

GPMHSC response to the Productivity Commission Draft Report: Mental Health

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Key recommendations and issues

Addressing the inequality between physical and mental health in the MBS System

The GPMHSC supports the stated position in the RACGP response that there are key inequalities to the structure of MBS items when comparing care coordination for physical health and mental health.

Early help for people, housing supply and suicide prevention

The GPMHSC supports the considerations the Draft Report has made in regards to early help for people, housing supply and suicide prevention.

MBS-rebated psychological therapy

The GPMHSC has concerns increasing the number of psychological therapy sessions without good evidence base.

MBS rebates available for focussed psychological strategies services provided by GPs who have additional training in that area should not count as part of the maximum number of MBS-rebated psychological therapy services available to patients.

Mental Health Treatment Plans

The GPMHSC supports further promotion of the Mental Health Treatment Plans (MHTPs) as an assessment and recovery tool, with consideration to the GPMHSC working with Primary Health Networks (PHNs) on improving knowledge in this space

Improve & strengthen training

The GPMHSC supports strengthening education and is a key stakeholder in this space

Advanced training

The GPMHSC supports further recognition of GPs with Advanced Mental Health Skills

Psychiatrist-advice via MBS

The GPMHSC supports multidisciplinary communication however consideration to the GPs time should be given

Out of pocket costs, Online therapy

The GPMHSC has concerns on both of these.

Group therapy

The GPMHSC supports group therapy

Effectiveness of Better Access and primary care research

The GPMHSC supports both of these.

Introduction

The General Practice Mental Health Standards Collaboration (GPMHSC) welcomes the Productivity Commission's (the Commission) overall objective to consider the role of mental health in supporting economic participation, enhancing productivity and economic growth. The issues around social determinants of health, mental health workforce distribution and remuneration are particularly important to ensure there is provision of training such as Focussed Psychological Strategies (FPS) by GPMHSC-accredited general practitioners (GPs).

GPs are an important source of support and referral for those who experience mental health conditions.¹ Often considered as the first point of contact for people concerned about their mental health, GPs are in a unique position to provide mental health care across the illness spectrum and lifespan. GPs are central to a patient's care coordination and play a key role in a stepped care model.

According to the Australian Institute of Health and Welfare (2017), approximately 18 million GP encounters in 2015-16 were mental health related. This is an annual increase of 4.7 percent and comparable to the 9 million services provided by State and Territory mental health services in the same period.²

The GPMHSC hopes the Commission's recommendations will assist to improve the mental health of the Australian population, a challenge GPs face in their consultation rooms every day.

About the General Practice Mental Health Standards Collaboration

The General Practice Mental Health Standards Collaboration (GPMHSC) is a multi-disciplinary body managed by the Royal Australian College of General Practitioners (RACGP) and is responsible for establishing standards of education and training for the Better Access to Psychiatrists, Psychologists and General Practitioners (Better Access Initiative) under the Medicare Benefits Schedule (MBS). The GPMHSC:

- establishes standards for GP training in mental health in relation to the Better Access Initiative
- accredits training activities related to general practice mental healthcare. This includes Level 1 Mental health skills training (MHST) and Level 2 Focussed Psychological Strategies (FPS).
- promotes accredited general practice training in mental health that aims to develop GPs' knowledge of and skills in detecting and treating mental illness
- promotes the uptake of MBS mental health items under the Better Access initiative
- develops resources to support GPs to provide mental health services
- regularly updates the general practice sector about current mental health issues and contributes to the development of policy for general practice and mental health.

The GPMHSC committee includes representatives from general practice, psychiatry, psychology and the community. The RACGP chairs the group, and provides Secretariat services. The GPMHSC is funded by the Commonwealth Department of Health.

Committee members are nominated by:

- The Royal Australian College of General Practitioners
- The Australian College of Rural and Remote Medicine
- Mental Health Australia (consumer and carer representatives)
- The Royal Australian and New Zealand College of Psychiatrists
- The Australian Psychological Society

Mental health funding in general practice

It is important to understand the current funding model for mental health in general practice. There are a number of key MBS item numbers that support GPs deliver mental health care, however many GPs will often bill using standard non-mental health specific MBS consultation items due to the inability of the MBS to keep up with appropriate remuneration.

