

1 May 2018

Professor Bruce Robinson
Chair, Medical Benefits Schedule Review Taskforce
Department of Health

By email to: mbsreviews@health.gov.au

Dear Prof Robinson

Re: Medical Benefits Schedule (MBS) Review Taskforce – supplementary submission

Further to your letter of 24 April 2018 and our other recent communications, please find enclosed the Royal Australian and New Zealand College of Psychiatrists (RANZCP) supplementary submission to inform the Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) review of psychiatry services.

This supplementary submission provides additional feedback to the Taskforce to build on the RANZCP response to the Taskforce consultation paper in November 2015. Together these two submissions address the issues you have requested views on. The RANZCP recommends priority areas where the MBS could be enhanced to deliver modern and effective mental health services to the community and to adequately address the needs of those suffering from mental illness, including substance use and addiction disorders. In particular this includes a greater focus on collaborative care with other medical and health professionals, as well as with consumers and carers.

The RANZCP looks forward to continued engagement with the Taskforce as the review progresses and is pleased to hear that the Psychiatry Clinical Committee will be established shortly. I would be pleased to provide further information as required to facilitate discussion of the themes raised in this submission.

To discuss any of the issues raised, I can be contacted via Rosie Forster, Executive Manager, Practice, Policy and Partnerships via rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Kind regards



Dr Kym Jenkins
President

Ref: 1102o



The Royal
Australian &
New Zealand
College of
Psychiatrists



Medicare Benefits Schedule Review Taskforce

Supplementary submission – April 2018

working
with the
community

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental healthcare. The RANZCP has more than 6000 members including over 4000 qualified psychiatrists and over 1500 trainees.

Executive summary

The RANZCP provides this supplementary submission to provide additional feedback to the Medicare Benefits Schedule (MBS) Review Taskforce ('the Taskforce'), to build on its [response to the Taskforce consultation paper in November 2015](#). As stated in its original submission the RANZCP recommends key areas where the MBS could be enhanced to deliver more collaborative and effective mental health services to the community and adequately address the needs of those suffering from mental illness, including substance use and addiction disorders.

This supplementary submission provides the following for consideration of the Taskforce:

- Additional suggestions on how the MBS can more broadly support disadvantaged populations
- Enhanced and supplementary evidence to support and refine the recommendations for rules and regulation changes made in the November 2015 RANZCP submission
- RANZCP response to issues relevant to mental health raised in the Taskforce Interim Report to the Minister for Health (2016)
- Additional issues to be considered by the Taskforce, including in regard to the changing models of care for mental health service delivery including the development of Primary Health Networks (PHNs).

The RANZCP provides its views on the 52 item numbers that will be assigned to the Psychiatry Clinical Committee, in particular focusing on items that should be regarded as high priority for review. The RANZCP has outlined these in detail in this supplementary submission, and in the table listed below. In considering these items the RANZCP has sought to address problems and issues with current services, as well as highlighting where the MBS can be modernised to suit contemporary psychiatry practice. In considering these items the RANZCP does not believe that any psychiatry services listed under the MBS represent low-value-patient care. The time-based psychiatry consultation model under the MBS is efficient, and psychiatrists are generally working using treatments informed by evidence. Only very few of the psychiatry item numbers are for specific treatments or interventions. The RANZCP has however identified some items that could be removed or adapted to encourage greater consistency of practice, and improve provision of services to patients.

The RANZCP considers it critical that the review is clinician-led to ensure that the expertise, experience and views of the profession are best utilised and would be pleased to provide further information and evidence to facilitate discussion of the themes raised in this submission.

