Consumers Health Forum of Australia

SUBMISSION

CHF Response to the Report from the Mental Health Reference Group

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Consumers Health Forum of Australia 2019
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Introduction

The Consumers Health Forum of Australia (CHF) is the national peak body representing the diverse interests of Australian healthcare consumers and those with an interest in health consumer affairs. CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems. We are pleased to respond to this Report from the Mental Health Reference Group (Reference Group).

Our positions are developed through consultations, research, and events like the Thought Leadership Roundtables involving consumers, health care providers, policy experts, academics and people in government. Further information about us and our publications can be found on our website, www.chf.org.au.

Thirty years following the creation of Medicare Benefits Scheme (MBS), a review is long overdue. CHF members believe that this review and a commitment to the regular evaluation of Medicare items is an essential to maintaining a world class health system and ensuring that funding is available for high value care.

General Comments

In March this year CHF undertook a consumer survey on mental health services to hear from people with lived experiences about how the current health service system works for them. In that survey we asked about people's experience of care, from a system integration and patient centred perspective and asked for ideas about how it could be improved

We used the results of this survey to inform our submission to the Productivity Commission's Inquiry into mental health services[1]. The results from that survey echoed the evidence to the Reference Group and from a plethora of other reports on mental health service provision that there is a need to improve access to services and provide more choice. We agree that more needs to be done to help people access services closer to where they live and to make those services affordable.

In our submission to the Productivity Commission Inquiry we called for a redevelopment of the Better Access program to ensure it is better targeted. CHF is encouraged that the reference group took a consumer-centred approach and looked to find ways to tailor services for populations in need. We want a service environment that helps reduce health inequities and helps people get the care they need when they need it. We support the emphasis on stepped care models as a way of facilitating that and ensuring valuable and scarce resources are used to the best effect. This is why we think Recommendation 8 that calls for measuring outcomes needs to be seen as something needing more immediate attention.

One word of caution on more targeted care approaches is that they can add complexity to an already complex system. The more services, and item numbers, are targeted the more

[1] CHF 2019 Response to the Productivity Commission Issues Paper for "the Social and Economic Benefits of Improving Mental Health"

complicated it becomes for the treating clinician and for the consumer. There comes a point when the added cost of that complexity outweighs the benefits.

In our submission to the Productivity Commission we also called for a move away from the current outmoded fee for service funding arrangements and for the development of more patient centred health care homes to assist with integrating primary health care services. We note this was outside of the scope of this review and so are commenting on the recommendations as they seek to improve the Better Access program within the current framework. However, these recommendations will always be suboptimal because they do not address the fundamental problem of a fragmented service system.

Response to the Recommendations

Key Recommendations:

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

CHF supports this recommendation.

We believe the evidence is strong for the effectiveness of early intervention, either for people who are showing early symptoms for the first time and those in danger of a relapse- the two categories used to define 'at risk'. This is an important part of the idea of right care at the right time.

We agree with the Reference Group's assessment that this extension would increase access to care for a group which is currently underserviced. There are very limited alternative options for people at risk and providing access to a range on mental health service providers would help to fill some of the current gaps. It is envisaged that this group of patients would initially be Tier 1 with access to a maximum of 10 services.

It would appear that the process of assessment for being at risk reduces the risk of over servicing under this item. It does put an extra degree of responsibility on GPs to make that assessment without a formal mental health diagnosis. A consideration for this cohort of patients is whether the referral is made in the context of a GP Mental Care Plan or a standard time-tiered consultation, noting that the GP care plan is intended to be comprehensive and attract a significantly higher rebate. A further consideration could be the scope for GPs to refer patients considered to be at low to moderate risk according to an appropriate risk assessment, for up to two sessions with a general or clinical psychologist for a comprehensive assessment to provide the GP with a more precise diagnosis of the mental illness and treatment recommendations. This model of consultation-liaison would promote team-based care – which is the ideal from a consumer perspective.

We also agree with the Reference Group's position that this could help to reduce stigma and because there may not be a formal diagnosis recorded, it may encourage some people, currently reluctant to seek help to do so.