Mental Health Skills Training

GPs who undertake GPMHSC accredited Mental Health Skills Training (MHST) are eligible to claim higher schedule item numbers related to the preparation of General Practice Mental Health Treatment Plans (GPMHTP): 2715, 2717.

The uptake of MHST has been extremely successful with approximately 91.2% of vocationally registered GPs in Australia registered with Medicare as eligible to access the corresponding item numbers.¹

Focussed Psychological Strategies Skills Training

GPs who complete Focussed Psychological Strategies Skills Training (FPS ST) and undertake Focussed Psychological Strategies Continuing Professional Development (FPS CPD) once every three years are eligible to provide specific evidence-based psychological therapies accessing item numbers: 2721, 2723, 2725 and 2727.

Uptake of the FPS ST has not been as successful as MHST uptake. Approximately 3.2% of vocationally registered GPs in Australia are registered with Medicare as GP providers of FPS.¹

The comparison with the MHST figures show the GP FPS item numbers are clearly under-utilised.

Responses to Draft Report overview and recommendations

Addressing the inequality between physical and mental health in the MBS System

The GPMHSC supports the stated position in the RACGP response that there are key inequalities to the structure of MBS items when comparing care coordination for physical health and mental health. Key changes highlighted in that response would ensure that GPs can provide the best quality care for those with mental health issues in consideration of the investment of time taken for assessment, planning and multidisciplinary communication.

Early help for people, housing supply and suicide prevention

The GPMHSC supports the considerations in the Productivity Commission's Draft Report in regards to early help for people, housing supply and suicide prevention.

A key aspect of GPMHSC-accredited skills training is to ensure genuine involvement and perspectives of consumers and carers within education activities. In addition, the GPMHSC encourages further involvement of carers and consumers in all other Mental Health (MH) and FPS CPD activities.

The GPMHSC believes addressing social determinants of health to improve outcomes from treatment is important in reducing the impact of mental illness. Ensuring stable housing is one aspect, however other measures to reduce social inequalities should also be considered.

Responses to suicide prevention should be accessible by all key health professionals. The GPMHSC supports suicide prevention services addressing effective aftercare and recommend steps are taken to ensure the GP remains a cornerstone of care through communication and the ability to access these services through direct referral.

MBS-rebated psychological therapy

The GPMHSC has concerns with increasing the amount of psychological sessions available without strong evaluation of evidence to ensure good outcomes from treatment. Consideration should be given as to whether increasing the number of sessions is better, or if focus should be on the quality of the sessions.

A key aspect of good psychological care is the open communication between the patient's treating professional and their GP. Patients should be supported to return to their GP for regular review of their Mental Health Treatment Plans.

The skills of GP Providers of FPS should be strongly supported, as this will help strengthen the Stepped Care Model. GP providers of FPS have the ability to support mental health crises for patients, however, they are undervalued in the current framework.

Patients with a Mental Health Treatment Plan (MHTP) can access up to 10 consultation sessions in total with a psychologist, a social worker, an occupational therapist or a GP Provider of FPS. However, the limit of 10 sessions per person per calendar year restricts the flexibility of GP Providers of FPS in treating patients who present with mental health issues. This restriction also affects patients' future referral options as these sessions are not excluded from those provided by psychologists.

By allowing up to 10 sessions to be delivered by a GP Provider of FPS, and excluding those sessions from the 10 allowed for psychologists and psychiatrists, coordinated multidisciplinary care can be provided depending on the needs of the patient.

The benefits of these 10 independent sessions would include increased accessibility to mental health services, patient choice by enabling them to see a mental health professional (their GP) they are already familiar with, and the option for referral to a psychologist or psychiatrist if further care is needed.

GPs are often the only mental health provider in rural and remote areas, where there is real need for GP FPS services. It is crucial that GPs are supported to provide appropriate mental health care in these under-served areas.

Anecdotal evidence suggests that most FPS provided by GPs is charged under general time-based consultation item numbers and therefore are not recorded in Medicare statistics. Appropriate remuneration for these skills is vital to support GPs in upskilling in FPS and providing appropriate treatment.

Mental Health Treatment Plans

How should the requirements of the Mental Health Treatment Plan (MHTP) and MHTP Review be changed to ensure that GPs assess, refer and manage consumers in line with best practice (as laid out in the Australian Department of Health's guidance)?