Key recommendations

Priority item for MBS improvement	Mechanism to achieve
Greater provision for clinical communication and care coordination	Review the application of the MBS under the Better Access Scheme to allow for greater coordination and collaboration between psychiatrists, general practitioners, psychologists and other allied health practitioners. This includes a new specific item for GP-psychiatrist consultation.
	Access to psychological interventions under the MBS be improved for people in residential aged care.
	Make changes to the provisions for case conferences to make them easier for clinicians to arrange
Greater provision for ongoing consultation with non-patients to enable psychiatrists to work collaboratively with other health professionals and agencies, and to engage constructively with family members.	Removal of the current requirement for item numbers 348 and 350 to be utilised only during initial diagnostic evaluation of a patient. This would remove of the current limit of only 4 consultations with non-patients per year for ongoing management.
Improved provision for telepsychiatry	Make telehealth available for anyone, anywhere, with the extra incentive 50% loading retained only for patients in rural and remote areas, in residential care facilities or under the care of an Aboriginal Medical Service (as currently defined). This would increase accessibility for people disability or severe disorders that make attending in person difficult (e.g. agoraphobia). Removal of obsolete telepsychiatry item numbers 353 - 370
Recognition of new and emerging treatments for which there is increased evidence	Provision for delivery of Repetitive Transcranial Magnetic Stimulation (rTMS) as a treatment for depression be included on the MBS.
Address the accessibility and affordability of psychiatric care	Introducing an MBS rural loading for face-to-face services for patient consultations in rural and remote areas
	Amend MBS item 14224 to properly reflect changes in the complexity of ECT treatment and the increased financial and time demands associated with credentialing and maintaining professional and legislative standards
	Remove the limit on 50 sessions per year for consultation for item numbers 300 – 308, to ensure equitable and affordable access to long-term therapy for patients with complex mental health needs.
	Medicare bulk billing rate for psychiatry services be increased to 100% of the schedule fee from the current 85%, particularly important for those who are socioeconomically disadvantaged.
	Advanced trainees be given access to the same MBS items as consultant psychiatrists, at 65% of the rebate available to consultants to improve patient access and support the provision of accredited training posts in the private sector.

Overview - psychiatry services within the MBS

The RANZCP maintains its position stated in its [November 2015 submission to the Taskforce](#) that there is need for increased funding for psychiatric services overall to meet prevention, early intervention and treatment needs for people with mental health problems. Whilst accepted that this requires a broader approach to mental health, the RANZCP believes that the MBS is a fundamental component that enables access to and provision of treatment within the private system, and that increased flexibility is required to meet these needs and deliver an improved quality of care. Details of how the MBS interacts with the broader health system is outlined in RANZCP's previous submission.

Where can the MBS be modernised?

Patient affordability of health care services remains a key concern for the RANZCP, particularly as a vast majority of patients requiring mental health services are socioeconomically disadvantaged. Psychiatric disorders are often chronic health conditions that require regular and long-term management. Whilst rebates for psychiatry services under the MBS remain notoriously low, the RANZCP welcomes the lifting of the MBS indexation freeze as part of the 2017-18 Australian Government Budget measure as one way of helping people living with mental illness to access and afford the care they need. The RANZCP further welcomes the abolishment of the proposed New Medicare Safety Net (originally planned for implementation in January 2016). The RANZCP believes that the MBS can be modernised to better support populations who are particularly vulnerable to challenges of psychiatric care affordability, and to better support mental health services delivered through primary care.

In its 2015 submission the RANZCP made two particular recommendations to help assist access and affordability of psychiatry services. The RANZCP reiterates that these two provisions are crucially important to improving access to psychiatry services:

- Medicare bulk billing rate for psychiatry services be increased to 100% of the schedule fee from the current 85%.
- Advanced psychiatry trainees be given access to the same MBS items as consultant psychiatrists, at 65% of the rebate available to consultants to improve patient access and support the provision of accredited training posts in the private sector.

Since 2015 there have been developments as part of the outcomes of the National Mental Health Commission national review of mental health programs and services. This has led to a number of changes to service delivery models that may help support access for people with mental health problems including the introduction of Primary Health Networks (PHNs) and Health Care Homes. This provides an opportunity to consider how MBS mental health services can be optimally delivered. In considering these models of care it is important that the role of psychiatrists and others involved in mental health can best work to deliver optimal care.

