendations

While Government needs to implement the above recommendations as a priority, we agree that it should also:

1. Increase the number of MBS sessions available under a single referral to 10 (recommendation 2 of the Report).

- The need for additional sessions is a consistent theme from Beyond Blue's community engagement research, in which 700 people with lived experience responded to a questionnaire that asked them how they manage their mental health and which services help them.
- However, for the same reasons as those outlined in respect of the large new cohort of 'at-risk' patients (see recommendations 1 and 2 to this submission), the broadening of clinical access should be undertaken at the same time as the development of the LINC service system and the introduction of mechanisms for consistent outcome measurement.
- While we support maximising sessions under a single referral, review points must be set to ensure optimal treatment is provided and progress is monitored. At a population level, review data will be fundamental to the effectiveness of any system of outcome measurement applied to Better Access.

2. Introduce three tiers of sessions available under a MHTP, for people with a diagnosed mental health condition (recommendation 3 of the Report)

- Provision should be made for care coordination under this recommendation. Care coordination will likely become important as people – particularly those with severe and complex mental health issues – move through more sessions and reviews under a tiered structure.
- Nurse practitioners and mental health nurse practitioners – acknowledged by the Reference Group as having a central role in coordinated care under recommendation 11 of the Report – should be considered as part of any coordination component. These practitioners should be supported in parallel with GPs and mental health professionals.

3. Enable family and carers to access subsidised therapy services under the MBS (recommendation 7 of the Report).

- The need for individualised support for carers of people with mental health issues is a consistent theme from Beyond Blue's community engagement research. The ability for carers and family members to claim MBS subsidised mental health services is long overdue.
- Taking a stepped care approach, rather than perpetuating individualised and expensive specialist treatment, is ultimately a more effective and sustainable approach for carers. As outlined in recommendation 1 to this submission in respect of 'at-risk' patients, LINC services are designed to be affordable, flexible, and outcomes driven. For families and carers fatigued from navigating a complex system on behalf of loved ones, accessing a LINC service can provide a more appropriate and inviting first step in prioritising their own mental health needs.

4. Monitor new funding for residents in aged care facilities (recommendation 13 of the Report) but take immediate action to ensure mental health screening and access to MBS services are extended to RAC residents.

- Although people over 65 years of age generally have better mental health than average,⁵⁴ this declines significantly for those who enter residential aged care. More than half (52 per cent) of all permanent aged care residents show symptoms of depression.⁵⁵ Yet, anxiety and depression among older people entering an aged care facility is often undetected and under-diagnosed.⁵⁶
- We need to do more than simply monitor the new budget funding for Residential Aged Care Facilities (RACFs) and hope⁵⁷ that it achieves the intended results. Residents should be screened for mental health conditions upon entry to a RACF and entitled to MBS rebates for mental health treatment as necessary.

About Beyond Blue

Beyond Blue is a national, independent, not-for-profit organisation whose vision is for all people in Australia to achieve their best possible mental health. We work to create change to protect everyone's mental health and improve the lives of individuals, families and communities affected by depression, anxiety and suicide.

Six priority areas for strategic impact

Beyond Blue delivers a suite of integrated initiatives across six areas that we believe are essential to improving Australia's mental health.

