

5 April 2019



Mental Health Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

To Whom it May Concern,

Music therapy is a critical allied health profession within Australia's healthcare system, changing the lives of some of Australia's most vulnerable people, including those living with mental health illnesses. Music therapy is proven to help improve cognitive function, social communication skills, motor skills, emotional development and overall quality of life.

For those living with mental health illnesses, there is strong evidence supporting the benefits of music therapy as a treatment for depression and anxiety. It can also improve the outcomes of other therapies when used as an adjunct, and improve an individual's capacity to function.

Unfortunately, as music therapy is not included in the Medicare Benefits Scheme (MBS), there are many vulnerable and chronically unwell Australians unable to access this life changing intervention. This further limits their capacity to meaningfully participate in Australia's social and economic growth.

Accordingly, the Australian Music Therapy Association (AMTA) submits this report to the Mental Health Productivity Commission. This report outlines the economic rationale for music therapy's inclusion in MBS, highlighting its health benefits and cost effectiveness.

Given the strong evidence supporting music therapy's benefits in healthcare including mental health, AMTA strongly recommends the inclusion of Registered Music Therapists (RMTs) within the group of allied health professions able to access mental health item numbers under the MBS.

AMTA is the peak body for the music therapy profession in Australia. It is responsible for the registration of music therapists, the accreditation of music therapy courses as well as the maintenance of professional standards and ethics. A member organisation of Allied Health Professions Australia (AHPA), AMTA supports its RMTs to use research-based practice that will actively promote the health, well-being and functioning of unwell Australians.

Should you require additional information or would like to discuss AMTA's report further, please do not hesitate to contact me.

Kind regards,

Bridgit Hogan
Executive Officer
Australian Music Therapy Association

An Economic Rationale for including Music Therapy on the Medicare Benefits Schedule

Australian Music Therapy Association

April 2019

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Australian Music Therapy Association (AMTA)

Formed in 1975, The Australian Music Therapy Association (AMTA) is the peak industry body for the music therapy profession in Australia. AMTA's mission is to enable, advance and advocate for the excellence in music therapy on behalf of its members and the community. AMTA is responsible for the registration of qualified music therapists, accrediting music therapy courses, as well as the maintenance of professional standards and ethics.

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This report was requested and funded by Australian Music Therapy Association and was independently prepared by Evaluate.

Authors

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Evaluate

Evaluate was formed in September 2016, to bring fresh thinking to policy and economic questions, particularly those in the social sphere.

Our particular goal is to identify long-term solutions to ensuring the sustainability of Australia's admirable social compact, including universal access to healthcare and education, and the supply of aged care, housing and other social infrastructure.

Our approach is based on a traditional microeconomic toolkit, moderated by the knowledge that social services are accessed by people with a vast variety of experiences, needs and resources. Consequently, we have no bias towards either public or private supply of services, noting that the access and welfare needs of different Australians typically require a mix of both.

The Principals of Evaluate are experienced professionals, and we complement this with external expertise where appropriate.

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Executive Summary

This paper explores the economic rationale for the inclusion of music therapy on the Medicare Benefits Schedule.

Our core conclusion is that it is both beneficial and of limited fiscal risk to provide Registered Music Therapists (RMTs) with access to MBS item numbers for their patients.

This would optimally include:

- Items within the *Better Access Initiative* for mental health services; and,
- Items relating to mental health interventions for persons with chronic diseases.

The evidence that RMTs can deliver large improvements in symptomatic relief over a modest number of treatments is strong, particularly for high-prevalence mental illness, such as depression and anxiety. We review the burden of disease and application of music therapy for a range of conditions.

The literature shows that for some patients, music therapy will dominate other psychologically-based treatment options, including those which are currently available under the item numbers we recommend. This means that if music therapy is not included, the Government is funding a lower-value treatment. There are issues of equity here for the patient cohort.

Our views on fiscal risk are underpinned by four observations:

1. The MBS item numbers under which we recommend the inclusion of music therapy are existing item numbers, with relatively low annual caps, so there is a constrained risk with any given patient;
2. At the same time - as these item numbers are already available for patients with mental illness and chronic disease - it is likely that in the majority of cases, music therapy will be a substitute for services which are already billed, so there is no expected incremental cost;
3. The cohort of Registered Music Therapists is fairly small (currently 284 currently in private practice) and there is alternative demand at rates higher than recommended under the MBS. For example, an RMT can be remunerated up to \$179 per hour within the NDIS, which is higher than the MBS rate; and,
4. We support the requirement of traditional referral models, either from a General Practitioner, Psychiatrist, hospital or other appropriate pathway, which limits moral hazard.

We commend the inclusion of Registered Music Therapists within the group of allied health professions able to access mental health item numbers under the MBS.

Music therapy and its role in health and wellbeing

Music therapy is a critical allied health profession within Australia's healthcare system, changing the lives of some of Australia's most vulnerable people. Music therapy is proven to help improve cognitive functioning, social communication skills, motor skills, emotional development and overall quality of life.

Registered Music Therapists, or RMTs, are tertiary qualified allied health professionals registered to practice music therapy. Practising in hospitals, residential care, schools and community settings, RMTs use music-based therapy techniques informed by research and clinical practice to improve the health and wellbeing of people with conditions as diverse as brain injuries, mental illness, neurological disorders and dementia as well as premature babies and those in palliative care.

In order to gain their registration, RMTs need to complete a tertiary course in music therapy accredited by the Australian Music Therapy Association (AMTA). Their skills are then maintained, as with other allied health professionals, through continuing professional development. RMTs draw on an extensive body of research and are bound by a code of ethics that informs their practice.

AMTA is the peak professional organisation for Registered Music Therapists (RMTs). AMTA is responsible for the registration of music therapists and the accreditation of music therapy courses together with the maintenance of professional standards and ethics.

At present, unlike numerous other allied health services, music therapy is not included in the Medicare Benefits Schedule. This situation significantly limits access to music therapy for people who need it, particularly those with mental health issues.

Including music therapy on the Medicare Benefits Schedule will allow people with mental health conditions and other chronic health problems which music therapy can help treat access to the support and help they need at the time they need it. Supporting people's mental health and other chronic conditions in this way will deliver substantial economic benefits.

Impact of mental illness

Australia's burden of mental illness is the third highest disease burden in the country. In 2011, the Australian Institute of Health and Welfare (AIHW) *Burden of Disease Study* found that Australians lost a total of 52,554 years of healthy life as a result of mental illness and substance abuse in the previous year.¹ The National Mental Health Commission found in 2016 that the cost of mental illness in Australia was around \$60 billion for the nation or \$4,000 per person.²

¹ Australian Institute of Health and Welfare (AIHW), Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011, 2016. <https://www.aihw.gov.au/reports/burden-of-disease/abds-impact-and-causes-of-illness-death-2011/contents/highlights> Accessed 19 February 2019.

² National Mental Health Commission, *Economics of Mental Health in Australia*, 8 December 2016.

<http://www.mentalhealthcommission.gov.au/media-centre/news/economics-of-mental-health-in-australia.aspx> Accessed 19 February 2019.

