

Recommended Integrated Governments Mental Health Initiatives

Introduction

The Australian Government wants to make a real and lasting difference in mental health.

This paper provides a range of proposals to assist Government deliberations in delivering on this agenda. The focus of these proposals is mainly on delivery through the private sector, which the Federal Government can influence more directly.

If we look at how Government money has been spent over the last five years, as revealed in the National Mental Health reports, we see that there is a need to rebalance where that money is spent. Significant funds have been directed to State and Territory Governments to subsidise public mental health treatment – and that commitment of funds should be continued and strengthened.

Extra funding has been directed to primary care through General Practitioners in the Better Outcomes In Mental Health (BOiMH) initiative. GPs care for a large proportion of Australia's mentally ill, with 75% of people aged over 18 who seek help for a mental health problem seeing their GP in the first instance. GPs are highly trained professionals. This makes it vital that their ability to care for mentally ill patients and refer to other professionals is not restricted. There needs to be a reduction in existing regulations that encumber efficient utilisation of BOiMH. Further mental health training should be encouraged and can be made available to GPs through the existing CPD system.

Background to Psychiatrist Recommendations

We believe that the new Government announcements are an opportunity to strengthen the relative position of psychiatry within the spectrum of medical specialties and private psychiatry across the sectors as identified in Table 1.

Table 1: Government Funds Spent on Mental Health Sectors in Millions of Dollars, and percentage increase in spending, from 1999-00 to 2002-03 (From National Mental Health Reports).

	1999-00	2001-02	2002-03	Percentage Increase
Public sector	1,558	1,798	1,976	27%
General practice	150	167	169	13%
Private Psychiatrists	193	197	198	3%

A particular reason to redress the balance of funding, is that most other mental health initiatives are designed to identify people who require treatment – but without an increase of specialist treatment resources, such case identification is likely to produce community concerns. The primary care initiatives, preventative strategies, suicide prevention strategies and NGO initiatives all have the effect of identifying people who require active mental health treatment. Public and private sector specialist mental health have not been adequately resourced to meet this growing demand.

There are also immediate workforce shortages that must be addressed at the same time to enable any new initiatives to be implemented. It is acknowledged that training measures are included in the initiatives announced in the Budget. However, it is crucial that learned bodies such as the RANZCP and the RACGP are provided an allocation for training resources, so that the specialist and primary care workforce are prepared for the greater treatment load expected under the new initiatives. A particular focus of training will be around collaboration mechanisms, and their best usage.