For example GP access to support and advice from psychiatrists on the management of patients with mental health issues is particularly valued (RACGP, 2016). However, referral to a psychologist is frequently an easier and more common pathway, but one that is not always the most effective. In 2013-14, an estimated 12.8 per cent of GP encounters included management of mental health-related problems - equivalent to an estimated 17.1 million encounters (Productivity Commission, 2016). The Fifth National Mental Health and Suicide Prevention Plan provides a good framework to ensure coordinated treatment and supports for people with severe and complex mental illness and suicide

reduction. People with a mental illness are at a higher risk of suicide than are the general population and there is a need to intervene early for people at risk (Productivity Commission, 2016). Easy two-way communication between psychiatrist and GP can help facilitate better care for patients in transfer between primary and secondary care, may reduce risk of suicide, and benefit patients continuing in primary care, giving them access to specialist care and opinions when necessary. This is particularly relevant in private practice, where regular collaboration is required with both GPs and psychologists. To assist in this area the RANZCP has developed [‘5 key facts for GPs’](#) in regard to MBS item 291.

The Australian Medical Association recently noted that access to MBS rebates for clinical care and treatment provided by GPs and psychiatrists must continue to be available on a universal basis for clinical need, and that this access should not be capped, bundled or rationed (AMA, 2018). The statement further noted that MBS items/funding need to be reformed to provide increased rebates for longer GP consultations for patients with mental illness who often have complex and multiple physical and mental health issues; for psychiatric care and treatment provided to patients with complex conditions by psychiatrists in community–managed settings; and for GPs and psychiatrists to coordinate care to ensure patients are able to continue treatment that keeps them out of hospital and living in the community.

Getting an appointment in a timely manner with a private psychiatrist continues to prove a challenge for many. Waiting lists remain long and some psychiatrists are forced to close their books to new patients. Timely and affordable access to psychiatry outpatient appointments is critically important to people affected by serious and severe chronic, acute and intermittent mental illness. This can prevent illness progression or relapse, and avoid such patients presenting in crisis situations at public hospitals, or through admission at a private hospital where the patient has adequate private health insurance cover. Most frequently it is waiting lists for private psychiatric outpatient appointments that impede access to services. The causes of this are multifactorial, and possible solutions occur at multiple levels, including adequate funding of public mental health services and increased training of psychiatrists. Although these are outside of the scope of the Taskforce, there are many other initiatives that could be addressed through the MBS that could remove impediments to practice, and incentivise good practice and communication to better meet consumer needs. These are detailed further in this submission and the RANZCP is further committed to contributing to the Taskforce to work to address these issues.

Key groups about which the RANZCP is concerned are as follows:

People in rural and remote areas

In 2015, the RANZCP identified that people in rural and remote areas had more limited access to psychiatric care (Meadows et al., 2015) as an outcome of workforce maldistribution. The RANZCP suggested that an MBS rural loading be introduced to build on the range of strategies relating to training, workforce, and innovative models of service delivery aimed at enabling rural communities to access a full range of mental health services as near to their place of residence as possible.

One particular issue is that currently a face-to-face consultation with a psychiatrist in a rural area is not as well remunerated as a telepsychiatry consultation with the same patient from a psychiatrist based in a metropolitan areas (where the psychiatrist can claim for an additional 50% of the item fee). Whilst telepsychiatry provides a valuable service to those in rural and remote areas, the RANZCP would also recommend that a 50% loading be applied to all psychiatry items delivered face-to-face by psychiatrists who work in rural and remote areas.

People from socioeconomically disadvantaged areas

It was noted previously that many people residing in rural and remote areas are also frequently socioeconomically disadvantaged. However, there are also many people living in metropolitan areas who are socioeconomically disadvantaged (Enticott et al., 2016) who would benefit from increased affordability of service.

The RANZCP recommended in its 2015 submission that the Medicare bulk billing rate for psychiatry services be increased to 100% of the schedule fee from the current 85%. This would be particularly valuable for people with a health care card or pensioner concession card.

People with comorbid physical health and mental health problems

As identified previously, there is extensive evidence that people with serious mental illness have much higher rates of chronic physical illness and increased mortality and morbidity rates compared to the general population. The current lack of attention given to the physical health needs of people with complex or chronic mental illness is a serious gap in the health care system, and there are approximately 1.9 million Australians with both complex physical and mental health needs (Royal Australian and New Zealand College of Psychiatrists, 2015). For instance, people with a serious mental illness are between two and three times more likely to have diabetes, six times more likely to die from cardiovascular disease, more likely to die from almost all key chronic conditions and more likely to die within five years of diagnosis. In addition there is a need to consider people with chronic (primary) physical illness and comorbid mental health disorders (2-3 times increased rates of mental disorders in this substantial group).