In individual terms, data consistently demonstrate that around 45% of Australians will experience a mental illness at some point of their lives and 20% of people experienced one in the last year.³ The most recent National Health Survey showed an increase in the number of people seeking support for anxiety, depression or feelings of depression.⁴

Around 560,000 young people aged between 4 and 17, or almost 14% of people in that age group, experienced a mental illness in the year before being surveyed.⁵

The role of multi-disciplinary teams in assessing and treating people with mental illnesses as well as delivering their mental health support and care is well established in the literature. Registered Music Therapists work both within multidisciplinary teams – including with occupational therapists, social workers, speech pathologists and others – as well as independently, and have a critical role to play in delivering care that supports their patient’s mental wellbeing.

Description of patients

Around one in five people between the ages of 16 to 85 experience a high-prevalence mental illness in any one year. Anxiety related and affective disorders tend to be the most common mental illnesses with around 25% of people experiencing more than one disorder. In addition to anxiety, conditions such as post-traumatic stress disorder and obsessive-compulsive disorder are grouped within the high-prevalence category. These mental health conditions tend to involve fewer hospital admissions traditionally and certainly fewer acute hospitalisations than low prevalence conditions.

The estimated prevalence of eating disorders varies but, for Australians aged 15 and over, the estimated prevalence is between 4 and 16%.⁶

In 2009, people with low prevalence mental health conditions, such as schizophrenia and other psychoses as well as for people at risk of self-harm, accounted for around 1-2% of the Australian adult population. Although less common, these conditions were responsible for around 80% of mental health expenditure.⁷

³ Australian Bureau of Statistics (ABS), '4326.0 - National Survey of Mental Health and Welfare: Summary of Results, 2007', 2007. <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0> Accessed 19 February 2019.

⁴ ABS, '4364.0.55.001 - National Health Survey: First Results, 2017-18', 2018. <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2017-18~Main%20Features~Mental%20and%20behavioural%20conditions~70> Accessed 19 February 2019.

⁵ Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR, *The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Welfare*, Department of Health, Canberra, 2015. [http://www.health.gov.au/internet/main/publishing.nsf/content/9DA8CA21306FE6EDCA257E2700016945/\\$File/child2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/9DA8CA21306FE6EDCA257E2700016945/$File/child2.pdf) Accessed 19 February 2019.

⁶ AIHW, *Australia's health 2018*. Australia's health series no. 16. AUS 221. Canberra: AIHW, 2018. <https://www.aihw.gov.au/getmedia/ab86db9d-410a-4c93-89c4-99c8bdbdf125/aihw-aus-221-chapter-3-13.pdf.aspx> Accessed 24 March 2019.

⁷ Commonwealth of Australia, *Fourth National Mental Health Plan—An agenda for collaborative government action in mental health 2009-2014*, 2009. [https://www.health.gov.au/internet/main/publishing.nsf/Content/9A5A0E8BDFC55D3BCA257BF0001C1B1C/\\$File/plan09v2.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/9A5A0E8BDFC55D3BCA257BF0001C1B1C/$File/plan09v2.pdf) Accessed 21 February 2019.

A recent survey indicated that around 37% of RMTs employed in mental health settings, work predominantly with people experiencing low-prevalence mental illnesses and 63% with those experiencing high-prevalence mental illnesses.⁸

Impact of mental illness on patients

People with mental illnesses experience a range of symptoms and impacts on their quality of life depending on the severity of their illness. People may experience suicidal behaviour; a low level of capacity to function; a high rating on the global impression scale of symptoms; significant role impairment; and/or psychosis. All of these impacts have significant impacts on people's quality of life and capacity to participate in society.

People who experience a mental illness are also at greater risk of experiencing adverse economic, social and health outcomes. Of people experiencing one of Australia's six major health conditions – cancer, cardiovascular disease, major injury, mental illness, diabetes, arthritis – those with mental illness have the lowest likelihood of being employed. People with a severe mental illness, particularly those with psychotic disorders, have shorter average life expectancy, second only to indigenous Australians.

People with mental illnesses are also over-represented in prison populations and those experiencing homelessness. Up to 75% of homeless adults are identified as mentally unwell and around a third of these experience severe disorders. Around 40% of Australian prisoners have a mental illness and 10–20% experience severe disorders.⁹

Access to mental health services depends greatly on an individual's socio-economic status and their geographic location. Groups such as the elderly, people in CALD communities and those living in rural and remote communities access fewer mental health services than appropriate or equivalent. More recently, the Queensland Council of Social Service, whilst recognising those groups, also added Aboriginal and Torres Strait Islander communities, people with a disability and LGBT people.¹⁰

Eating disorders are responsible for significant psychological distress and were the tenth leading cause of non-fatal disease burden for Australian females aged 15–44 in 2011.¹¹

Broader burden of disease

The Royal Australian and New Zealand College of Psychiatrists estimated in 2016 that severe mental illness cost Australia \$56.7 billion per annum. This included both the direct economic costs of health

⁸ Information provided by the AMTA following a survey of members 2019.

⁹ Commonwealth of Australia, *Fourth National Mental Health Plan—An agenda for collaborative government action in mental health 2009–2014*, 2009.

[https://www.health.gov.au/internet/main/publishing.nsf/Content/9A5A0E8BDFC55D3BCA257BF0001C1B1C/\\$File/plan09v2.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/9A5A0E8BDFC55D3BCA257BF0001C1B1C/$File/plan09v2.pdf) Accessed 21 February 2019.

¹⁰ Queensland Council of Social Service, 'Mental Health', 2011.

https://www.qcross.org.au/sites/default/files/QCOSS_Policy_Position_Sept_2011_Mental_Health.pdf Accessed 4 March 2019.

¹¹ AIHW, *Australia's health 2018*. Australia's health series no. 16. AUS 221. Canberra: AIHW, 2018.

<https://www.aihw.gov.au/getmedia/ab86db9d-410a-4c93-89c4-99c8bdbdf125/aihw-aus-221-chapter-3-13.pdf.aspx> Accessed 24 March 2019.

and other services required by people with mental illness and loss of productivity due to people's inability to work due to their mental illness.¹²

The cost of mental illness to employers has also been undertaken. Mental Health Australia found that mental illness in workplaces cost \$12.8 billion in Australia in 2015-16. This is an average cost of \$3,200 for each employee with a mental illness and rose up to \$5,600 for those people experiencing severe mental illness.¹³

Requirements

Psychotherapeutic and psychopharmaceutic treatments are common modes to support people with mental illness and have been shown to be effective in many but not all patients.¹⁴ A number of patients fail to respond satisfactorily to these approaches and, for them, there is a substantial need for additional forms of treatment and therapy that can more effectively support them and their wellbeing.

Impact of music therapy on mental illness

The primary conclusions of a survey of results for music therapy as a treatment for depression are:¹⁵

- Music therapy delivers short-term beneficial effects for people with depression and increases the outcomes of other therapies when used as an adjunct; and,
- There is observed efficacy in reducing anxiety levels of people with depression and improving their capacity to function.

These outcomes are typical of the type of symptomatic relief which music therapy treatment deliver for people with high-prevalence mental illness and support its inclusion as an MBS-rebated therapy.

Following from the Cochrane review relating to depression, and Gold's work (cited elsewhere in this paper), there is currently a study underway to look in detail at the impact of group music therapy for patients with long-term depression. This will continue to build the evidence demonstrating the benefits that music therapy can provide.¹⁶

¹² The Royal Australian and New Zealand College of Psychiatrists, *The economic cost of serious mental illness and comorbidities in Australia and New Zealand*, 2016. <https://www.ranzcp.org/files/publications/ranzcp-serious-mental-illness.aspx> Accessed 19 February 2019.