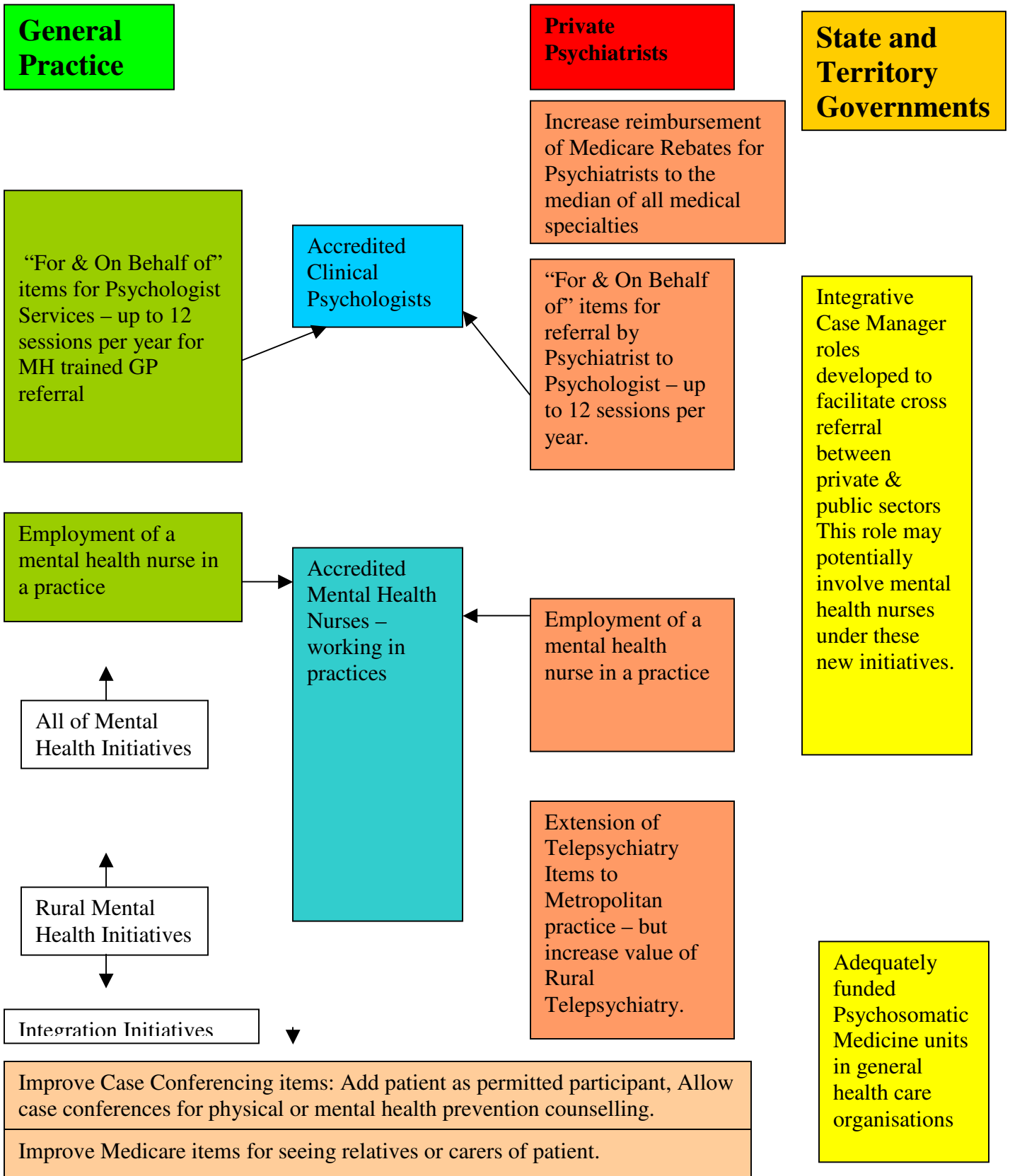
Key policy objectives of our proposals include:

- Improving integration of all mental health care sectors.
- Improving integration of care for both mind and body.
- Strengthening rural mental health initiatives.
- Putting illness prevention and health promotion strategies firmly on the mental health care agenda.

The main implementation components we stress, include:

- Designing the changes to complement existing medical business processes in private practice, rather than design unwieldy changes that will not be used.
- Integrating mental health practice nurses into private psychiatry and GP practice, in a similar way to the implementation of GP practice nurses
- Arranging referral mechanisms to psychologists, for GP's and psychiatrists in a similar way to the chronic disease mechanisms – ensuring integration of the care system.
- Providing relevant training programmes run and coordinated by the Colleges.

The following Table 2, summarises the suggested Medicare item reforms, in the context of key Government Mental Health policy aims.



Background to General Practice Recommendations

Australian Government has put some funding into primary care based mental health care, through the Better Outcomes in Mental Health Initiative (BoiMH). Funding to State and Territory Governments for mental health has been increased markedly but complaints about lack of access to services continue to rise.

The Federal Government has worked with General Practitioners to identify some of the unnecessary red tape that impedes uptake of new initiatives. The elimination of bureaucratic procedures that limit mental health service delivery has to be taken further.

The Federal Government is in a position to take the lead in another key principle of mental health delivery: a desperate need to integrate mental health delivery with primary (physical) health care delivery. For too long mental health delivery has been separated from physical health care delivery, and mental health care has been at a consistently lower standard. The physical health of people with mental illness has also been consistently poor. Only through Medicare, which integrates the two areas of care financially, is there the possibility of true integration of total health for consumers.

While the detail would need to be worked through carefully it is our view that ensuring a greater integration of mental health care with primary care could be achieved by extending the current allied health item, related to the GP Enhanced Primary Care (EPC) items and BOiMH that allows for referral to a psychologist. We propose that these items permit MBS coverage for six sessions, plus another six in some situations, within a 12 month period, and with a higher value for the psychologist service, to ensure lower patient co-payments.