Medical specialists (in addition to GPs) can already refer to psychiatrists however there could be a place for additional MBS items to encourage this practice as it would further support collaborative models of care that would integrate physical and mental health and improve outcomes in both areas.

The RANZCP recommends that, in conjunction with the Primary Health Care Advisory Group, utilising the Review to make:

- the relationship between physical and mental health a priority area
- effective models of care that integrate physical and mental health and aim to improve outcomes in both areas a focus of funding reform.

Psychiatry in primary care

The provision for support for psychiatrists to offer consultation-liaison work in a primary care setting would help support patients requiring this service. This would be particularly valuable in rural and remote areas, and other areas where the availability of psychiatrists is limited, and for particularly relevant specialty areas such as child and adolescent and psychiatrists working with intellectual and developmental disabilities. There are opportunities through the implementation of programs through the Primary Health Networks (PHNs) to support such initiatives, for example through general practice settings. Implementation could be assisted through MBS funding to support such initiatives for psychiatrists.

One way to deliver this is through the introduction of an MBS item for a GP to consult with a psychiatrist about a patient. This would assist GPs in managing patients with mental illness locally and potentially reduce the need for referral to a psychiatrist. All psychiatrists would be well placed to participate in this service, as every psychiatrist has received training in consultation-liaison as part of their psychiatry core skills. This approach is consistent with the Australian Government's commitment to a stepped care

approach to mental health to improve the efficiency and sustainability of the mental health system. The RANZCP would be pleased to discuss further the documentation required to support this intervention for clinical support for the GP, in collaboration with GPs.

Recommendation: That a new MBS item number be introduced to support psychiatrist-GP consultation to discuss a patient and provide clinical support to GPs.

Problems and proposed changes to existing psychiatry item numbers

In its 2015 submission, the RANZCP made a number of recommended changes to MBS psychiatry item numbers to introduce increased flexibility within the MBS to allow psychiatrists to better be able to deliver high quality patient care, and to improve patient accessibility. In addition to the information provided in the 2015 submission, the RANZCP further sought and received non-publicly available Medicare data from the Department of Human Services to help support its recommendation. Together with publicly available MBS data the RANZCP has found that much of the data supports its recommendations and details are included below. The RANZCP therefore calls on the MBS Review Taskforce to update the MBS as suggested below to better support contemporary psychiatry practice.

Item numbers 291 and 293: interface between psychiatrists, general practitioners, psychologists, and allied health professionals (collaborative care)

Key issues: There is a need to streamline the Better Access process – specific suggestions included simplifying the referral process, reconsidering requirements for the interim report, and improving communication as part of the MBS payment.

Key recommendations:

- Review the application of the MBS under the Better Access Scheme to allow for greater coordination and collaboration between psychiatrists, general practitioners, psychologists, and allied health practitioners.
- Access to psychological interventions under the MBS be improved for people in residential aged care.
- Open up access to item 291 to be utilised in settings other than consulting rooms (e.g. residential aged care facilities).

Data received from the Department of Human Services confirmed that:

- In 2015-16 19,260 individual patients had both a 306 (consultation of 45 – 75 minutes with a psychiatrist) and 80010 consultation (consultation of more than 50 minutes with a clinical psychologist).
- In 2015-16 17,864 individual patients had both a 306 (consultation of 45 – 75 minutes with a psychiatrist) and 80110 consultation (consultation of more than 50 minutes with a psychologist).

Based on these data it is estimated that in any given year approximately 40%¹ of the total number of patients who see a psychiatrist also see a psychologist (clinical or registered) but only a minority (approximately 3-5%) of patients who see a psychologist also consult with a psychiatrist. This confirms that there is a need to ensure that referral and communication channels are as simple and streamlined as possible to deliver optimal patient care, particularly for patients seeing a psychiatrist. As noted in our previous submission, the RANZCP would be pleased to work with other colleagues to address issues that may arise and consider how to provide a services that works optimally for both patients and clinicians.