Impact area	Major initiatives
1. Prevention and early intervention where people live, work and learn	<ul style="list-style-type: none"> • Healthy Families: providing practical resources to build children's resilience and support mentally healthy parents and carers. • Heads Up: facilitating the adoption of workplace mental health strategies in organisations across Australia; lifting resilience, recovery and productivity. • Be You: Australia's national education initiative, changing the mental health trajectory of Australia's children and young people.
2. New service innovation to support reform of the mental health system	<ul style="list-style-type: none"> • NewAccess: coaching people with mild-to-moderate depression and anxiety; delivering a recovery rate of 70 per cent and a cost-benefit of 1.5. • The Way Back: supporting people after a suicide attempt with one-on-one, non-clinical care and practical support. • BeyondNow: An app for people to develop a suicide safety plan that they work through when they're experiencing suicidal thoughts.
3. Changing the conversation - improving mental health literacy, stigma & discrimination	<ul style="list-style-type: none"> • Campaigns: e.g. 'Know When Anxiety is Talking', a national campaign to help people to recognise and take action on anxiety conditions. • Traditional and social media: Beyond Blue reaches millions of Australians daily through our newsroom contacts, media releases and opinion pieces. Beyond Blue also has over 760,000 followers on social media.
4. Supporting people in need	<ul style="list-style-type: none"> • Beyond Blue Support Service: helping nearly 170,000 people a year with free advice and counselling from trained mental health professionals. • Online peer-to-peer forums: helping over 1.2 million people a year seek advice and support from others with similar experiences with very positive outcomes. • Beyond Blue website: helping almost 12 million people in the past year with information and tools to recognise and recover from depression, anxiety and suicidal thoughts.
5. Policy advocacy and research to drive system change	<ul style="list-style-type: none"> • Policy advocacy: delivering high quality policy propositions through expert analysis, strategic insights and collaboration with key stakeholders. • Research: Since 2002, Beyond Blue has invested \$65 million in research to identify and disseminate best practice.
6. Partnering with people affected by anxiety, depression or suicidality	<ul style="list-style-type: none"> • Blue Voices: an online reference group of more than 8,300 people who provide feedback that informs all aspects of Beyond Blue's work. • Speakers and Ambassadors: 30 high profile Ambassadors and 240 Speakers undertake 900 national engagements a year, lifting mental health literacy and helping to eliminate stigma.

Appendix 1: Early intervention programs that work

MindSpot

MindSpot is an established service that provides telephone and online supported CBT for the treatment of anxiety and depression. Individuals are assessed using the MindSpot Online Screening Assessment and are supported to complete an 8-week evidence-based CBT online course. They access weekly contact from an experienced therapist. Progress and safety are monitored, and individuals receive a check in three months after completing a course. Research has shown that the online courses have been found to be effective in more than 45 clinical trials with over 10,000 participants.

To date, it has provided services to more than 40,000 Australians with 82 per cent of participants not otherwise in contact with mental health services. Most people find symptoms of anxiety and depression reduce by 50 per cent, with the majority (95 per cent) of people reporting that they would refer a friend.

MoodGYM

MoodGYM is an e-mental health CBT-based program, with a strong, established evidence base for its efficacy. The online self-help program is designed to help people prevent and manage symptoms of depression and anxiety. There are five modules, which each contain information, exercises and quizzes, and printable summaries. It is available worldwide in five languages.

The BRAVE Program

BRAVE is an online self-help program that contains both resources and information for children, teenagers and their parents, which has strong evidence to support its efficacy. It is designed specifically to help young people with anxiety to overcome their worries and improve the quality of their lives. There are programs tailored for children as young as three, right through to 17 years of age. The program is designed to be completed weekly, with each session taking around 30 to 45 minutes. It is free throughout Australia.⁵⁸

This Way Up

This Way Up is an established e-clinic that provides online learning programs, education and research in anxiety and depression. Their high completion rate (75 per cent) is helped by sending reminders, offering choices of course and timing, and imposing a modest financial cost, which contributes to improved adherence.

The review found the provision of educational material holds promise, with a small but significant benefit. It addresses the need to reach many people, to increase mental health literacy and to encourage help-seeking. Good mental health literacy has been positively associated with the use of LINC interventions.

NewAccess

NewAccess is Beyond Blue's LINC CBT program, based on the successful IAPT model in the UK. It is an Australian-first initiative, using coaches to deliver evidence-based LINC non-clinical support to people with mild to moderate depression and anxiety. It operates within a stepped-care framework, ensuring people can be stepped up if they require more intensive treatment and support. An evaluation of the pilot by Ernst and Young found:

- **High referral acceptance and retention rates:** 88 per cent of all people referred to the program proceeded to treatment, and 72 per cent continued treatment to completion.
- **High recovery rates:** 67.5 per cent of people who participated in the trial were below the clinical threshold for anxiety and depression when they finished treatment. Recovery rates in current services are now lifting to 70 per cent and beyond.
- **The program is cost effective:** the indicated cost-benefit ratio is 1.5. It also reduces the level of demand on upstream services.

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