Measures that improve the capacity to employ or integrate the services of mental health nurses into private psychiatrists' office based practices and GP practices, are also suggested. Again, the positive improvements in the employment and integration of practice nurses into general practice and the measures put in place to drive this change may offer a model for the way forward for integration of mental health nurses into private psychiatric care.

General Practitioners

We believe that GPs should be encouraged to seek further mental health training if they are caring for a significant proportion of mental health patients. GPs are currently trained to provide mental health services.

Under our proposal, GP's would be able to refer patients to a psychologist for six visits, followed by six more after review by the GP, within one year. Mental health would be included as an eligible condition for access to the allied health items through the chronic disease items and/or the associated team based arrangement items. Referral to psychologist should also continue to be available through the Better Outcome initiative.

Under the Better Outcome initiative, appropriately trained GPs are also able to provide focussed psychological services at a higher remuneration.

The structure of the EPC items should be simplified to allow ease of access to mental health care. In the current situation a self managed patient whose asthma is exacerbated by severe anxiety can only access a psychologist if the GP undertakes a team care arrangement when, in fact, all that may be required is the development of a care plan. The restriction on access to psychologists by patients with chronic and complex illness where a team care arrangement has been put in place, should be removed for patients who require mental health care. Access to psychologists by GP referral should be available where a patient has a chronic illness, either associated with or diagnosed as, a mental health condition, and where the GP has developed a care plan.

We wish to explore these issues in much greater detail with the Department given the significant complexities that arise around the proposal to consider integrating this new mental health initiative within the current EPC and BOiMH items. In spite of the complexities that will need to be resolved this represents a quality approach in that it delivers “time” to GPs to focus on a comprehensive care plan for patients with a mental illness. It gives the GPs the opportunity to care for the patient where appropriate in accordance with the care plan, and/or to develop team care arrangements and/or to refer on to either a psychologist or psychiatrist as appropriate. Combined with mandatory reporting requirements to the GP incorporated into the allied health items, and additional requirements on psychiatrists to report back, the proposal creates a strong link between primary and specialist care essential to quality, continuity and whole person care.

Illness Prevention Case Conference Items

It is suggested that the existing Case Conference item numbers be made available for GP's to call a case conference in order to discuss ways to implement preventive and early intervention strategies for the mentally ill patient. It would be expected that such conferences would include as many of the people providing service to the patient as possible, but would be expected to include any treating psychiatrist. A proposed change to current approaches to case conferencing is the inclusion of the patient, where appropriate, in the case conference. Uptake of case conferencing items has been poor. In that context it would be important to re-examine the MBS fee for case conferencing with an eye to increasing the schedule fee for GPs (and other specialists) who may convene a case conference and for health and medical who may participate in a case conference.

Private Psychiatric Services

General Increase of Schedule Fees.

The Australian Government policy in relation to Medicare schedule fees has been to let the schedule fees gradually lag more and more behind the real cost of running a medical practice. This has led to an increase in the co-payment made by consumers for all medical services. Private Psychiatrists have been treated in the same way as procedural specialists, and the schedule fees for psychiatrists have lagged more than for GPs. Many

consumers of psychiatrist services are financially disadvantaged on account of their illnesses. Private psychiatrists often discount their patients, but as the schedule fees have lagged, more psychiatrists are now charging higher co-payments (as pointed out by Hickie, et al, 2006). Unless private psychiatrist schedule fees are raised, there will be a need for psychiatrists to continue to increase their patient co-payments.

We suggest an increase in private psychiatrist fees across the psychiatrist schedule to the median hourly rate of all medical specialties and the development of an appropriate indexation system as already required for the entire schedule. Initially there would be a “catch up” percentage increase of 15%, followed by further increases over the next five years to reach this median.

Full Rebate of MBS Items for Healthcard holders

To enable patients on Healthcare Benefits to access private psychiatrists, we propose that they receive one hundred percent rebate on these services. This would significantly increase access for this group of patients to ongoing private psychiatric care and decrease pressure on the public mental health system.