¹³ Mental Health Australia and KPMG, *Investing to Save: the economic benefits for Australia of investment in mental health reform*, May 2018. https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf Accessed 19 February 2019.

¹⁴ Gold, C. et al., "Dose-response relationship in music therapy for people with serious mental disorders: Systematic review and meta-analysis", *Clinical Psychology Review*, 29 (2009).

¹⁵ Aalbers, S., "Music therapy for depression (review), *Cochrane Database of Systematic Reviews*, 11 (2017).

¹⁶ Carr, E.C., "Feasibility and acceptability of group music therapy vs wait-list control for treatment of patients with long-term depression (the SYNCHRONY trial): study protocol for a randomized controlled trial", *Trials*, 18:149 (2017)

Other applications

While treatment of mental illness appears to be the best-recognised application of music therapy, there are other conditions, including disability, stroke, dementia, terminal illness and autism, in which music-based therapies are effective.

Disability and rehabilitation

Since the establishment of Australia's National Disability Insurance Scheme (NDIS) in 2013, Australians living with disabilities, and their carers, have been able to access a range of services through individualized funding packages funded by NDIS.

Music therapy is included as a therapy that individuals can purchase under the NDIS. According to the 1 February 2019 price guide, registered music therapy providers may charge up to \$179 per session per session.¹⁷

One of the key aims of music therapy for people living with disabilities is to improve social behaviour. A recent study found statistically significant outcomes in terms of initiating and participating in conversation, and expressing emotions.¹⁸

Similar benefits are seen for people with intellectual disabilities, including in group settings. A recent UK trial emphasised the capacity of music therapy to provide the context for expression of emotions and needs without judgment.¹⁹ This is particularly important in institutional environments.

These results provide compelling evidence for the continued inclusion of music therapy in the NDIS.

As well as support for long term disability, music therapy has important application in rehabilitation, particularly from head injuries. The most celebrated recent case of this in the US is of Congresswoman Gabrielle Giffords, who had been shot in an attempted assassination and was nonvocal, but through music therapy treatment slowly regained the ability to speak.²⁰

Dementia and other conditions of ageing

There is a great deal of recent research looking at the value of music intervention on an ageing population. For example, engagement in community singing for groups of older adults has been found to be marginally more cost-effective than other community activities in terms of supporting the mental health components of quality of life, particularly reduction in reported depression and anxiety.²¹

¹⁷ <https://www.ndis.gov.au/providers/price-guides-and-information#price-guide-for-ndis-providers-as-of-1-february-2019>
Downloaded April 2019.

¹⁸ Baumgarten, H.R. & Wheeler, B.L., "The Effects of Music Therapy on the Prosocial Behaviour of Adults with Disabilities", *Music and Medicine*, 8:3 (2016).

¹⁹ <https://voices.no/index.php/voices/article/view/2303/2058>

²⁰ Holmes, D., "Music Therapy's Breakthrough Act", *The Lancet Neurology*, 11 (2012).

²¹ Coulton, S. et al, "Effectiveness and cost-effectiveness of community singing on the mental health related quality of life of the older population: a randomized controlled trial", *British Journal of Psychiatry*, 207:3 (2015).

Depression is a common co-morbidity of dementia. The relationship appears to be bi-directional, with depression being both a prodromal (or early) symptom and a risk factor for developing dementia. The need for nonpharmacological interventions such as music therapy, becomes more acute in the instance of dementia and other psycho-degenerative conditions associated with, but not exclusive to, ageing.

The pathology of dementia which music therapy seeks to address is sometimes described as a process of contact, awareness and resolution, in which narrative agency is supported by increased lucidity. This is driven by use of familiar music, that is modified in the moment to meet the needs of the individual to allow a person living with dementia to find context and become more social and responsive to carers and others.²² Music therapy research has demonstrated clear decreases in depression via the Cornell Scale for Depression in Dementia Survey²³ and the Montgomery and Asberg Depression Rating Scale.²⁴

Comparative review of studies on a variety of practices in aged care environments shows not only that music therapy is the most frequently offered (or possibly studied) therapy, but that it is ranked first in the delivery of large effects for dementia relief.²⁵

Particular benefits of music therapy are found in treatment of anxiety and depression, and in agitation, at least in the short term.²⁶ In some cases, the effect is substantial enough to allow the discontinuation of antipsychotic and anxiolytic medication,²⁷ which presents direct savings.

Alongside benefits for patients, there is also evidence of benefits from the use of music in dementia for staff and carers, with observed positive outcomes in terms of a more vibrant and less stressful environment.²⁸

Australian research looking at music use in aged care facilities in Sydney shows significant use of musical activities, including sing-alongs and performances, and notes that these are more effective when led by musically-trained staff members or volunteers. However, music therapy remains the least common form of musical support for people living with dementia. This is partly because of funding gaps, but also reflects some concern about stigmatisation of people receiving music therapy (presumably as opposed to broader musical participation) by residents.²⁹

²² Matthews, S., "Dementia and the Power of Music Therapy", *Bioethics*, 29:8 (2015).

²³ Petrovsky, D., Cacchione, P.Z. & George, M., "Review of the effect of music interventions on symptoms of anxiety and depression in older adults with mild dementia", *International Psychogeriatrics*, (2016).

²⁴ Werner, J., Wosch, T., & Gold, C. (2015). Effectiveness of group music therapy versus recreational group singing for depressive symptoms^{of} elderly nursing home residents: pragmatic trial. *Aging & Mental Health*, 21(2), 147-155. doi:10.1080/13607863.2015.1093599.

²⁵ O'Connor, D.W. et al, "Psychosocial treatments of behavior symptoms in dementia: A systematic review of reports meeting quality standards", *International Psychogeriatrics*, 21 (2009).

²⁶ Ijaopo, I.J., "Dementia-related agitation: a review of non-pharmacological interventions and analysis of risks and benefits to pharmacotherapy", *Translational Psychiatry*, 7 (2017).

²⁷ Thomas, K., "Individualised Music Program is Associated with Improved Outcomes for US Nursing Home Residents with Dementia", *American Journal of Geriatric Psychiatry*, 25:9 (2017).

²⁸ Sabran, K. et al, "A Study on Applicability of Sound Art as Therapy for Alzheimer's Patients", *Advances in Economics, Business and Management Research*, (2017).

²⁹ Garrido, S. et al, "The use of music in aged care facilities: A mixed-methods study", *Journal of Health Psychology*, 1-14 (2018)

Palliative care

Palliative care is a distinct approach to care in which improvements in a patient's quality of life are sought without expectations of prolonging life. Consequently, its benefits accrue largely to the individual patients and their families. The role of Registered Music Therapists in palliative care is a subset of their broader mental health role, to address the psychosocial challenges associated with terminal illness.

Strong evidence exists for the use of music therapy in palliative care. A recent publication describes its use as "... an instrument for reducing pain, anxiety and stress and improving quality of life, both in the physical, emotional and spiritual domain".³⁰

While palliative care services are typically funded via the States and Territories, the availability of adjunct music therapy via the MBS would be a significant contribution for many patients.

³⁰ Aguilera, K.C. et al, "Effectiveness and Interventions of The Music Therapy in Patients in Palliative Care", *Amadeus International Multidisciplinary Journal*, 2:4 (2018).

