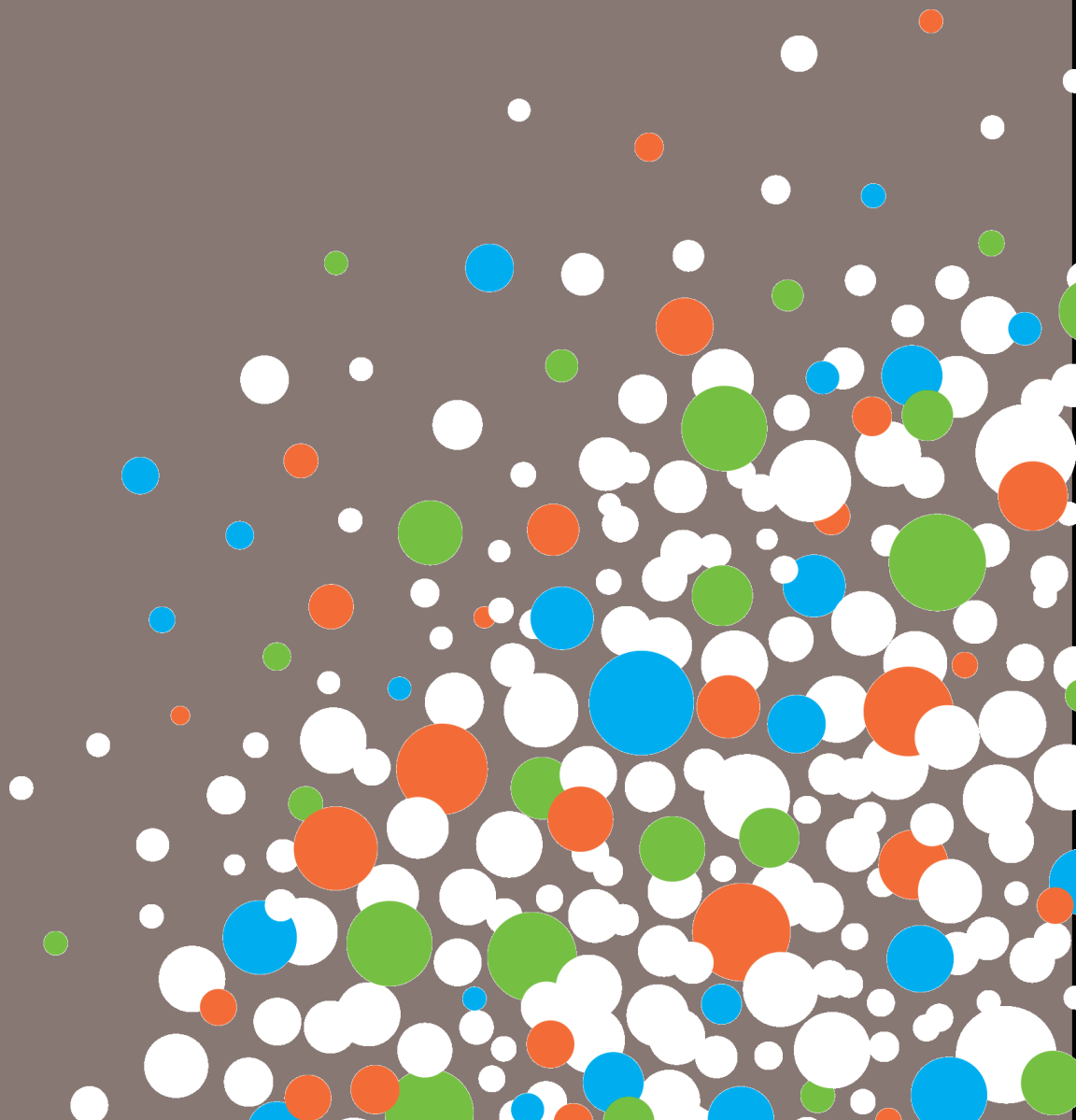
Orygen

The National Centre of Excellence in Youth Mental Health

Medicare Benefits Schedule Review Taskforce

Response to Consultation Paper



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1. About this submission

This submission is made on behalf of Orygen – The National Centre of Excellence in Youth Mental Health. The purpose of this submission is to highlight the scope for reforms to the Medicare Benefits Schedule to cost-effectively and sustainably improve the mental health and wellbeing of young people in Australia.