People in residential aged care facilities

There is an inequity in access to psychological therapies provided by allied health practitioners for residents of aged care facilities (RACF). They receive significantly less services compared to those living in the community. Key to this is the exclusion of residents of aged care facilities from the GP Mental Health Treatment Plan under the Better Access Scheme.

Whilst it is acknowledged that people residing in RACF who are managed exclusively by GPs are able to access psychological therapies via the Chronic Disease Management MBS item number 731, the number of services available per calendar year and the length of consultation is significantly lower than for those living in the community. This is likely to act as a disincentive for psychologists to undertake this work compared to the Better Access work, and will also limit access to clinical psychologists. This is particularly relevant as people residing in RACF are also highly likely to require access to other allied health services (e.g. physiotherapy) and therefore will run down their five funded sessions quickly.

It is recognised that residents of RACF are also able to access allied health services (psychological therapies) utilising item numbers 80000 to 80020 and 80100 to 80170. However to access these services, patients must have seen a psychiatrist, including as part of the development of a referred psychiatrist assessment and management plan. This limits access for patients who are being managed exclusively by GPs. Patients in this group would benefit from direct referral from GPs, particularly given the high mental health needs of this population group. This is in line with the Faculty of Old Age Psychiatry guidelines that general practitioners should be supported as the primary providers of health care for older people.

The RANZCP recommends that the GP Mental Health Treatment Medicare items be expanded to allow residents of aged care facilities to access these item numbers, subsequently improving access to psychological interventions for this important group of people.

Supporting people with complex disorders through multidisciplinary working

The [Taskforce interim report](#) (2016), largely based on feedback from consumers and health professionals, raises the inadequacy of 10 funded psychological sessions each year to meet the needs of people with complex conditions. The need for people to access the services they need to promote recovery and initiatives to facilitate access to services is supported by the RANZCP. In particular multidisciplinary care is supported, and the role of mental health nurses and psychologists in delivering care is invaluable to many patients.

¹ These estimates were made based on the total number of services delivered per year for these item numbers, divided by the average number of consultations as stated in the AIHW publication 'the use of MBS subsidised mental health-related services'

It is noted that the emerging organisational structure following the establishment of Primary Health Networks (PHNs) and health care homes may have relevance to service delivery. Therefore potentially a broader approach considering service delivery may be within the parameters of the Taskforce.

Key priorities for service delivery under the MBS include preventing service fragmentation and ensuring quality consultations. It should also be considered that the number of services required depends on the individual patient's needs, rather than determining a set number of consultations at the beginning of treatment. There is potential to improve access with additional Medicare funded sessions by mental health nurses and/or psychologists, as a way of addressing some of the private outpatient psychiatrist access issues previously raised (e.g. long waiting lists, closed books). The role for mental health nurses and psychologists in this situation could be to follow up and provide additional care, linked to the psychiatrists' practice, but in collaboration with the psychiatrist. The RANZCP believes it important that, particularly when patients have complex disorders, there should be continued oversight and clinical leadership from a psychiatrist to ensure best possible outcomes and value for money. This is important as the level of support required by each patient will frequently vary depending on clinical need, for example patients with a severe mental illness such as schizophrenia and bipolar affective disorder may require different clinical oversight to patients requiring intensive therapy for other reasons.

In addition to considering the role that psychologists and other allied health professional have in supporting people with mental illness, the role of mental health nurses is also important but funding for appointments with mental health nurses are not currently funded under the MBS. Mental health nurses provide broad support for patients with mental disorders. Their clinical skills are complementary to psychiatric care and contribute to a team-based approach in the private sector. When a patient has completed their 10 sessions of allied health care but is in need of further care, it is often the psychiatrist in the private sector who is asked to assess and provide care. Access to MHNs provides vital back up care. With the transfer of Mental Health Nurse Incentive Program (MHNIP) funding to PHNs, it is important that service delivery continues to support those people with mental illness who require these services. The role for the MBS in delivering this should be considered.