Other Applications

An extensive review of music therapy for cancer patients finds a range of measurable benefits, including:

- Reduction in anxiety;
- Physical benefits via small reductions in heart rate, respiratory rate and blood pressure; and,
- A large effect on patient quality of life.³¹

This is consistent with general medical experience that cancer care is supported by appropriate psychosocial interventions. While this is somewhat subjective, the evidence is strong that music therapy as an adjunct therapy for cancer care could usefully be included in the MBS.

Music Therapy Services

Description in Australia

“Music therapy is a research-based practice and profession in which music is used to actively support people as they strive to improve their health, functioning and wellbeing.”³² (AMTA) “Registered Music Therapists working in mental health settings are qualified professionals who use music and therapeutic skills to support people to participate in music experiences within the context of a therapeutic relationship”³³. “Specifically tailored music-based interventions are developed to meet patients’ idiosyncratic objectives. Commonly used interventions include song writing, lyric analysis, improvisation, facilitated drumming, music and relaxation.”³⁴

Songs are used by patients as a structured and safe way of expressing feelings that they may not be able to access or express otherwise and these music experiences are used in a therapeutic manner to support discussions or reflections that enable patients to explore their experiences and/or to relate experiences in therapy to their life.

Similarly, patients and RMTs may choose instruments on which to play improvised music and therapists support patients by identifying tones, rhythms and instruments that can support therapeutic interactions.

Registered Music Therapists empower the people they work with to use music as a health resource. For example, the creation of playlists can assist patients in supporting their wellbeing outside of music therapy sessions and provide ongoing therapeutic support to their mental wellbeing.

³¹ Bradt, J. et al, “Music interventions for improving psychological and physical outcomes in cancer patients (Review)”, *Cochrane Database of Systematic Reviews*, 8 (2016)

³² <https://www.austmta.org.au/content/what-music-therapy>

³³ Bibb, J., Castle, D., McFerran, K. S. (2018). Stakeholder input into the implementation of a new music therapy program in a mental health service. *Mental Health Review Journal*, Vol. 23 Issue: 4, pp.293-307, <https://doi.org/10.1108/MHRJ-12-2017-0056>,

³⁴ Silverman, M.J. (2015). ‘An overview of music therapy as a psychosocial intervention for psychiatric consumers’ (pp. 53-70) in *Music therapy in mental health for illness management and recovery*. NY: Oxford University Press.

Governed by their professional Standards of Practice (AMTA Code of Ethics)³⁵ Registered Music Therapists, like other allied health professionals, are practiced in the processes of preparation, assessment, service delivery, and evaluation. Likewise, they work with their patients to establish goals for therapy and document this as part of their regular practice and reporting.

Music therapy is recognised and funded in Australia by the National Disability Insurance Scheme as an allied health profession important for a range of participants to meet their capacity building goals.

International experience

The UK National Health Service (NHS), like many other social insurance systems, employs RMTs and actively promotes music therapy service provision as a field of study and career. As with other NHS activities, RMTs are salaried rather than remunerated through an MBS-type activity-based payment, with starting salary at £30,401.^{36 37} This pay is consistent with experienced paramedics and clinical psychologists under supervision.

Looking at the US – a diametrically-opposed healthcare environment relying predominantly on private insurances – a typical health insurance describes music therapy as positive component of treatment: “You can use music therapy to help your mental and physical health. It helps people express themselves, find new memories, and calm the body and mind through its rhythm, order, and predictability.” Specific applications of music therapy here include dementia treatment, preparation for surgery, and analgesia in cancer treatment.³⁸

The question of whether US insurances are cost-effective for music therapy is more fraught. As with any therapy, this depends on type of insurance, copayment arrangements and deductibles. An illustrative example shows that, in the US, consumers may be better not to use their insurance, simply because the deductible is so high.³⁹ This an artefact of the US health insurance system, with no community rating, rather than a reflection on music therapy itself. The cost-effectiveness will depend upon whether music therapy is the primary component of their healthcare for that year.

An interesting third variant is seen in Canada where, despite the evidence for clinical effectiveness, music therapy is generally only available for out-of-pocket (OOP) payment. Consequently, a charitable trust has been established which seeks to increase access to music therapy through direct funding.⁴⁰

Looking at advanced healthcare systems in our region, Singapore now funds publicly available music therapy within its hospital system, advising: “Music therapy is an established allied health profession where music and music activities are used to address physical, psychological, cognitive and social needs of individuals. It is the clinical and evidence-based use of music interventions to accomplish

³⁵ https://www.austmta.org.au/system/files/code_of_ethics_2018.pdf

³⁶ <https://www.healthcareers.nhs.uk/explore-roles/allied-health-professionals/roles-allied-health-professions/music-therapist> Downloaded April 2019.

³⁷ Band 6: £30,401: <https://www.healthcareers.nhs.uk/working-health/working-nhs/nhs-pay-and-benefits/agenda-change-pay-rates> Downloaded April 2019.

³⁸ <https://www.cigna.com/individuals-families/health-wellness/hw/medical-topics/music-therapy-tn7371spec> Downloaded April 2019.

³⁹ <https://harmonymusictherapy.com/will-insurance-cover-music-therapy/> Downloaded April 2019.

⁴⁰ <http://musictherapytrust.ca/about-us/> Downloaded April 2019.

individualized goals within a therapeutic relationship.”⁴¹ However, as of the most recent report, music therapy had still to be recognised as a medical discipline which is required in Singapore for patients to access their insurance funds.⁴²

Unlike Australia, many international systems recognise the value of music therapy and support its funding, either directly by government or via private health insurance. At the same time, some of the challenges found in Australia are also replicated in some countries, such as the lack of awareness of the most appropriate application of music therapy; and lack of support from the public and/or private insurance systems. Each of these can be addressed by normalisation of music therapy as a recognised allied health care activity through public funding initiatives.

Case Studies*

*Fictitious names are used for the below Case Studies

Anna benefits from music therapy

Anna is a 22 year-old horticulture student who loves animals and watching movies. During high school, Anna struggled with poor body image and social anxiety. When she was 17 years old, Anna was involved in a traumatic car accident and her boyfriend died. Since then Anna has found it difficult to cope with the intense emotions she has felt in response to this experience.

Anna has tried different ways of coping with her feelings from both the past and in everyday life. This has involved using drugs and alcohol and cutting herself with razor blades. Anna has also dieted on and off over the years, but lately she has begun eating only once a day and exercising three hours a day in an attempt to lose weight and feel a sense of control in her life.

In the last six months, Anna lost 10 kilos and her BMI is currently 15. Anna’s dieting behaviours are making her more withdrawn and anxious. She has stopped eating with her family at home and spends most of her time in her bedroom. Anna still goes to uni classes some days but she has trouble concentrating and her friends and family are concerned about her.

Anna thinks about all kinds of things, just as any person does, but at the moment her thoughts mostly relate to her eating disorder and have become overwhelming and consuming. Around meal times particularly, Anna feels a sense of guilt, shame and hatred of herself and has a strong urge to control her food intake, purge food or exercise excessively.

One day, Anna fainted at university and was taken to hospital. She was admitted to the eating disorders unit at her local hospital because her weight was dangerously low and she had a low heart rate and body temperature. While she was in hospital Anna attended the weekly music therapy group which was offered by a Registered Music Therapist.