The submission provides some general commentary relating to the terms of reference of the MBS Review Taskforce as it relates to young people with mental ill-health before providing brief responses to a number of the questions outlined in the Consultation Paper.

2. About Orygen – The National Centre of Excellence in Youth Mental Health

Orygen, The National Centre of Excellence in Youth Mental Health is the world's leading research and knowledge translation organisation focusing on mental ill-health in young people. The organisation conducts clinical research, runs clinical services (four headspace centres), supports the professional development of the youth mental health workforce and provides policy advice to the Commonwealth Government relating to young people's mental health.

Orygen's current research strengths include early psychosis, personality disorders, functional recovery and neurobiology. Other areas of notable research activity include emerging mental disorders, mood disorders, online interventions and suicide prevention. Priority research areas for further development include disengaged and vulnerable young people, addiction and eating disorders. Orygen supplements its clinical research with a developing health economic programme that spans the range of its research areas.

Orygen is a not-for-profit company limited by guarantee. It is a charitable entity with Deductible Gift Recipient Status and is an approved research institute. The Company has three Members: the Colonial Foundation, The University of Melbourne and Melbourne Health.

3. General commentary

We support the primary and secondary objectives of the review and have a number of general comments relating to each objective.

3.1 Primary objectives

3.1.1 Achieve best patient health outcomes for MBS expenditure

The MBS Review presents an opportunity to identify MBS reforms that help achieve significant improvements in morbidity and mortality in mental health similar to those achieved in cancer and cardio-vascular disease over recent decades. This opportunity is based on:

- the timing of the onset of mental illnesses;
- the significant burden due to mental ill-health;
- the role that poor system design plays in missed opportunities to improve outcomes for people with mental illnesses;
- the major role of MBS funded services in recent mental health reforms (in particular with regard to early intervention strategies); and
- the cost-effectiveness of early intervention in mental ill-health.

3.1.1.1 The timing of the onset of mental illnesses

Unlike physical illness, the onset of mental illness peaks in emerging adulthood (1) and extends across the prime productive years of life, and we do not yet respond early, expertly or consistently enough. Mental ill-health the key health issue facing young people world-wide, contributing 45% of the overall burden of disease in those aged between 10 and 24 years (2).

A significant proportion of mental ill-health in young people is mild to moderate in nature, with symptoms tending to resolve by the late twenties (3), but, during the course of, and even after, the illness it results in much suffering, unrealised potential and disability. For the proportion of young people whose mental health issues do not resolve with time, current evidence strongly suggests that persistent mental health problems in adolescence significantly increase the risk of mental illness in adulthood (3-6).

3.1.1.2 The significant burden due to mental ill-health

Mental illness is estimated to pose the greatest threat to worldwide economic growth of all non-communicable diseases, including cancer and cardiovascular disease (7). Mental illness in turn increases the likelihood of developing additional mental disorders, substance use and a range of serious physical health problems, including cardiovascular disease, stroke and diabetes (8-15). Conversely, positive mental health can impact the onset, course and impact of both physical and mental illnesses (16).

Serious physical comorbidities are a major reason why the relative risk of mortality amongst people with mental disorders is twice that of the general population and why mental disorders have been estimated to be responsible for 14.3% of worldwide deaths in 2012 (17). People with mental illnesses are also more likely to attempt and complete suicide (18-20). Overall, people with serious mental illnesses have been estimated to die twelve to twenty five years earlier than those in the general population (21, 22).

Amongst young people alone, the cost of mental ill-health in Australia has been estimated to be in the region of $6-10 billion each year (23, 24). These costs include direct healthcare services, productivity losses, lost income, imprisonment, disability and premature mortality.