Recommendation 2 – Increase the maximum number of sessions per referral

CHF supports this recommendation.

Both of these recommendations improve access to services and need to be seen as a package. They both improve access to a range of services which we know make a difference to people's lives. The data presented shows many people don't use all their allocated services whilst others use them up quite quickly.

The increase in the maximum is well overdue and the changes to the explanatory note to make it clear this is a maximum and not everyone will necessarily need that many is important. We welcome the inclusion in the explanatory note that the GP should have a discussion with the person about the number of services and that they may not recommend 10 if they do not think this is necessary.

We also welcome the amendment to the explanatory note that requires communication between the mental health service provider and the referring GP within the first four Better Access sessions. This would also allow the treating mental health clinician to flag early if additional services were needed. It is important that there is good communication between treating clinicians so that the patient's progress is monitored and the GP, as the referrer, has a clearer understanding of whether or not the patient is going to need more sessions. It also gives the referring GP an early heads up when a patient does not take up the Better Access services that have been recommended

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

CHF supports this recommendation.

In our submission to the Productivity Commission we call for the implementation of stepped care that allows for the intensity of service provision to be flexible to meet people's varying needs. This measure is aimed at people with moderate to severe mental health disorders and is designed to ensure that have access to the right number of services. The three tiers, 10, 20 and 40 are again maximums in a 12 month period and many people will not use their full allocation.

CHF supports the notion that not everyone has to start on a Tier 1 and then be reassessed for higher tiers. Depending on the nature and severity of the disorder GPs should be able to directly refer people to Tiers 2 or 3 with reassessment required if someone needs to move into a higher tier. This would provide better continuity of care for patients and allow for a longer term therapeutic relationship to be established.

We are also pleased to see in the example text for the items that the planned session can be delivered through videoconference for people living in telehealth -eligible areas. We note that Recommendation 14 seeks to increase access to telehealth services which CHF also supports.

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

CHF supports this recommendation and agrees with the Reference Group's call for this work to be done as soon as possible.

Ensuring that the most appropriate mental health professional is the one providing the care at any given time is an important component of ensuring people are getting the right care. It is also important to have flexibility about who can provide services, particularly in rural and remote areas where the full suite of mental health professionals may not be available.

The membership of the proposed group will be critical with all professional groups needing to be represented. CHF believes there needs to be two consumers on the group, both with lived experience as either a consumer or a carer.

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

CHF supports this recommendation.

Group therapy can be an efficient and cost effective way to provide therapy. They are not just a cheap way of providing care. They can be a useful tool for a range of conditions and for some people, at certain stages of their mental health disorder, can be more beneficial than one on one services. Some consumers prefer group therapy and the reduction in minimum size gives more people the opportunity to choose.

The proposed reduction in the minimum size of the groups improves access to this type of therapy. We see this as particularly advantageous for people living in rural areas where there may not be sufficient numbers of people to make up a larger group. Reducing the group size also makes it possible for service providers to be more flexible about timing and composition of groups, which in turn make them more patient centred. It also could allow consumers to choose which group they attend.

Recommendation 6 - Add a new group item for therapy in larger groups

CHF supports this recommendation.

Sometimes larger groups are needed to allow services to meet increased demand for group therapy and sometimes they are preferred by the therapists and consumers. This item gives more flexibility and more choice and should improve access for some consumers.

The additional item is needed to reflect the different workload involved in managing a larger group and for therapists working in pairs in some cases. There may need to be more definitive boundaries or at least some more guidance around which types of therapy can use this item as the evidence presented in the report suggests larger groups are beneficial for certain types of therapy.

Longer-Term Recommendations:

The report does not give timeframes for the longer-term recommendations. CHF believes they need action sooner rather than later.

Recommendation 7 – Enable family and carers to access

CHF supports both parts of this recommendation

Families and care givers tell us of their frustration at not being consulted and listened to about the treatment options for the person they are caring for. Extending current items as in 7a and then moving to the proposed new item at 7b is designed to address that concern as it is specifically for consultation with people other than the patient. This recognises the key role families/care givers play in providing support and care and that they can be a valuable source of information about the patient. This is long overdue.