⁴¹ <https://www.sgh.com.sg/patient-care/specialties-services/Music-and-Creative-Therapy-Unit> Downloaded April 2019.

⁴² Kwan, M. et al, “Developing Music Therapy as a Professional Allied Healthcare Discipline: The Task Ahead for the Association for Music Therapy, Singapore”, *Music and Medicine*, 6:1 (2014).

During music therapy sessions, the RMT encouraged Anna and the others in the group to participate in singing, listening, choosing and discussing familiar songs together, as she knows that familiar music is most effective in engaging young people in therapy. They were able to choose songs from a songbook, which the RMT played live with voice and guitar, and to share their own music preferences. The RMT assessed the emotional state of participants in the group and intentionally played the songs in a way that matched the feelings expressed in the group, changing the tempo, rhythm, pitch or key and emphasising certain lyrics.

Listening to the music the RMT played triggered emotions in Anna and she didn't know why. She couldn't describe her feelings but the music helped her to cry and feel something inside her, when for months she had simply been feeling numb. Releasing the emotion made Anna feel calmer and helped her have a break from the anxiety and negative thoughts that consumed her. Hearing other people who had the same condition talk about their emotional reaction to the music also helped her to feel not so alone in her experience. She was able to connect to the other people in the group through their similar music choices and Anna opened up and began to talk with other people - something that she had not done in months.

Over the weeks in hospital, as Anna's condition improved and she began to restore weight, she chose to participate in individual music therapy sessions too. She worked with the RMT to recognise which songs were helpful when she was feeling low or anxious, and which ones actually made her feel worse.

The RMT assessed Anna's use of music during difficult times and together they created playlists that ordered Anna's chosen songs in a purposeful attempt to help her improve her mood and cope with anxiety at home. Each week they worked towards achieving a set of goals around tolerating her emotions and processing them through music listening. The RMT and Anna worked towards this by choosing songs that were familiar to her but that also matched the level of anxiety Anna felt initially after eating and progressively lowering this, through different qualities in the music.

The songs in Anna's playlists helped her to tap into her emotions, making her feel in control of her thoughts and experiences. Anna also began to listen to the songs that she and her boyfriend used to play together at high school. In the past, Anna had avoided listening to these songs or listened to them in order to make herself feel guilty about the accident and to harm herself. When Anna listened to those songs with the RMT and talked about the memories and emotions they evoked, she was no longer scared if they came up randomly on her iPod or while she was watching the TV.

When Anna was discharged from hospital, she was referred to a different RMT at a private clinic and continued to attend weekly individual music therapy sessions in the community. Although Anna's recovery was full of ups and downs, Anna's experience of music therapy allowed her to use music in her life to regulate her emotions instead of relying on self-harm or dieting. Music and music therapy helped Anna to process her trauma and her emotions and experiences in a healthy and helpful way.

Beth's experience without music therapy support

Beth is a 30-year-old woman who works as a graphic designer and enjoys reading and playing basketball. Over the last few years, Beth has struggled with anxiety and depression and finds it difficult to cope with the intense emotions she experiences.

Beth lives with a friend and together they go out to the local pub for trivia nights and to watch live music. Lately though Beth has become withdrawn and doesn't go out with her friend anymore. She still attends work most days but comes home and spends most of her time in bed as she feels sad and tired. Beth has tried different ways of coping with her feelings by using drugs and alcohol and cutting herself.

Beth also listens to music in her bedroom as a way of trying to process her emotions, but sometimes she deliberately listens to songs that make her feel even sadder and can't stop herself from listening to them over and over again. Beth will sometimes drink alcohol while she listens to music in this way and the emotions build up often leading her to harm herself in order to find a release.

Beth's friends are worried about her but she thinks they would be better off without her. One day Beth's friend approached her about her behaviour, but this made Beth feel angry and added to the intensity of emotions she was already feeling. Beth stayed in her bedroom that night and played the music she knew would make her feel sad and even more angry, cutting herself and drinking while listening to certain songs on repeat.

Beth felt worse and worse but didn't get the release of emotion she usually felt from harming herself. The songs played over and her feelings built up even more, until she didn't care if she lived anymore, feeling helpless and hopeless. Beth was taken to an emergency department later that night after her friend found her in her bedroom after having attempted to end her own life. She then spent a month on the inpatient psychiatric unit in the hospital.

Although a song or a particular piece of music is unable to 'cause' someone like Beth to want to end their own life, music can be intentionally used in unhealthy and unhelpful ways that can lead to suicide. This is particularly relevant for someone like Beth who already experienced difficulty regulating her emotions and used music in isolation.

It is important that people with mental illness like Beth have access to music therapy with an RMT in order to engage in ongoing discussions around the healthy and helpful use of music and individualized playlist creation. It is essential that access to music therapy is prioritized in community mental health treatment to ensure that music is used safely as a helpful coping strategy for long-term recovery.

Delivering support to indigenous people through music therapy

*Consent has been given by Jim's custodian to share this story.

Jim is a 32-year-old indigenous man from Arnhem Land in the Northern Territory. Jim's family follow Yolngu culture and speak Yolngu Matha. At home, Jim enjoys doing 'men's business' and going hunting and fishing on his land.

A few months ago, Jim was visiting Darwin with his family when he was influenced by others to drink in the 'long grass' and did not return home. Jim continued drinking each night in Darwin which led him to get into trouble with the law and he served three months in prison.

After leaving prison, Jim was placed into an Alcohol and other Drug rehabilitation program for three months by his parole officer. During this time, Jim attended music therapy with a Registered Music Therapist along with other therapies provided by the facility.

Jim attended weekly group and individual music therapy sessions with the RMT with the goal for him to express himself through verbal and non-verbal communication. This was important as Jim had a limited understanding of English and also had trouble expressing his emotions. The RMT used culturally appropriate songs which were familiar to Jim and supported him to share his memories and feelings associated with the music with the rest of the group.

Through this process, Jim shared his desire to be back 'on country' with his family and to be healthy and happy again. The RMT also encouraged Jim to express how he was feeling through drumming by improvising on her guitar using different modes and keys which reflected Jim's drumming patterns and his changing mood states.

Upon leaving the program Jim reported that exploring his emotions through music with the RMT allowed him to develop a greater understanding of the consequences his actions had on his health and his family. Music therapy helped Jim to process his feelings and communicate how he was feeling at a time when he had come to rely on alcohol for coping instead.

Greta's support from music therapy

Greta is a 14 year-old in grade 10. She was admitted to the adolescent mental health inpatient unit for increasing suicidal ideation, school refusal and deliberate self-harm. Greta had been engaged with medication treatment and management with her GP and private psychologist for the past 12 months. This was Greta's first mental health inpatient admission. Greta had not attended school since week 4 of Term 1 and her parents were concerned about her. Greta's GP referred her for a mental health inpatient admission due to her increased suicidality in the context of experiencing social and academic stressors related to commencing school again.

Greta was referred to the hospital's Registered Music Therapist as the medical team found it difficult to engage with her. This was further heightened by Greta's pre-existing speech and language difficulties.