In addition to resulting in such serious long term health and mortality impacts, mental ill-health experienced prior to age 25 have a significant impact on social and economic outcomes at age 30 (6). Many young people with a mental illness are at risk of never entering the labour market, instead moving early onto disability benefits. People with a mental illness are 50% more likely to be not in the labour force than those without mental health conditions (25). Young people seeking help for mental health problems are almost twice as likely to be Not in Education, Employment or Training (NEET) as young people in the general population (26).

Amongst young adults, over 70% of all new disability benefit claims are for reasons of mental ill-health (27). Given the early onset of mental illness, there is a potential for a young person to spend more than forty years on disability payments, an avoidable personal and economic disaster (28). The resulting unemployment can in turn compound psychological illness, social exclusion (29) and economic disadvantage. Conversely, participation in work and education are seen as key elements of the recovery process for people with mental ill-health. (28)

3.1.1.3 The role of poor-system design plays in missed opportunities to improve outcomes for people with mental illnesses

A significant component of the burden of mental ill-health is avertable through improved access to care and increasing the proportion of care that conforms to evidence based practice (30). The National Mental Health Commission's recent National Review of Mental Health Programmes and Services concluded that current mental health system design is not fit for purpose. The Commission notes that half of all Commonwealth mental health expenditure spent on the costs of system failure – disability support payments to individuals whose lives would have been more fulfilling and contributing had they received better and more appropriate support for their mental health needs earlier in life (25). As a result the Commission has called for mental health service systems to be

redesigned by investing in early intervention in order to avert the downstream costs of preventable disability.

Significant long term system development is still required as overall service responses for young people's mental ill-health needs remain poorly matched to the scale of the personal, community and economic needs. Currently, many young people with mental ill-health do not have adequate access to care. As highlighted by most recent Australian Child and Adolescent Survey of Mental Health and Wellbeing, only one third of 12-17 year olds with a mental disorder had their needs fully met and one in five did not have their needs met at all (31). Even if young people do gain access to traditional primary care and specialist services, adolescents and young adults often fail to engage or respond poorly to such contact.

3.1.4 The major role of MBS funded services in recent mental health reforms (in particular with regard to early intervention strategies)

The potential to avert many of the impacts of mental illness in young people have resulted in policy, practice and research momentum for early intervention, with the ultimate aim of preventing or pre-empting the emergence of serious and enduring illness.

Although, as highlighted above, significant system redesign is still required, there have been a number of positive policy developments to increase the capacity to provide evidence based early intervention services for individuals experiencing mental ill-health. **MBS funded services have been essential components of a number of the most influential reforms.**

Primary mental health care has improved over the past decade and especially so for young people with the early stages of mild to moderate mental ill health. Specifically the Australian government has funded the Better Access Program for all age groups and has taken a number of steps towards the development of a youth mental health service system.

The Better Access Program introduced a number of changes and additions to the MBS, resulting in:

- greater GP participation in providing mental health services;
- private seeing more new patients;
- improved availability and affordability of psychological services provided by psychologists, social workers and occupational therapists in private practice; and
- the provision of education and training to GPs and primary care service providers to better diagnose and treat mental illness (32).

The MBS now plays a major role in mental health service provision, with mental health MBS expenditures estimated at $907.9m in 2012, representing a quarter of Commonwealth expenditure on mental health services (or 9.5% of all Commonwealth mental health expenditure – which includes income support payments to individuals with mental illnesses and their carers and research and system improvement initiatives).

Additionally, a number of policy and service reforms over recent years such as the establishment and roll-out of headspace and the Youth Early Psychosis Program (YEPP) aim to improve access for young people aged 12-25 with emerging mental health problems to timely, appropriate and evidence based care. Both programs are based around the ideas of early intervention and the provision of integrated support across the range of domains that impact the lives of people with mental health issues: mental health care, physical and sexual health, alcohol and other drugs and education and employment.

headspace centres are located across metropolitan, regional and rural areas of Australia in soon to be 100 locations. headspace centres are built and designed with input from young people so they do not have the same look or feel as other clinical services. They provide young people with access to a general practitioner, psychologist, social worker, alcohol and drug worker, counsellor, vocational worker or youth worker. A number of centres also have Aboriginal and Torres Strait Islander health workers, welfare workers and family therapists. The MBS is an essential component of headspace service provision, funding 57% of mental health services, 69% of physical and sexual health services, 21% of engagement services and 18% of alcohol or other drug services (33).

