RACGP

Royal Australian College *of* General Practitioners

RACGP submission to MBS Taskforce report from the Mental Health Reference group

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1.1 Overall RACGP position and response

1. Make more opportunities available for stepped-care approaches to mental health treatment
2. Patient rebates for access to mental health care need to be equivalent to those for physical health care.
    - mental health work needs to have an equivalent Team Care Arrangement (TCA) item to rebate patients for care coordination and formulating detailed or multiple referrals to psychologists and/or psychiatrists, which is the equivalent level of work to referring to multiple providers as with a chronic disease management TCA
    - the patient rebate for preparing a GP Mental Health Treatment Plan should focus on the formulation, goals of treatment, actions to be taken by the patient, and timings of reviews
    - the process of assessment and diagnosis should receive separate rebates and is likely to occur over one or more prior consultations.
3. Improve access to general practice mental health care as this has the potential to reduce hospital admissions while improving productivity and workforce participation.

1.2 RACGP response to taskforce recommendations 1-6

Recommendation 1 – The recommendation to expand the Better Access Program to at-risk patients is commendable; however, the RACGP anticipates it will be difficult to implement without the substantial risk of unintended consequences (eg labelling patients with "pre-disease" states, overdiagnosis) and cost blow out.

Recommendation 2 – The RACGP supports increasing the maximum number of sessions per referral with appropriate safeguards and measures implemented. The RACGP strongly believes that regular general practitioner (GP) review of Mental Health Treatment Plans will ensure that patients receive appropriate high-value care that achieve management goals.

Recommendation 3 – The main recommendation to introduce a three-tiered system has merits; however, significant safeguards should be implemented to avoid bias for patients who do not wish to be 'discharged' from psychotherapy

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

Recommendation 5 – The RACGP supports the recommendation to reduce the minimum number of participants in group sessions from six patients to four patients

Recommendation 6 – The RACGP supports the recommendation to add a new group item for therapy in larger groups to deliver group education sessions; however, these should be linked with a maximum number of participants

1.3 RACGP response to taskforce recommendations 7-14

Recommendation 7 – The RACGP supports the recommendation to enable family and carers to access therapy as it is often common for GPs to see a parent or carer of the patient where the consultation is fundamentally about the patient

Recommendation 8 – The recommendation to measure the Better Access Program outcomes seems reasonable; however, the RACGP cautions this is unlikely to be achievable within the Medicare Benefits Schedule (MBS) system

Recommendation 9 – The RACGP supports the recommendation to update treatment options that receive MBS rebates should only apply to contemporaneous and evidence-based psychological therapies

Recommendation 10 – The RACGP strongly supports the recommendation to unlink GP focussed psychological strategy (FPS) telehealth items from M6 and M7. This recommendation should be implemented promptly and should not be a longer term recommendation, as a stepped-care model cannot be achieved if GPs are not encouraged to offer FPS.

Recommendation 11 – The RACGP advocates for coordinated care for patients with chronic and mental illnesses; however, the RACGP does not support nurse practitioners working autonomously in the primary healthcare sector.

Recommendation 12 – Detailed information on the recommendation to promote the use of digital mental health and other low-intensity treatment options needs to be made available before the RACGP can provide any feedback and comments

Recommendation 13 – Patients in residential aged care facilities must be supported to have equivalent access to mental health treatment plans and psychological therapies from their GP. Restrictions on residential aged care facility patients accessing mental health services provided by GPs need to be removed.

Recommendation 14 – The RACGP supports the recommendation to review the announced expansion of access to mental health telehealth services in rural and remote areas in two years

2. The Royal Australian College of General Practitioners

The Royal Australian College of General Practitioners (RACGP) is Australia's largest medical organisation, representing more than 40,000 members who provide more than 154 million general practice services each year to more than 24 million Australians.