What should be added to the MHTP or MHTP Review to encourage best-practice care?

Are there current unnecessary aspects of the MHTP or MHTP Review that should be removed?

Are there additional or alternative clinical thresholds (to a mental disorder diagnosis) that a consumer should meet to access Psychological Therapy Services or Focused Psychological Strategies?

Should consumers continue to require a MHTP for therapy access if being referred by a GP?

What new clinical thresholds, if any, should be introduced to access additional sessions beyond the first course of therapy? Should these be part of or separate to the MHTP Review? Should a MHTP Review be required to access additional sessions, instead of just a new referral?

How could audits be used to ensure that clinicians are assessing, referring and managing patients in line with best-practice and the stepped care model?

What information should clinicians be required to give the consumer when completing a MHTP or MHTP Review? Should they be required to give the consumer the completed and reviewed Plan?

Should GPs continue to receive a higher rebate for MHTPs and MHTP Reviews than for standard consultations?

The GPMHSC acknowledges the questions raised by the Commission around the use of the MHTPs. The GPMHSC proposes that the main goal of the MHTP is not to provide information for the psychologist. The MHTP should be a discussion between the GP and the patient in regards to Medicare requirements and agreed goals for outcomes in treatment.

The MHTP should guide the GP in assessment and discussion of issues and serve as a tool to empower the patient to take part in their own recovery journey. It is the patient's decision as to whether the MHTP is shared with the psychologist. A requirement of an MHTP is an assessment to decide on appropriate treatment and exclude other physical diagnosis.

The GPMHSC notes that there are times when a patient will not want detail recorded on an MHTP, which may be especially true in rural and remote locations where patients seek privacy even from practice staff who may be friends or family. This is where communities and health professionals are intertwined in everyday life.

Guidance from Medicare infers that the MHTP alone should not be used as the referral. The referral should be a separate document in the form of a letter to the psychologist. As stated previously, the creation of the MHTP is for the GP and the patient, and is an authority to access the treatment.

The GPMHSC acknowledges there is a disconnect between the requirements for claiming of the MBS items and the reality of what occurs in the consultation room. This could be explained by the differences in the available MBS items for coordination of physical health issues when compared to those for mental health.

The RACGP notes that *MHTPs are currently the poor cousin to the GP Management Plan (GPMP) and Team Care Arrangement (TCA) for physical illness because in the MHTP assessment and care coordination are required. These separate functions are separately funded for physical illness.*

Any evaluation should bear in mind that currently, both assessment of mental health and completing a management plan are billed under the same MBS item number. Any changes to the MBS item number need to be cognisant of the time and complexity required of GPs to complete this.¹

Without the process of assessment and review of MHTPs, there will be open access to psychologists and other allied health without the necessary exclusion of any physical health diagnosis. The Draft Report acknowledges GPs as the gatekeeper, and that the 'Better Access' education, standards of which are set by the GPMHSC, is sufficient for GPs, however then questions the use of MHTPs.

The GPMHSC suggests further work is needed to promote the requirements of the MHTP, improve best practice assessment referral and the importance of the document not only in assessment but as a tool in recovery for the patient. One of the key roles of Primary Health Networks is to support GP practices to build workforce capacity and high quality care. By working with the GPMHSC in accreditation of further education activities for mental health skills training and continuing professional development, GP skills and knowledge in MHTPs can be further developed.

In regards to the questions raised, the GPMHSC will use these to form key discussions and considerations as it updates a literature review and conducts a focus group to inform updates to MHTP templates developed in 2012 and piloted in 2013. Currently, the templates are a frequently visited page on the GPMHSC website and continue to be a key part of promotion for the GPMHSC.

Improve & strengthen training

The GPMHSC supports the recommendation for further MH CPD for GPs in pharmacology that is evidence-based and unbiased. It is important to note that the first line treatment for high prevalence anxiety disorders is not medication, and for depressive disorders it is a combination of medication and psychological therapy. A focus on the quality of psychological services should be at the forefront of treatment.

It should also be acknowledged that the high rate of mental health prescribing referred to in the Draft Report covers a number of medications including those used as chemical restraints in the wrong context and pain medication.

The GPMHSC can devise standards for a pharmacological module and ensure it caters to the different levels of education for GPs. Any education should ensure freedom of conflict from pharmaceutical business. This may be done through the MBS.