A young person can usually access headspace after a relatively short time or no wait at all. Whilst headspace is equipped to deal with mild to moderate problems (33, 34), once a young person develops a more complex problem and perhaps suicidal risk or significant disturbance or aggression, then headspace needs back up specialised assistance from, for example the YEPP (currently only available alongside a selected number of headspace centres).

However, these two programs are not currently designed to meet the full spectrum of mental health needs of Australia's 4.36m young people (approximately one quarter of whom will experience a mental disorder in any one year). It should be noted, that under current policy and levels of provision headspace is expected to reach capacity when it provides services to under 15% of young people with mental disorders each year. A key factor that limits headspace capacity is the number of providers who chose to work in headspace centres. headspace faces significant challenges relating to provider recruitment, most notably with regards to the recruitment of GPs. Although headspace provides a number of attractive features as a work environment for private providers – in particular facilitating onsite multi-disciplinary collaborations – the current design and rules of the MBS mean that the relatively high non-attendance rate amongst young people acts as a significant financial disincentive to work in headspace compared to environments serving populations who more reliably attend scheduled appointments. Recruitment challenges are likely a factor in the trend for waiting lists at headspace centres to get longer with time (33).

3.1.5 The cost-effectiveness of early intervention in mental ill-health

Treatments, incentive-structures and models of care for mental ill-health in young people have been subject to numerous economic evaluations (24, 35-96), providing an evidence base that facilitates distinctions between cost-effective and non-cost-effective strategies in mental health care for young people. The strong research capacity within the developing Commonwealth funded youth mental health service system, presents further opportunities to extend this evidence base and increase its relevance to Australian policy-making. In particular, there is an opportunity to trial and economically evaluate innovations in MBS design/implementation/item numbers within headspace centres.

3.1.2 Achieve best evidence-based, clinical practice supported by the health professional services funded through the MBS

In keeping with the health system more broadly, there remains significant scope for mental health services to achieve better outcomes through improving the use of evidence based treatments. A little over half of encounters for depression in the Australian healthcare system result in appropriate care being provided (similar to the average rate across twenty common health care conditions) (97). Within the youth mental health system, barriers to appropriate service delivery include guidelines that do not adequately capture the complexity, diversity and severity of clinical presentations and issues relating to service organisation and clinician knowledge and beliefs (98, 99).

There is potential for the MBS to play a significant role in increasing guideline concordant care in mental health using a number of levers including:

- the type of interventions selected for reimbursement;
- the criteria used to determine the contexts in which those interventions will be reimbursed; and
- incentivizing training and the appropriate use of evidence based decision aids.

However, MBS reforms may be most impactful when combined with other strategies such as:

1. The provision of services in primary care settings that successfully integrate care for a young person's physical health, mental health and substance use needs(which have been demonstrated to be more effective for young people with mental health issues than traditional primary care settings) (100).
2. Models of care that embed ongoing data collection, analysis and reporting, strong quality and fidelity processes and research activity into governance and operation structures (as is the case with headspace and the YEPP).

It is likely that trialing and evaluating alternative combinations of MBS/non-MBS strategies may be the best approach to identifying the optimal approach. We strongly recommend that funding and infrastructure be put in place to support such trials.

3.2 Secondary objectives

3.2.1 Clarify and align expectations for the MBS, including its scope and the rules that underpin MBS payments

Given the major role the MBS currently plays in mental health care (in particular with regard to early intervention in mental health care), it is highly desirable that the MBS's future role in enhancing the use and effectiveness of early intervention strategies to address the burden of Non-Communicable Diseases in general and mental health in particular, is clearly specified and aligned with other relevant Government policies.

3.2.2 Improve alignment between need for services and access to services

As highlighted in the previous section, there remains significant unmet need for mental health care amongst young people in Australia. Addressing this issue will improve outcomes for young people and their families, avert future disability and make significant progress in shifting the focus of Australia's mental health system towards earlier intervention.