The RACGP's mission is to improve the health and wellbeing of all people in Australia by:

- supporting general practitioners (GPs), general practice registrars and medical students through its principal activities of education, training and research
- assessing doctors' skills and knowledge
- supplying ongoing professional development activities
- developing resources and guidelines
- helping GPs with issues that affect their practice
- developing standards that general practices use to ensure high-quality healthcare.

General practice plays a central role in the provision of mental health care. In Australia, people in distress frequently turn to a general practice team for help. Easily accessed without referral, general practice is key to providing equitable access to care for mental health issues. An estimated 13% of general practice encounters are for mental health-related issues.[1]

GPs are at the forefront of Australia's healthcare system, and are best placed to provide appropriate, tailored and long-term mental health care for their patients. The RACGP's Health of the nation 2018 found that psychological issues (eg depression, mood disorders, anxiety) remain the most common health issue managed by GPs.[2]

The RACGP provides recommendations on the taskforce's review and addresses each of the review's recommendations.

3. RACGP recommendations and comments

3.1 Stepped-care model

Stepped care is an adaptive model of service delivery that adds or removes intensity of treatment according to patient need. For stepped care models to operate, the GP needs to regularly review the patient. The patient rebate for review of a GP Mental Health Treatment Plan provides an ideal vehicle for stepped care. The Medicare Benefits Schedule (MBS) should continue to require GP review at regular intervals during a course of psychological treatment. Furthermore, GP-delivered focussed psychological strategies should not reduce patient access to rebates for subsequent psychotherapy delivered by psychologists.

There needs to be more opportunities available for stepped-care approaches to mental health treatment, similar to those proposed by the:

- National Mental Health Commission's *National review of mental health programmes and services report*
- Department of Health's draft *Fifth National Mental Health and Suicide Prevention Plan*
- General Practice Mental Health Standards Collaboration's (GPMHSC's) *Working with the stepped care model guide*
- RACGP's *Vision for general practice and a sustainable healthcare system*.

3.2 Disparity between patient rebates for mental health care and chronic disease management

Patient rebates for access to mental health care needs to be equivalent to those for physical health care. Mental health plan preparation items are time tiered, pay less than equivalent GP Management Plan (GPMP) items, and include assessment of the patient and treatment planning. In contrast, GP Chronic Disease Management (CDM) items cover the planning element only, with additional item numbers available to support the assessment of the patient. Moreover, patient rebates are available for both a care plan (item 721) and case coordination in the rebate for team care arrangement (item 723).

Mental health work needs to have an equivalent Team Care Arrangement (TCA) item to rebate patients for care coordination and formulating detailed or multiple referrals to psychologists and/or psychiatrists, which is the equivalent level of work to referring to multiple providers as with a Chronic Disease Management Team Care Arrangement.

3.3 Separate assessment and planning in MBS

Similar to the GP Management Plan for physical disease, the patient rebate for preparing a GP Mental Health Treatment Plan should focus on the formulation, goals of treatment, actions to be taken by the patient and timings of reviews. The process of assessment and diagnosis should receive separate rebates and is likely to occur over one or more prior consultations.

3.4 Patient access to mental health services

Improving access to general practice mental health care has the potential to reduce hospital admissions while improving productivity and workforce participation. While the increasing uptake and use of mental health care plans suggests that access to mental health services is improving, current levels do not reflect the rates of mental health experienced in the community with one in five people experiencing a mental health illness disorder in a 12-month period.

3.5 Nurses

The recommendations in this report fail to recognise and support the upskilling of practice nurses and other allied health professionals working within general practice. Nurses working in general practice can:

- be engaged in case finding mental health illness in patients who are at risk
- help monitor recovery
- help with psycho-education
- help with self-management support
- help with goal setting/adherence for behavioural activation.

Nurses act as care managers while GPs make clinical decisions. This model of care has been supported by numerous trials for depression management and evaluated in a Cochrane Review.[3] Medicare could support these services within a fee-for-service framework or a block-funded framework (where block funding is achieved using a GP Management Plan and review item numbers adjusted accordingly).