The descriptor for 7b needs to include the same provisions for informed consent as those outlined in 7a.

We believe that Option 7a could and should be implemented immediately and then work on 7b could occur.

Recommendation 8 – Measure Better Access outcomes

This recommendation is supported.

The net effect of the recommendations in this report appears to be an increase in expenditure through the Better Access Program as the stated aim is to improve access and choice. It is important that there be some measure of the outcomes that are coming from that increased investment.

We believe this should move up into the key recommendations and work commence on getting agreement on outcomes measures as soon as is practical. Whilst the reference Group's recommendations are based on the available evidence that evidence is piecemeal, uses inconsistent measures and the results are not comparable. In today's world of evidence - based care and looking to offer only high value care it is important that we get a consistent set of measures that can show if the program is making a difference to the lives of people receiving services through it.

We agree with the four principles that should underpin the outcome measures. One of the current deficits in this area is an agreed set of outcome measures that are consistent across therapies and professions.

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

CHF supports this recommendation

In our submission to the Productivity Commission Inquiry we look closely at the needs of people with comorbidities of chronic disease and mental health disorders. We note that there is an interrelationships between the two although causality is not always clear. What we do know is that people need services that address both the physical and mental illnesses and that the two should not be conflated.

The changes suggested under this recommendation put physical and mental health concerns on an equal footing and note that people may need allied health services under a team care arrangement in addition to services under a mental health treatment plan. The acknowledgment of the increased risk of chronic disease that having a mental health disorder brings and allowing that to be a trigger for a general health plan will benefit many people.

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

CHF supports this recommendation.

Effective digital transformation has a significant role to play in health system transformation and sustainability. However, for it to be effective it has to not just be at the margins, as an optional addon to the business as usual model but more requires a thorough overhaul of how we offer services. The recommendation here should be seen as the first instalment but clearly there is going to need to be more work done in the not so distant future In future MBS items might need to be agnostic about how services are delivered i.e. digital, face to face, virtual. There needs to be more research on how these different modes of delivery impact on the outcomes i.e. can you take a program designed to be delivered face to face and make it virtal and get exactly the same outcomes or does the mode of delivery have an impact. This could be included in future work.

There has been a lot of work done on digital mental health services and these are being promoted through the *head to health* initiative of the federal Government. It is clear that many consumers like using digital services as they are more flexible and easier for many to access. They offer a cost effective form of delivery for some lower intensity services. They can assist with access in terms of reducing waiting lists and by reducing travel times/costs and time off work can reduce the burden of out of pocket costs for many consumers.

The challenge is to ensure that they are of high quality and fit for purpose. We note the Australian Commission for Safety and Quality in Health Care is currently undertaking some consultations around the development of a certification framework for such services

Once we have that in place then the it would be a good time to look at how to build them into the MBS framework for reimbursement.

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

CHF support this recommendation.

CHF notes that this recommendation is about the continued monitoring of the recently introduced additional funding for mental health services in residential aged care.

We would make the point that residents in aged care should have access to the same mental health services as people living in the community. We also note that they are an underserviced group and that there are difficulties in providing quality in- reach services to them that needs to be overcome.

Linked to this are the difficulties of getting GP services into residential aged care an. As GPs are pivotal in the Better Access program there clearly needs to be better GP servicer provision if we are to get better mental health services and better mental health outcomes for this vulnerable group.

Recommendation 14- Increase access to telehealth services

CHF supports this recommendation and agrees with the reference Group that the enhanced measure should become permanent.

CHF believes that telehealth services for many conditions, not just mental health, should be expanded. Telehealth services offer efficiencies for mental health professionals and maximise the time they can spend 'seeing' patients as opposed to travelling. This provides better access. Consumers benefit from shorter waiting times and increased convenience, in some cases it makes the difference between a timely appointment and not having one at all. If we want to ensure right care at the right time then telehealth is an important part of the service continuum

The suggested review should include some evaluation of consumer satisfaction with the services using either a Patient Recorded experience(PREM) or Outcome (PROM)measure.

CHF has no comment on Recommendations 9 and 10