3.2.3 Optimise interface between MBS funded services, public and private hospitals

The establishment of headspace, which provides physical and mental health services principally funded through the MBS, has added a new layer of interface between MBS funded services and hospital based services for young people with mental illnesses. A young person may receive care in headspace while their mental ill-health is mild-moderate, before being referred to a specialist mental health service should their condition become severe and be discharged back to headspace once their symptoms improve. This cycle may repeat as the severity of illness fluctuates over time.

Although this new interface has the potential to provide appropriate stepped care when working well, it should be noted that there is some evidence that as funding has been withdrawn from State funded specialist mental health services, headspace services are being increasingly expected to provide care for young people whose mental health needs are more complex than those for whom headspace is designed to serve (25). We recommend that

- the experience of headspace centres might usefully be examined by the Task Force to identify opportunities and challenges relating to improving the interface between MBS funded services and hospital based care; and
- any proposals that the Task Force develops relating to improving this interface be analysed for their potential impact on current initiatives in this area, including headspace.

3.2.4 Improve data collection to help inform future health service planning, without increasing red tape

We support this goal and note that with regards to youth mental health, efforts should be made to ensure that the data collected routinely through the MBS and through youth mental health platforms headspace and the YEPP avoid unnecessary duplication of effort, are complementary and where appropriate facilitate linkages between datasets.

3.2.5 Sustained implementation

As outlined above, there is significant scope for MBS reforms to play a major role in continuing to move the emphasis of Australia's mental health system towards a greater focus on earlier intervention. This is a medium to long term project, so sustaining and sequencing reforms will be essential to realizing this goal.

3.2.6 Ensure ongoing improvements by designing a process for the MBS to remain current

As outlined above, there are a number of opportunities to improve the evidence base to inform future MBS reforms. We therefore recommend that the Review identify clear processes to support evidence generation and ongoing review of new evidence as it is produces to inform iterative improvements to MBS system design.

4. Responses to Consultation Paper Questions

4.1 The Review – Issues for Stakeholder Comment

Do you think that there are parts of the MBS that are out of date and that a review of the MBS is required?

We believe that an MBS review is timely in order to ensure that the goals and operation of the MBS are consistent with current healthcare priorities, systems and practice. We note the economic and public health requirement to do more to address the burden of non-communicable diseases and in particular to keep step with community expectations to achieve similar access and care quality in mental health as in physical health. The MBS should also be updated to respond to the significant evidence base that has developed in support of the effectiveness and cost-effectiveness of early intervention in mental health. The MBS has a major role to play in shifting the emphasis of Australia's mental health system towards earlier intervention and increased use of evidence based care and should be continually updated in order to be optimally designed to meet this goal. We believe that the evolution of the MBS should be aligned with the ongoing development of Commonwealth funded early intervention initiatives such as headspace and YEPP.

Do you have any comments on the proposed MBS Review process?

We support the process outlined and believe that a number of issues relating to mental health (and in particular early intervention in mental health) may merit examination via the 'deeper dives' by clinical experts envisioned by this review. We suggest that the experience and expertise of individuals working within the youth mental health sector would be relevant to such examinations and that it would be highly desirable to ensure that this expertise is appropriately accessed.

We also believe that MBS reform that is of lasting benefit to people with mental illnesses and their families, will be a long term, iterative project that supports the generation and analysis of relevant new data. We recommend that the review process explicitly outlines how such a long term process of continuous improvement will be operationalized.

Should the role of the MBS be simply that of an administrative tool, or should it be used actively to guide quality medical practice?

We believe that as the MBS plays such an influential role in Australian healthcare provision, that it is important to explicitly outline an active role in guiding and measuring delivery of quality medical practice. We believe that the MBS has a major potential role in rebalancing Australia's mental health system in favour of earlier intervention and increased use of evidence based care and that this role should be made explicit and be consistent with other Commonwealth policy and programs in these areas.

What implementation issues should be considered when amending or removing MBS items?

Such amendments/deletions should be informed by the best available evidence. Where evidence is equivocal or absent and where the potential health and/or financial impacts may be sufficiently large, appropriate funding and infrastructure should be in place to undertake studies to generate evidence to inform the decision. Where possible, effort should be made to identify potential consequences of the changes under consideration such as 'work-arounds' and creative interpretation of other MBS items.