The RANZCP has noted the recent establishment of the Eating Disorders Working Group (EDWG). The treatment and management of eating disorders is acknowledged as complex, and there is frequently comorbidity with other psychiatric disorders. The RANZCP is supportive of ensuring that the review of mental health items is thorough, clinician-led, and synchronised with other relevant reviews. The RANZCP therefore recommends that the work of the EDWG aligns closely with the review of other mental health item numbers, as many of the issues discussed, particularly in relation to management of complexity, are likely to apply across other psychiatric disorders.

Note: The RANZCP notes that the further specific recommendation made that Item number 291 be amended from 'Consultant Psychiatrist, Referred Patient Assessment and Management' to 'Consultant Psychiatrist, Referred Patient Assessment and Management *Plan*' has been updated in the MBS and welcomes this change.

Item numbers 348, 350 and 352: Interviews with a non-patient (including carers and multidisciplinary clinicians)

Key issues: Currently, unless consultations with non-patients is undertaken in the course of initial diagnostic evaluation (first month), there is a limit of four consultations with non-patients each year. Involvement of carers and family members is important in providing high quality and inclusive mental health care. This is inadequate, particularly for children and adolescents, geriatric patients and people with intellectual and developmental disability, and other groups as identified in the 2015 submission.

To overcome these restrictions it is suggested that psychiatrists may be billing for longer consultation lengths to allow this collaboration to take place as part of a patient consultation time, or billing to see the family member as a separate patient. This is not best practice and cultural change in this area should be supported through the MBS.

Key recommendation:

- To enable psychiatrists to work collaboratively with other health professionals and agencies, and to engage constructively with family members, greater provision should be made for ongoing consultation with non-patients. This could be achieved through the removal of item 352, provided that item numbers 348 and 350 are amended to be utilised at any point in the treatment of the patient (rather than being utilised only during initial diagnostic evaluation of a patient as currently stated in the criteria).

Data received from the Department of Human Services confirmed that:

- In 2015-16 the total number of individual patients who had a consultation under item number 352 was 15,343. The total number of services was 24,542. This suggests that the average number of consultations with a non-patient in a one year period was 1.6 (notably, much lower than the 4 allowable – however it is acknowledged that this is only an average).
- In 2015-16, the bulk billing rate for an item 352 was 82%, suggesting that bulk-billing of these items is higher than for general psychiatry consultations (approx 33%). Of those that did not bulk-bill, the average charge was \$166.34 (MBS fee = \$126.75).
- In 2015-16, the average number of consultations with a non-patient during initial diagnostic evaluation (first month) was 1.3. This number is currently unlimited. 58% of these consultations are between 25-45 minutes (item 348), and 42% are greater than 45 minutes (item 350). The bulk billing rate for a longer consultation is only 58%, compared to 74% for a shorter consultation. Of those who do not bulk bill, the average charge was \$150.30 for item 348 (MBS fee = \$126.75) and \$238.90 for item 352 (MBS fee = \$175.00).
- Publicly available MBS data supports that nearly 40% of these consultations occur for people in the 0-24 age group, who may require more than the average number of non-patient consults.
- Publicly available data confirm there has been an increase in the number of interviews with non-patients, both in respect of initial diagnostic evaluation of the patient (item number 348), and in the ongoing management of the patient (item number 352). Increases were from 2,042 in 2008 to 13,648 in 2015 for item 348, and 3,277 in 2008 and 19,613 in 2015 for item 352.

The data support the idea that the increased utilisation in these item numbers has led to an increased focus on multidisciplinary working and engagement of carers in management of patients with mental health problems. However, the consultation numbers are still generally very small given the importance of this area of practice. Data also confirms that it would appear to be very limited cost impact in terms of expanding this area of practice, particularly given the relatively high bulk-billing rates reflecting that most consultations (particularly for a 352 item) are not likely to be long, and that there is a low average number of consultations per year. Expanding this item would allow patients who do require greater support in this area (for example children and adolescents) to access it. Working in this collaborative manner with carers has been stipulated as a basic requirement, particularly in the field of child and

adolescent psychiatry, and intellectual and developmental disability psychiatry and geriatric psychiatry, and usually requires separate interview time at each substantial consultation.

As noted in its 2015 submission, as part of the ongoing review, the RANZCP would be prepared to discuss limits per year on the use of these items in line with best practice and patient group needs. It may also be appropriate to consider an alternative option of a shorter consultation time for this item number.