During Greta's 10 day hospital admission, she participated in 6 music therapy sessions during which the RMT completed an initial risk assessment. This revealed that, prior to Greta's hospital admission, Greta developed an unhealthy relationship with music. She had started to listen to music that triggered traumatic memories of being bullied at school which included students writing notes to "kill yourself" to Greta. This further heightened her feelings of isolation and eventually resulted in an attempted suicide and subsequent hospital admission. During Greta's initial music therapy sessions, she also disclosed her intention to try to take her life again to the RMT.

As part of her treatment plan, the RMT continued to engage with Greta through guitar playing and song writing with a goal to increase emotional literacy and management, expression and help-seeking. Greta told the RMT how she was feeling and together they developed the words and music in the song.

The RMT used her skills in improvisation to play different modes and chord progressions on the guitar to match the music with Greta's changing feelings. She also used her skills as a therapist to build rapport with Greta and draw out what she was feeling to develop the song lyrics. This process helped Greta to understand her feelings through the music and the song made it easier to share how she was feeling with her parents.

The RMT also worked with Greta to develop a safety plan, detailing steps of how and when to use music listening and guitar playing to express emotions, manage low and negative mood states, and minimise the potential for further suicide attempts when she left hospital. With the RMT's guidance, Greta developed a tailored song list she could use to communicate with her parents, alerting them to when she was feeling unsafe. Along with playing her guitar, this song list was Greta's preferred means of expressing her emotions to her family. The RMT also worked with Greta's parents, training them on how to use Greta's music engagement at home as an "emotional thermometer" to support her ongoing mood management and promote help-seeking.

Registered Music Therapists

Training

Registered Music Therapists in Australia have graduated from a music therapy course accredited by the Australian Music Therapy Association and, in addition, must continue to meet the competency standards established by AMTA through compulsory participation in AMTA's continuing professional development program.

Currently there are two courses accredited by AMTA in Australia – the Master of Music Therapy at The University of Melbourne and the Master of Creative Music Therapy at Western Sydney University. Both courses have four streams focusing on research, theory, methods and clinical training.

The courses support practitioners to learn how to use music as a therapeutic modality through selecting, improvising, composing and arranging music with and for patients to meet individual and group needs. Students are required to undertake external clinical placements as part of their training and are exposed to people across all stages of the life span from premature babies to the elderly. These placements are supervised by Registered Music Therapists in settings such as hospitals, schools, residential care and the community.

In addition to clinical placements, students are engaged with reflective practice and critical thinking process through research.

Most people who undertake music therapy training are graduates from either the field of music or from courses relating to health and wellbeing.

The two-year Masters program provides advanced knowledge of the theory and research of music therapy. Traditional and innovative approaches to practice are taught together with playing and voice skills, improvisation, songs and receptive music therapy.

The courses also include study of the professional development and history of music therapy and the various theoretical constructs and methodologies that inform clinical work. The focus is on a thorough and formal understanding of the clinical issues that practitioners need to manage as well as their professional and ethical responsibilities.

Accreditation

Accreditation of courses by AMTA provides assurance to Registered Music Therapists, their patients and employers as well as the broader Australian community that appropriately high standards of education and training are undertaken by graduating practitioners.

Each music therapy course is reviewed by the Education Committee of AMTA before being accredited and accreditation is granted to new courses for a provisional period of two years. At the end of that time, the course is validated against strict criteria and accreditation either confirmed or removed. Courses are then reviewed every five years to validate and confirm their ongoing accreditation status.

Some of the requirements for accreditation include: that courses must be offered by an approved university or affiliated with a university; each course is at least two years full time specialisation in music therapy at Masters level; Course Directors should have a PhD in music therapy and have worked at least four years full time as an RMT; and applicants for entry need to be tertiary qualified in music or equivalent.

In addition, at least 640 hours of clinical training must be offered as part of the course and clinical training must be completed in at least three different sites and with a diversity of patients, both individually and in groups. This is in line with other allied health professional training, such as speech or occupational therapy.

Changes to already accredited courses need to be reported to the Chair of AMTA's Education Committee and any significant changes require the endorsement of the Committee.

Regulation

Currently, the Australian Health Practitioner Regulation Agency (AHPRA) is responsible for the regulation of only a limited selection of Australia's allied health professionals. Registered Music Therapists are not currently incorporated within this selection and, as such, AMTA is currently undergoing the process of applying for registration with the National Alliance of Self-Regulating Health Professionals (NASRHP).

The AMTA is also a member of Allied Health Professions Australia (AHPA), which is the peak body for the broader sector. AHPA provides the definition of an allied health profession in Australia.

NASRHP is committed to providing assurance to consumers, government and other entities regarding the safety and quality of self-regulating health services and maintaining an evidence-based national framework of regulatory standards. Membership of NASRHP ensures that the commitment has been translated into practice and membership is limited to peak professional bodies responsible for regulating a specific allied health profession.

Competencies

On graduating from one of the AMTA accredited Masters courses, students are required to meet AMTA's competency standards across a variety of skills including music skills for therapy practice; psychosocial knowledge; clinical knowledge; and music therapy knowledge and practice.

Music skills for therapy practice include capabilities such as playing a musical instrument and utilising their voice at an advanced standard of musicianship and one deemed therapeutically effective by clinical supervisors; appropriate and sensitive improvisation skills; the capacity to perform a wide repertoire of songs suitable to a range of ages, cultures and interests; and have receptive music therapy skills that enable them to select appropriate music for therapy sessions with individuals or groups.

Other skills include understanding the aetiology and characteristics of various disorders and/or conditions that patients may experience at different ages and stages; the impact and role of government policy on health and welfare services; and the role of music therapy alongside medical and other allied health professional services.

In addition, the capacity to design music therapy programs and assess and evaluate the effectiveness of these and patients' responses to them is critical as are strong communication and interpersonal skills, ethics and self-care.

Numbers of Registered Music Therapists

There are currently 583 Registered Music Therapists in Australia and approximately 61 students expected to graduate in the coming year. Some 284, or slightly under half of these RMTs are in private practice, including under the NDIS. However, these may overlap with public positions, which explains the data below.

The workforce is currently female dominated as is the student cohort. At the same time, there is significant diversity within the workforce, including a small number of aboriginal practitioners.

Working environment

RMTs working in the area of mental health are employed in a variety of settings. Nearly 60% are employed in organisations in either full time, part time or casual roles with the remaining practitioners working on a contract basis, either with individuals and/or organisations.

Around 43% of RMTs work with inpatients in public hospitals and 35% work in the public community settings funded by Government or bodies such as the NDIS, transport accident commissions, WorkCover and the like.

Approximately 10% of RMTs work in private inpatient settings and another 10% are working in the community funded by private individuals directly. Around 2% work in community settings where funds are provided by grants or fundraising.

18% of therapists surveyed work in other environments.⁴³

Workload

The workload of RMTs varies greatly depending on the environment in which they work. Those working in private inpatient settings work an average of 6 hours a week whilst those working privately in the community do so for an average of nearly 8 hours weekly.

Those working in public settings tend to do so at a higher average rate weekly. Those in public inpatient settings work an average of 15 hours a week and those in publicly funded community settings work around 8 hours weekly as do those who answered 'other' to the survey.

Median income for RMTs is between \$40-59,000, though it is unclear how this is affected by full- or part-time employment.

⁴³ Information provided by AMTA: figures do not add to 100% due to many practitioners working in a variety of settings.