4. Key taskforce recommendations

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

This recommendation is commendable; however, the RACGP anticipates it will be difficult to implement without the substantial risk of unintended consequences such as labelling patients with "pre-disease" states with attendant stigma, insurance and employment consequences. The term 'at-risk' is currently not defined, and may in fact be difficult to clearly define. This could then result in the unintended consequence of overdiagnosis. There is also a risk that costs may blow out.

In addition, many patients who would not otherwise benefit from formal psychotherapy, or where the benefit is not clinically necessary, will receive MBS rebated services. For example:

- The most appropriate and cost-effective approaches for some patients are often through public health services and health promotion rather than individual psychotherapy
- There could be a bias towards providing ongoing sessions for patients who should be discharged from ongoing psychotherapy back into ongoing primary care
- Performance and occupational psychology (eg sports, workplace) may fit under the definition of 'at-risk' even though this would not be normally considered within the remit of MBS-rebatable services
- Expanding the program to at-risk patients without any plans to expand the mental health workforce risks leading to reduced service availability for those with moderate-to-severe mental health illnesses

Recommendation 2 – Increase the maximum number of sessions per referral

The RACGP supports increasing the maximum number of sessions per referral; however, appropriate safeguards and measures need to be implemented including:

- Return communication back to the GP
- Communication with the GP within the first four to six weeks

The RACGP strongly believes that regular GP review of mental health treatment plans will ensure that patients receive appropriate high-value care that achieve management goals.

The evidence presented in *Appendix E* of the Report does not appear to support a significant increase in the number of sessions for patients (ie 10 sessions). The consequence of a four-fold expansion in access to rebates will be to distribute psychological services according to how many providers exist rather than according to patient need.

According to *Figure 3 Difference in patients attending seven, eight or nine sessions, compared to six or 10 sessions*, the modal number of Better Access Program sessions used in the first 12 months following a patient's mental health treatment plan is one (then two and three). This figure demonstrates 'supply driven demand', and could be interpreted that a significant proportion of providers use all available patient rebates, driving up the number of patients who receive the full 10 visits. As evidence suggests that the 'minimum effective dose' for psychotherapy treatments such as cognitive behavioural therapy (CBT) is six to eight, it could be assumed that patients who are referred do not meaningfully benefit from it.

There is also a need for greater clarity and accessibility on what to do when a patient wishes to transfer from one psychological service under the mental health care plan to another. Provider Digital Access (PRODA) would also need to be more accessible so GPs can see how many psychological service visits have been billed for patient review.

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

The main recommendation to introduce a three-tiered system has merits; however, significant safeguards should be implemented to avoid bias for patients who do not wish to be 'discharged' from psychotherapy. The peripheral recommendation as noted on page 35 to change from 'calendar years' to 12-month periods is supported by the RACGP.

The issues with Recommendation 3 are similar to that of Recommendation 1, especially around rebates for 'at-risk' patients.

Consideration should also be given to whether the proposed expansion of funding is best allocated to psychology providers through MBS rebates, or whether better service design could be achieved through the commissioning of services through Primary Health Networks (PHNs) for the most complex, high-needs patients. The RACGP believes the PHN model would be more likely to assist vulnerable patient groups to access psychological support.

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

The RACGP supports this recommendation. The important role of the GP to advocate what is best for their patients cannot be underestimated.

Recommendation 5 – Reduce minimum number of participants in group sessions

The recommendation to reduce the minimum number of participants in group sessions from six patients to four patients is not unreasonable to the RACGP. However, RACGP members have noted that this will only affect a small proportion of patients as group sessions are infrequent.

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

The RACGP welcomes this recommendation to deliver group education sessions; however, this should be linked with a maximum number of participants.