Front end loading

We understand that the Government is intending to use a front end loading mechanism to see more people. We have in the past not supported this approach and continue to have reservations. We would be willing to discuss this issue with Government, and explain our concerns in detail. There would need to be commitment by the Government to ensure that there is no erosion of existing psychiatric treatment item numbers. It needs to be acknowledged that psychiatrists have a dual role of both assessment and ongoing treatment of patients. Private psychiatrists have a major role in providing continuity of care for a group of psychiatric patients with complex needs.

Referral to Psychologists

We propose that psychiatrists can directly refer to clinical psychologists for specific focussed psychological treatments up to 12 hours annually where appropriate. The mechanisms of referral need to be simple and time efficient.

Psychiatrist Case Conference Items

It is suggested that the existing Case Conference item numbers and associated schedule fees be made available for Psychiatrists to call a case conference in order to discuss ways to prevent physical illnesses in people suffering mental illness. It would be expected that such conferences would include as many of the people providing service to the consumer as possible, but would be expected to include any treating GP. A difference to other case conference regulation would be that the patient could be included as one of the number of people present for the conference (and indeed would almost always be present). As has been pointed out, since case conferencing has only been taken up sparsely, it is further suggested that the schedule fees for case conferences be raised for Psychiatrists and other specialists.

Review of Telepsychiatry Item Numbers

These items have been poorly used under Medicare, yet Australia could be leading the world in the provision of telepsychiatry services to rural and remote areas. We believe there are two main reasons for this, which must be addressed. First, these services require great skill, significant medico-legal risk, and significant infrastructure cost and cost of maintenance. The low level of private psychiatrist remuneration under Medicare is well known to Government (noted in Hansard). The level of fees for telepsychiatry services to rural and remote communities should be considerably increased – we think it will need to be quadrupled. Consideration must also be given to the level of remuneration for GPs who participate in telepsychiatry services as part of the provision of mental health care to their patients, particularly in rural and remote communities.

The other problem is a simple business model issue. If a private psychiatrist is only providing the necessary infrastructure for such services for a limited rural and remote set of communities, even if Medicare schedule fees are raised, there is a residual significant business model hurdle: to bother to set up the infrastructure in the first place. We suggest it is necessary to allow telepsychiatry item numbers (with a set of schedule fees set above existing schedule fees) to apply for the application of such services, even in metropolitan areas. We can see the possibility of practitioners providing such services to other practice settings through video-conference; such as GP rooms, nursing homes, private hospitals and even to physically disabled patients at home. Providing such services more widely makes the cost of the infrastructure more worthwhile. Skills can be developed and practised so regularly, that real expertise is created. The psychiatrist can only deal with one person at a time, so the schedule fees for these items can be set in such a way that there will be little increase in cost to Government, except for a small aliquot for infrastructure establishment and maintenance. Experienced practitioners are likely to find remote telepsychiatry much easier to engage in, when video conferencing is a significant part of their normal practice. Rural teleconferencing items may cost extra, but this would be balanced by better service delivery to a needy community.

Item 291 and 293

To enhance the utilization of the Referred Assessment and Management items the rebate needs to be reviewed. To increase utilization of these items by both GPs and psychiatrists there is a need for further education and training and a coordination at the local level between psychiatrists and GPs to ensure easy access for GPs to psychiatrists (as occurs in SA where there is a local coordinator who organises the appointments).

Item 319

There remain unresolved issues regarding this item number that have been the subject of ongoing discussions. We would expect that within any MBS Item negotiations there is opportunity to review the criteria for this Item.

Integrative care measures

We propose that integrative Case Manager roles be developed to facilitate efficient cross referral mechanisms between private & public sectors. This role may potentially involve mental health nurses under these new initiatives.

This proposal would require additional resources to ensure adequate staffing to provide the aforementioned services. This will enhance the integration across public, private, primary and specialist sectors.

There are a group of consumers who largely miss out on adequate mental health care, and these people reside in General Hospitals, Nursing Homes, Homes for the Intellectually Disabled, and other similar institutions in the community. The management of these consumers with physical illnesses can be significantly improved in clinical outcome and financial outcome terms, when mental health care is provided at the same time as general health care. Such service delivery requires the provision of adequately staffed and resourced Psychosomatic Medicine services for those facilities. We recommend that these services should be funded by secure, “ring-fenced” health funding.

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