Inadequate access without MBS

Absence of MBS rebates for patients means there is a technically incomplete market for music therapy in Australia. Given the dominance of the MBS as a health funder in Australia, as well as its dominant presence in the Australian public mind, this presents three problems:

1. Other psychological therapies which are funded under the *Better Access* and chronic disease management initiatives, will not always dominate music therapy as the optimal choice for all patients. Consequently, but funding these but not music therapy the Government risks inefficient health spending. In these cases, there is also no saving;
2. Outpatients who require music therapy and do access it currently face out-of-pocket costs. This may be a hardship where music therapy is prioritised within a tight household consumption equation, and may also lead to inadequate consumption, limiting the effect of the therapy; and,
3. Australians tend to judge the quality of therapy by whether it is funded via the MBS. This is a motive of credibility. While the evidence for music therapy is strong but awareness is constrained by lack of publicly-funded access, appropriate consumption of music therapy will be sub-optimal.

There is a fundamental equity issue to be addressed here. Music therapy has proven benefit, but is more available to those in higher socio-economic circumstances.

Consequently, inclusion of music therapy on the MBS is an important next step in providing appropriate psychological support for Australian patients.

Pathways of Treatment

Clinical decisions for the selection and referral to a Registered Music Therapist are outside the scope of this paper. However, positive evidence exists for multiple applications, including anxiety and depression; psychoses; disability and rehabilitation; dementia; and pain management.

Both in order to ensure appropriate clinical selection and to constrain costs, access to any MBS number for music therapy would require primary care referral, either:

- By a general practitioner;
- By a relevant specialist, such as a psychiatrist or paediatrician; or,
- Upon hospital discharge.

While other members of the allied health profession (e.g. clinical psychologists) may be well-placed to recommend music therapy, it is formally better if access still requires referral via normal pathways. This is a limited hurdle as general practitioners will commonly support patient desire for recommended therapies.

This will potentially require a program of education for potential referrers such as general practitioners.

Better outcomes delivered via MBS funding

Benefits which may be captured following MBS funding will generally fall into two categories:

- Publicly-captured benefits, including:
 - Increased participation in the workforce, amongst both patients and carers, and the broader economic participation, including tax revenues and consumption, which flows from this;
 - Reduction in consumption of other healthcare and support services, particularly hospital services and other MBS-funded interventions;
- Privately-captured benefits, including:
 - Greater health and wellbeing;
 - Higher levels of social participation; and,
 - Less burden on family and other informal carers.

These are equally important goals, and both have significant economic value.

How to deliver MBS funding

Which MBS numbers are most appropriate

Registered Music Therapists treat people with a range of mental health issues, ranging from anxiety and depression to eating disorders, such as anorexia and bulimia, through to serious low-prevalence disorders including psychosis and schizophrenia. In addition, music therapy is an appropriate treatment for those living with disabilities and certain chronic conditions as well as palliative care and conditions of ageing.

Given this, there are various ways by which MBS funding can be provided to support people requiring music therapy, particularly through the *Better Access Initiative* and through MBS rebates available to allied health professionals for chronic disease management. Importantly, given the current programs in place, access to music therapy can also be delivered within the current funding envelope enabling patients both greater access to care and more choice in the services delivered to them.

Better Access initiative

The *Better Access* initiative provides Medicare rebates to patients requiring selected mental health services provided by a range of medical and allied health practitioners with the aim of improving their outcomes.

Medicare rebates are available for up to ten individual and ten group allied mental health services annually to patients who are referred by their GP under a GP Mental Health Treatment Plan; under a psychiatrist assessment and management plan; or a psychiatrist or paediatrician.

Services that can be provided within this initiative include assessment and therapy services together with “focussed psychological strategies services” akin to those provided by RMTs.

At present, these services can be provided by allied health professionals such as social workers and occupational therapists as well as appropriately qualified GPs and eligible psychologists. Given the alignment in the training and accreditation of the other allied health professionals recognised by this initiative and that of RMTs, it would be appropriate to broaden the eligibility requirements to include RMTs within the list of those professionals able to provide mental health services under the *Better Access* initiative.

Chronic Disease Management

Under the MBS, GPs are able to plan the health care of patients who have chronic or terminal medical conditions. These are conditions that have been or are likely to be experienced by a patient for more than six months and who need a structured approach to their health, such as ongoing care from a multidisciplinary team of healthcare providers. Patients in residential aged care facilities can also access chronic disease management support.

A patient’s eligibility for chronic disease management services is subject to referral from their GP and the patient also needs to have a GP Management Plan or Team Care Arrangements in place in order to access MBS rebates for these services. Where the patient is eligible, they can access up to five allowable items each calendar year.

These services include “mental health services” provided by an eligible mental health worker (MBS item 10956). Mental health workers include psychologists, mental health nurses, occupational therapists, social work, Aboriginal and Torres Strait Island health practitioners and Aboriginal health workers.

Given the alignment between the training and workflows of many of these practitioners and RMTs and the benefits available from music therapy, including RMTs within the list of eligible mental health workers would deliver both choice to patients and greater access to the treatment they need at the appropriate time.

Benefit-Cost Analysis

Individual Case

Here a fundamental benefit-cost analysis (BCA) is applied to music therapy. Music therapy potentially reduces a number of costs and losses within the Australian health system, some of which are easier to quantify than others. Potential benefits include:

- Direct reduction in burden of disease, which is the principal target of most therapies;
- Reduction in associated economic losses, including the patient's capacity to participate in the economic marketplace as well as that of their carers;
- Reduction in demand for other healthcare services due to the impact of music therapy on the condition it is treating; and,
- Privately consumed benefits, in terms of wellbeing and life experience.

Against these gains, we also need to net any potential costs. While these will include the direct costs of music therapy services, in many cases these would substitute for other psychological interventions. In these cases – and particularly if the relevant MBS number were the same – the incremental cost would be zero.

Accordingly, the basic analysis of the incremental benefit of any music therapy (of any duration) is given as:

$$Gain = \Sigma_{MT \text{ reduction in losses}} - \{C_{MT} - C_{foregone}\}$$

Where,

$\Sigma_{MT \text{ reduction in losses}}$ is the sum of all the benefits described above, to the extent they can be quantified. Importantly, this is the share of any gains which may be ascribed to music therapy, which we recognise may be part of a multidisciplinary therapeutic set. For healthcare funding purposes, this will typically be expressed in disability-adjusted life years (DALYs) gained.

C_{MT} is the public cost of providing music therapy. This is simply any prospective MBS payment(s) for a course of therapy. It does not take into account capital costs (which we assume are vanishingly small, as music therapy requires little specialist equipment or facilities). Any out-of-pocket (OOP) costs, either direct (fee for service) or indirect (transport, value of waiting time etc) are also excluded. On the latter, OOP costs are minimal compared to many other medical and allied health services.

$C_{foregone}$ is the cost of any healthcare service to the Government which may be obviated by substituting music therapy. We presume in the private sector - where MBS payments will apply - that this is a common event. Whereas in hospital settings, it is common to offer a multitude of therapeutic interventions, according to availability, anecdotally private patients tend to pursue one allied health intervention at any given time.