Advanced training

The RACGP response indicates GPs will often choose to build on their existing skills in mental health through formal education (eg mental health first aid, focussed psychological strategies skills training, postgraduate qualification). This is supported by our data where 90% of GPs have completed the GPMHSC-accredited Mental Health Skills Training.

The GPMHSC supports the education, recognition and CPD requirements of MHST GPs and GP FPS Providers under the current Better Access framework and the MBS. In the latest issue of the GPMHSC's [Mental Health Training Standards](#), a [position statement](#) recommended key requirements to be accredited by

the MBS system to ensure further valued upskilling by GPs to provide wider access to mental health treatment for those in underprivileged or rural and remote areas.

Anecdotal feedback from GPs who have access to provide MBS-rebated FPS indicates that remuneration is often inadequate.

Any recognition for should sit within the existing GPMHSC accreditation framework for Better Access, that is MHST-trained, GP FPS Providers and Advanced Mental Health Skills GPs. Any proposal to amend the registration arrangements for GPs to recognise those who have specialist qualifications in mental health must include input from, and be administered by, the RACGP and GPMHSC.

Psychiatrist-advice via MBS

The GPMHSC supports increasing access and interdisciplinary communication with other specialists to improve quality assessment and treatment. However, as stated in the response from the RACGP, this may be out-of-scope for the MBS system in providing funds for a non-treating health professional.

Out of pocket costs

The GPMHSC is also concerned with the increasing out-of-pocket costs for consumers, with Australia ranking high on this OECD measure.² GPs often see the pressure of increasing costs placed on consumers despite overall increased spending on mental health care.³ Programs such as Psychological Support Services (previously ATAPS) for consumers with health care cards – where out of pocket expenditures are not required – are limited in access to a relatively small number of people in the community.

Online therapy

As stated in the previous GPMHSC submission, while there are now a wide range of e-mental health interventions, there are continued concerns around persistent promotion of e-mental health care that is not evidence based as a preferred solution to barriers in treatment.

The GPMHSC has reservations on the required level of patient literacy and mental functioning needed for this therapy to be effective. This is especially concerning in contexts where the effect of social determinants or an active disorder may each impact effective patient literacy at time of help-seeking.

This may perpetuate inequitable provision where people in poorer areas may be offered an online service while better positioned and resourced citizens may receive face to face services with better demonstrated effectiveness due to availability of services.

Group therapy

The GPMHSC supports further access to group therapy MBS items, however these should also be extended to GP Providers of FPS.

Effectiveness of Better Access and primary care research

The GPMHSC supports further investment in quality longitudinal research around the consumer journey within primary mental health care, such as National Survey of Mental Health and Wellbeing. Further consideration should be given to the limited statistics in relation to Aboriginal and Torres Strait Islander mental health.

In addition, this area is lacking evidence of increased productivity and good outcomes from the range of services available to consumers and has resulted in many expensive short-term solutions of unknown efficacy. A comprehensive evaluation of Primary Health Network-commissioned services is needed.

Appropriate funding for research such as the effectiveness of MBS-rebated psychological therapy in primary mental health care would contribute an evidence-base for addressing the multiple factors of mental ill health.

Conclusion

GPs, being the first point of contact with the health care system for most patients, are best placed to provide appropriate, personalised, and long term mental health treatment and support. In a stepped care model, the GP should be central to a patient's care coordination, ensuring they do not fall through cracks in service provision. Productivity is limited when large numbers of individuals who need greater care fail to progress beyond the first hurdle.

The current complex, disjointed and siloed system has created numerous barriers and much confusion for those seeking timely help. The absence of agreement on causes, effective treatments and optimal outcomes for mental illness is reflected in the complexity and ad hoc nature of current approaches. It is very difficult to improve productivity when there is no consensus about desired outcomes.

The GPMHSC remains committed in supporting the development of a mental health workforce that is better equipped to respond to needs of patients. For this to happen, the barriers to the accessibility and quality of mental health services in Australia need to be addressed.

References

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3. Meadows, G; Enticott, J; Rosenberg, S. Three charts on: why rates of mental illness aren't going down despite higher spending. Available from: <https://theconversation.com/three-charts-on-why-rates-of-mental-illness-arent-going-down-despite-higher-spending-97534>

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