Item numbers 855 – 866: Case conferences

Key issues: There is a need for increased flexibility in regard to case conferences which are an important area of practice but frequently administratively burdensome leading to them being underutilised to the detriment of the patient. The more people who are required to attend case conference, the less likely they are to go ahead – to the detriment of consumer care. Frequently attendees are called away urgently to attend other emergencies suggesting that an alternative approach is needed to allow for this. A related issue is that private health insurance companies frequently refuse to reimburse for case conferences in private inpatient settings.

Key recommendations:

- To support care coordination between appropriate clinicians, the requirement to have another medical practitioner present, in addition to a psychiatrist, should be reviewed. For example, it is often a psychiatrist and a psychologist who need to case conference. Also, to better support ongoing coordination, there should be no annual cap on this item.
- The involvement of carers should be counted towards the minimum number of attendees at the case conference acknowledging the significant role that carers play in coordinating care for consumers.
- There should be no limit on the number of case conferences required each year, to ensure that these adequately accommodate a way of working with service providers, for example under the NDIS.
- Remuneration should be available whether or not the psychiatrist is the person to formally arrange and coordinate case conferences. This acts as a disincentive to attend such conferences, which is not in the best interest of the consumer.
- Provision be made through a dedicated MBS item number for joint consultations between GP and psychiatrists (and/or other specialists or allied health professionals) to acknowledge the increasing importance of collaborative work to improve outcomes for consumers.

Data received from the Department of Human Services confirmed that:

- In 2015-16 the case conferences most frequently used were item 855 (1,617 uses per year) and item 861 (4,644 uses per year). Item 855 relates to a community case conference and item 861 relates to a discharge case conference – both between 15-30 minutes long.
- The average number of case conferences per patient for a community case conference is 1.6 per year (item 855). The average number of discharge case conferences per patient is 1.9 per year (item 861).

- Publicly available data confirm that there has been a consistent across the board increase in use of item numbers 855 – 866 that relate to the organisation of case conferences both for the ongoing management of patients and for discharge of patients. The total number of case conferences has increased from 1,046 in 2008 to 5,852 in 2014. These case conferences require three formal care providers (including the psychiatrist plus one other medical practitioner) to be present for discussion. This reflects the move towards collaboratively working with other professions.
- Discharge case conferences (861 – 866) are used more than community case conferences (855 – 858). The most frequently utilised discharge case conference and community case conference are usually between 15 – 30 minutes.

The RANZCP did originally request data relating to the average number of clinicians involved in each case conference. However, this data was unobtainable as, whilst it may be recorded in the notes, it is not a requirement for payment and therefore not recorded in the DHS data. Bulk billing data was not sought, but could be an area to further investigate as part of the Taskforce work to determine cost to patients. It is anticipated that, like consultation with non-patients, bulk-billing is likely to be fairly high in this area of practice.

The data support that case conferences form a small but important part of practice that frequently prevent relapse. Publicly available data indicates use of case conferences steadily increasing reflecting the move towards collaborative working with other professions and engagement of carers. Therefore, there is scope for increasing flexibility and improving logistics to deliver optimal care to patients at minimal cost.

Item numbers 342 – 346: Group therapy

As noted in 2015, group therapy is greatly valued within the MBS, and is still a very effective and inexpensive form of therapy. It is used efficiently in cases such as addiction therapy and in providing assessment and treatment of mothers and infants in the perinatal period. The RANZCP recommends that provision for this therapy be continued and enhanced within the MBS. The RANZCP previously recommended that provision for delivery of this therapy via telepsychiatry be considered.

In addition it is further supported that recognising infants as patients is an important clinical priority. It is therefore recommended that specific acknowledgement that infants are not excluded from item number 346 be included in the MBS item descriptors. Psychiatrists frequently report issues with claiming for the infant to be included as a patient in a family group of two. This is incongruous with the strong evidence base for treating infants and their mothers concurrently, and the importance of the early years of infant development (Newman, 2015).

Item number 288: Telehealth

Key issues: Telehealth is particularly well suited to the practice of psychiatry. There is a need for continued focus on access for rural and remote patients, but this should be extended to those with physical disability and others who have difficulty in attending consultations due to their mental illness, who are compromised by socio-economic disadvantage or who require access to a psychiatrist who understands their language and culture. This would greatly improve accessibility and affordability.