Are there any other principles that should guide the review?

We support a recommitment to the principle of universality and adding the principle of continuous improvement. In practical terms the continuous improvement principle can be implemented through processes and infrastructure to generate and respond to new evidence.

4.2 Need for evidence-based reviews

Which services funded through the MBS represent low-value patient care (including for safety or clinical efficacy concerns) and should be looked at as part of the Review as a priority?

We note that the National Mental Health Commission has recommended that the GP Mental Health Treatment Plan requirement is made optional and that GP referral for psychological statement can be made via a simple referral letter(25).

Which services funded through the MBS represent high-value patient care and appear to be under-utilised?

The Better Access program has made a significant contribution to improving care provision for people with mental ill-health. However, a number of improvements to the program would improve the access to and effectiveness of services provided under Better Access.

1. The current poorly targeted ten session cap on the number of psychological treatment sessions allowable in each year actively mitigates against provision of treatment with appropriate and evidence based intensity. We are not aware of any economic evaluation suggesting that the current cap is economically efficient. We note the National Mental Health Commission's recommendation that for people with severe or complex disorders, the maximum number of sessions of psychological treatment allowable in any one year should be increased to sixteen sessions. Furthermore, we note that for a number of more complex conditions (such as some eating disorders) guidelines and evidence support funding for 20-30 sessions per year (101, 102). We recommend that MBS design is modified to ensure that people with complex mental disorders receive psychological treatments of appropriate intensity, consistent with clinical guidelines and cost-effectiveness evidence.
2. The range of professionals eligible to provide services that are reimbursed through Better Access could be extended and the targeting of those professionals improved. As recommended by the Commission, psychological treatments for individuals with more complex disorders should be provided by a clinical psychologist (with psychological treatments provided by other allied health providers targeted at individuals with less complex conditions). Again, in line with Commission recommendations, the Better Access program should be extended to include services provided by neuropsychologists as better cognitive assessments will enable earlier detection of cognitive issues and more appropriately targeted care. We also support the Commission's recommendations to explore extension of the Better Access program to services provided by nurses with post-graduate mental health qualifications and additional allied health disciplines (e.g. speech pathologists with mental health training). Any potential extension of Better Access to services provided by nurses should explore supporting outreach services provided by nurses as this is a priority area to develop within headspace centres.
3. There is also an opportunity to provide clarification among GPs and other primary health care professionals that some complex presentations of mental ill-health with significant comorbidities (including eating disorders) are eligible for coordination of medical care through the Chronic Disease Management Plan. Education and raising awareness about this option of care is also required for individuals and their families experiencing a complex mental health condition. These measures may help address current under-utilisation of the Chronic Disease Management Plan by these groups.

Should cognitive (clinical diagnostic) services receive priority attention?

We support the recommendation by the National Mental Health Commission that neuropsychologists be included as service providers under Better Access. Cognitive functioning is commonly affected in psychiatric and neurodevelopmental conditions, which have their onset early in life, meaning they have a lifelong impact. Cognitive clinical diagnostic services can inform early intervention and

significantly and positively affect treatment approaches and improve outcomes (e.g., education and vocational) in young people affected by cognitive difficulties.

We further support the trialing of additional MBS items for speech pathology services provided to young people with mental ill-health by speech pathologists with mental health training.

4.3 MBS legislation and 'rules'

Are there rules or regulations which apply to the whole of the MBS which should be reviewed or amended? If yes, which rules and why? Please outline how these rules adversely affect patient access to high-quality care.

We believe that the MBS could make a number of changes that encourage a process of continuous improvement within the MBS. As outlined below, we feel an ongoing and proactive approach should be taken to identifying issues of current and significant importance but which lack adequate evidence for a clear determination as to recommended reform directions.

Are there rules or regulations which apply to individual MBS items which should be reviewed or amended? If yes, which rules and why? Please outline how these rules adversely affect patient access to high-quality care.