5. Longer term taskforce recommendations

Recommendation 7 – Enable family and carers to access therapy

The RACGP supports this recommendation as it is often common for GPs to see a parent or carer of the patient where the consultation is fundamentally about the patient. These consultations currently do not attract an MBS rebate unless the patient is physically present in the consultation.

Recommendation 8 – Measure Better Access outcomes

The recommendation seems reasonable. However, the RACGP cautions this is unlikely to be achievable within the MBS system.

Recommendation 9 – Update treatment options

The RACGP supports the recommendation to update treatment options that receives MBS rebates should only apply to contemporaneous and evidence-based psychological therapies.

Recommendation 10 – Unlink GP focussed psychological strategy items from M6 and M7

The RACGP strongly supports the recommendation to unlink GP focussed psychological strategy (FPS) telehealth items from M6 and M7. The RACGP believes this recommendation should be promptly implemented and should not be a longer term recommendation. Indeed, we advocate that face to face GP FPS sessions should also be unlinked.

A stepped-care model cannot be achieved if GPs are not encouraged to offer FPS. Currently, only a small number of GPs who are trained and able to provide FPS use the MBS telehealth items from M6 and M7 as it may disadvantage patients who may need to go on to seek psychological therapy from another mental health professional. The current rules restrict the potential scope of practice of GPs with an interest in mental health, and acts as a barrier to capacity building in general practice.

There is often more incentive for a GP to refer patients to a psychologist, even though it may be better for the patient to have FPS with their regular GP, where it is better for the health system (lower cost) and GP (incentive to build capacity and additional skills).

Uncoupling in this way could encourage a stepped care approach and increase interest in training GPs in FPS.

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

The RACGP advocates for coordinated care for patients with chronic and mental illnesses (refer to the RACGP's *2019 Federal election statement*); however, we do not support nurse practitioners working autonomously in the primary healthcare sector.

The RACGP's position statement recognises the value nurse practitioners add when they work collaboratively as part of a GP-led practice team delivering coordinated care. Clinical roles, responsibilities and accountabilities within a GP-led general practice team should be assigned according to each health professional's level of education, training, supervision and clinical expertise. Ultimate responsibility and oversight of patient care when provided as part of a GP-led general practice team should rest with GPs.

Excluding the number of mental health sessions toward allied health sessions under the team care arrangements of a GP Management Plan would add unnecessary complexity to the system.

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

Detailed information on the recommendation to promote the use of digital mental health and other low-intensity treatment options needs to be made available before the RACGP can provide any feedback and comments.

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

Patients in residential aged care facilities must be supported to have equivalent access to mental health treatment plans and psychological therapies from their GP. Restrictions on residential aged care facilities patients accessing mental health services provided by GPs need to be removed, as these services are available to other Australians via the Better Access initiative.

Recommendation 14 – Increase access to telehealth services

The RACGP supports the recommendation to review the announced expansion of access to mental health telehealth services in rural and remote areas in two years.

The RACGP believes the MBS review should consider expanding accessibility to telehealth services to all patients who have an active mental health plan. GPs often provide over-the-phone advice and counselling for patients who are unwell, depressed or close to suicide. Regular supportive (over the phone) counselling during the waiting period between the patient's medication taking effect and contact with psychological services can provide enormous support and relief to patients and reduces the burden on the hospital system.

6. Conclusion

Thank you once again for the opportunity to provide feedback and comments. We look forward to hearing about this Review's progress and outcomes.

7. References

[1] Britt H, Miller GC, Henderson J, et al. General practice activity in Australia 2013–14. Sydney: Sydney University Press, 2014.
[2] The Royal Australian College of General Practitioners. Health of the nation 2018. Melbourne: RACGP, 2018. Available at www.racgp.org.au/general-practice-health-of-the-nation [Accessed 5 April 2019].
[3] Archer J, Bower P, Gilbody S, et al. Collaborative care for people with depression and anxiety. Cochrane Database Syst Rev 2012;10:CD006525.