To translate this into a proper BCA, using the Australian Government's preferred incremental cost-efficiency ratio (ICER) we would have:

$$\frac{C_{MT} - C_{PT}}{DALYs\ Gained}$$

Where,

C_{PT} is the cost of an alternative prevailing therapy for which music therapy seeks to substitute. This is relevant where music therapy replaces a therapy currently being funded by the MBS. Two features are important here:

In the case that the price of C_{MT} and C_{PT} are the same (e.g. both *Better Access* and at the same frequency), then $C_{MT} - C_{PT} = 0$, and of course the entire equation must equal zero. In this case, the test is simply which delivers more DALYs, which is the basis for clinical selection. In this instance, the Government is indifferent both in terms of healthcare and cost;

Where music therapy is simply an additional treatment, it does not replace any prevailing therapy, so the incremental cost will simply be C_{MT} itself. In this case, we have a simple ratio of $C_{MT} : DALYs\ Gained$

No on-costs are expected alongside the music therapy, so these are not included in this version of the ICER. The general test here is whether the outcome of the equation is less than \$50,000, which is the commonly-applied value of a life-year for health funding purposes.

As noted above, while there is a vast literature which accepts the benefits of music therapy across a wide spectrum of disorders, there are difficulties with data. As noted earlier, there is a tendency to describe effects in relative terms of small, medium and large, which is not strictly quantitative.

Despite this, detailed quantitative evidence exists demonstrating that scaling up treatment for depression and anxiety (of which music therapy is in some cases an appropriate treatment), will – in high income countries – deliver:⁴⁴

- A benefit-cost ratio in dollars of 2.5:1, if solely economic effects are taken into account; and,
- A benefit-cost ratio of 5.3:1, if the value of health outcomes is included, which in turn accounts for some private consumption.

⁴⁴ Chisholm, D. et al, "Scaling-up treatment of depression and anxiety: a global return on investment analysis", *Lancet Psychiatry*, 3 (2016).

These are significant returns and may be regarded as a baseline for any further public funding of music therapy. Where it is a substitute, there is no cost so the returns are effectively free.

Similarly, another study concludes that: "... the use of music therapy for the reduction of anxiety and stress levels is shown as an auxiliary therapy, which, in association with other treatments, is cost-effective ... in palliative care."⁴⁵ Here, music therapy is an adjuvant treatment. Cost-effectiveness in palliative care is notoriously difficult to demonstrate, and requires such modifiers as end-of-life premiums, so this is a highly encouraging assessment.

Nonetheless, given the broad spectrum of treatment, and the general heterogeneity of patient profiles, any economic analysis of creative therapies faces limits.⁴⁶ Part of the problem here is that benefits are expressed in personal utility, which is subjective, and notoriously difficult to quantify.

Accordingly, the better approach is to invert the equations to ask what level of outcome is required to justify the costs of music therapy.

Here the question of dosage is considered. Gold notes that as few as 16 sessions may be required to deliver 'a large effect' in mental health. This is used as a proxy for other conditions, as dosage is most clear here. N.b. while many patients may have more sessions than this in a given year, it is within the 10+10 limits of the *Better Access* initiative, which is our constraint. In this situation, music therapy is assumed to be the primary therapy consumed under this scheme, which will permit an adequate number of sessions.

For comparison here, the following is used:

- 8 items of the individual psychologist rate in consulting rooms (MBS item number 80100) of \$60.10⁴⁷ = \$480.80, plus;
- 8 items of the psychologist group rate (MBS item number 80120) of \$21.65 = \$173.20;
- Leading to an annual MBS cost for a large effect of some \$654.00.

If a DALY is worth \$50,000, then the compensation for this expenditure would need to be .013 or 1.3% of a DALY. Even if all 20 sessions of the *Better Access* initiative are used at the combined rates (\$817.50) and there are no savings elsewhere, only 1.6% of a DALY needs to be delivered to justify them.

Given the disease burden of mental illness discussed earlier, is unimaginable that this would be considered as a large effect, so the proposed inclusion is implicitly cost-effective. This does not take into account the other economic effects described. Given the availability of the *Better Access* initiative to Australians currently, this is not a novel availability of funds, and the cost is minimal for expected benefit.

⁴⁵ Aguilera, Op. Cit., p.104.

⁴⁶ For comparison, see: Uttley, L. et al, "The clinical and cost effectiveness of group art therapy for people with non-psychotic mental health disorders: a systematic review and cost-effectiveness analysis", *BMC Psychiatry* 15:151 (2015).

⁴⁷ These assume 75% funding.

Similarly, the access to mental health services for chronic disease – MBS item number 10956 – is limited to five visits each calendar year at an 85% contribution of \$52.95. The maximum payment for one person per year is therefore limited to 0.5% of a DALY.

As anxiety and depression are the highest source of lost DALYs in Australia for women at 10% and third for men at 4.8%,⁴⁸ increased availability of effective mental health services should be a priority. Again, the selection of music therapy over alternative therapies within the MBS *Better Access* and chronic disease management caps is a clinical matter, but widening the available selection of therapies at little incremental cost is an attractive policy proposal.

Overall exposure

The overall exposure to the MBS for inclusion of music therapy is primarily constrained by caps for allied mental health services. While it is difficult to anticipate the number of patients currently using neither the *Better Access* or chronic disease mental health programs who will become novel music therapy patients, this can be reasonably expected to be a small number.

New patients are likely to be mostly those who are purchasing music therapy from their own pockets and not currently accessing the MBS for other psychological services. Anecdotally, this is a small number. In any case, these are patients for whom music therapy is the most appropriate treatment and it is inequitable if less-effective treatments are funded to its exclusion.

A further constraint for growth, amongst private practitioners, is that the rate available from the NDIS dominates the proposed MBS rates. Even if the MBS item number 10956 were levied for its minimum 20 minutes, which is highly impractical for music therapy, then the hour would be worth less than \$179.

Finally, the Government's exposure is further limited by the size of the sector, the limited venues for training of RMTs, the small number of hospital positions, the training cost and unpredictability of private practice.

Looking at current figures:

- With 284 private practitioners currently;
- If we assume a modest annual retirement or new vocation rate of 5%; and,
- That 61 new graduates will enter private practice at the same participation rate of 49%, giving us 30 new entrants per year;

⁴⁸ <http://www.health.gov.au/internet/publications/publishing.nsf/Content/womens-health-policy-toc~womens-health-policy-key-womens-health-policy-key-burden> Downloaded April 2019.

- Then:
 - In five years, the expected cohort will be 343; and
 - In ten years, it will be 442.

This rate will be constrained by normal market factors, mostly latent demand, and capacity to obtain referrals. Given median salaries, music therapy will continue to be a vocationally- rather than a financially-driven career option. Student numbers are limited to meet demand, and permit organic growth within the RMT specialisation.

In comparison with the 5,300 registered psychologists currently working in Australia, who already have access to the relevant MBS items, this will have minimal impact.

Recommendations

The evidence for positive impact of music therapy for a range of conditions is sufficiently clear to warrant public funding as part of a suite of allied healthcare.

The ideal inclusion is under the *Better Access* initiative, as music therapy is typically a substitute for or adjunct to other psychological therapies. This will also constrain public exposure as the number of sessions for which the Government pays is limited per patient for all services within the initiative.

Similarly, access to the chronic disease mental health treatment number 10956 is an appropriate means for patients to access music therapy and it is similarly capped.

To further strengthen the existing data on music therapy's benefits, in cooperation with the NHMRC, the AMTA and the accredited music therapy courses, the Government could commission a longitudinal study of patient-reported outcomes from MBS-funded music therapy.