As outlined above, we believe the current cap on the number of psychological treatment sessions is inappropriately targeted and mitigates against evidence based treatment intensity for individuals with severe and complex disorders. This cap should be reviewed and amended in line with current evidence. There may also be scope for modified/new item numbers relating to psychological treatments to play a greater role in encouraging use of evidence based treatments.

For a number of mental health conditions there is strong evidence or emerging evidence for the appropriate dosage and duration of treatment. For example, eating disorders such as Binge eating disorder (BED) and bulimia nervosa (BN) twenty sessions of CBT-E are recommended (101). Thirty sessions of FBT is recommended for anorexia nervosa (102).

What would make it easier for clinicians and consumers to understand and apply the rules of regulations correctly?

As highlighted previously, we believe that education and raising awareness about the option of coordination of care through the Chronic Disease Management Plan would be beneficial for individuals with complex presentations of mental ill-health with significant comorbidities. Education through primary health networks, the Royal College of General Practitioners, large service providing networks such as headspace should be considered. Efforts to engage consumers and their families should be sensitive to the potential barriers created around the language used to label specific item numbers. For example, for young people with eating disorders and their families, appearing to apply the word 'chronic' to the disorder (e.g. through managing care under a Chronic Disease Management Plan may conflict with the emphasis in treatment on hope, optimism and recovery.

Are there existing rules which are causing unintended consequences or are outmoded and should be reviewed?

As highlighted previously, we believe the poor targeting of the cap on psychological treatments under Better Access and insufficient provisions to ensure that individuals with the most complex mental disorders receive psychological treatments from clinical psychologists mitigate against achieving optimum service use and outcomes.

In amending any existing rule/s, are there any potential adverse impacts on consumers, providers or government?

We believe that adopting the continuous improvement process outlined above, which incorporates trialing of potential new/modified items in a number of pilot sites would help to identify potential adverse impacts on consumers, providers and government prior to formal adoption of such a change or addition.

4.4 Access to MBS data

What kind of information do consumers need to better participate in decision about their health care?

We believe that the evidence base around the use of specific decision aids should be reviewed as it becomes available and, if sufficiently strong, that consideration should be given to trialing incentives for the use of such decision aids. Carers can be influential in treatment decisions in mental health and should be considered in deliberations relating to optimizing information provision.

Should the MBS be used to encourage more systematic collection of data?

Where possible, but priority should be given to strategies that increase data without increasing admin burden on clinicians (e.g. linkages and complementarity between datasets). In youth mental health, opportunities for synergies between MBS routinely collected data and headspace routinely collected data should be explored.

Should the MBS items support participation in the creation or development of other data sources? E.g. myHealth Record, clinical trials, funding linked to evidence production.

An ongoing and proactive approach should be taken within the MBS to identifying issues of current and significant importance but for which current evidence is too weak to sufficiently reduce decision uncertainty.

In these instances, the funding and infrastructure should be in place to initiate and undertake trials of potential changes to the MBS and for evidence from these trials to inform any changes in MBS design and operation. We recommend that the Task Force examine a number of options relating to how to implement such an ongoing process of identification of potential reforms, trials of these reforms in pilot sites and incorporation of trial evidence into changes and additions to the MBS. These options should include potential roles for targeted calls through the National Health and Medical Research Council, the Medical Research Future Fund or research commissioned directly by the Department of Health.

Examples of the type of potential reforms which we feel merit trialing for cost-effectiveness under such a scheme include:

- Modified MBS items relating to provision of GP services in youth mental health service platforms (e.g. headspace) to encourage GP participation in multi-disciplinary, holistic early intervention care settings
- MBS item numbers for dieticians, exercise physiologists and sexual health nurses providing provide physical and sexual health monitoring and treatment in youth mental health service platforms.
- MBS changes that facilitate a new early intervention eating disorder service in youth mental health service platforms which can provide twenty-thirty sessions of psychological treatment by a clinical psychologist, family education and support and allied health support from a dietician and OT/ Social Worker.

5. Further contact

For further contact and follow up relating to this submission, please contact Matthew Hamilton, Senior Policy Analyst at: Matthew.hamilton@orygen.org.au or 0413976905

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