Key recommendations:

- Expand item 288 to incorporate further appropriate psychiatry item numbers to be deliverable via telepsychiatry (e.g. 344, 346 – group therapy).
- Include people with a physical disability, as well as those with severe agoraphobia, obsessive compulsive disorder, social anxiety disorder, including children with separation anxiety, in the defined list of people able to access telepsychiatry under item 288.
- Make telehealth available for anyone, anywhere, with the extra incentive 50% retained only for patients in rural and remote areas, in residential care facilities, under the care of an Aboriginal Medical Service, or other conditions as defined in point 2 above
- Removal of telepsychiatry item numbers 353 - 370

Data received from the Department of Human Services confirmed that

- In 2015-16, a total of 41,147 telepsychiatry services were used, and delivered to 12,309 individual patients. On average this equates to 3.3 sessions per patient. The bulk billing rate for item 288 was 99% (note that this fee is 50% of the schedule fee for the associated psychiatry item – e.g. 50% of item 291 if delivering this item).
- In 2014-15 a total of 24,368 telepsychiatry services were used, and delivered to 8022 individual patients. On average this equates to 3.0 sessions per patient. The bulk billing rate was 97%.
- In 2013-14, a total of 14,177 telepsychiatry services were used, and delivered to 5,231 individual patients. On average this equates to 2.7 sessions per patient. The bulk billing rate was 97%.
- In 2015-16 psychiatrists who consulted via telepsychiatry to deliver item 306 (consultation of between 45 mins to 75 mins in length) bulk-billed the item 306 at 20%. In 2013-14 and 2014-15 the comparable bulk billing rate was 33%. The average charge for this type of consultation is \$269.00 (schedule fee = \$83.65)
- A breakdown of the geographical locations of people utilising telehealth has been provided. This indicates which regions are well served by telepsychiatry services. This is based on SA3 regions.

The RANZCP did also request data on the number of patients who were using telehealth to undertake a 306 consultation. This data was cell suppressed as this involved fewer than 20 patients. The RANZCP accepts that this may indicate a trend towards shorter consultations for telehealth, perhaps as many consultations take place in GP practices in a team approach, but was still surprised at the low numbers reported. It is suggested that as part of the MBS Taskforce committee work that data be sought to determine what psychiatry services are most frequently being utilised by telehealth as this may have implications for future practice in this area.

The DHS further confirmed that it is not possible to get a breakdown of the number of patients (i.e. rural/remote, Aboriginal and Torres Strait Islander peoples, those in residential care facilities) who have accessed a 288 item as this data is unavailable. It was also not possible to obtain data on the number of patients with a physical/medical disability who have billed for a psychiatry item number as DHS cannot link to Centrelink data.

This confirms that telehealth as a method delivering psychiatry services is increasing year on year, indicating greater practitioner engagement and patient confidence in using this as a method of service delivery. The increase has both been in terms of absolute numbers of patients using the services, as well as an increase in the average number of sessions per year. This indicates that telehealth is working as an initiative to increase access to psychiatry. The bulk billing rate for item 288 remains very high, suggesting that nearly all psychiatrists are bulk-billing the telehealth aspect of this work, although the bulk-billing rates for the associated consultation are in line with average face-to-face consultations. However, in 2015-16, the bulk-billing rate for 306 did drop, which could be related to psychiatrists recouping costs following the cessation of telehealth incentives, or more broadly because of the Medicare Freeze rebate (noting however that this is based on a low sample number of consultations). Either way, the data support that telehealth is being utilised and this provides scope to support the RANZCP position to increase access to other populations.

Expanding telehealth into non-rural settings

Broadening the use of telehealth to patients not in regional and remote areas, particularly those who may face access difficulties in other ways (e.g. socioeconomically disadvantaged, people limited by disability) remains a priority. Whilst many people can live close to a service, the logistics of getting there and the tolerance of the environment are a barrier. Many psychiatric illnesses have an anxiety component that affects a person being able to go to appointments or cope in a busy waiting room. Some patient populations, for example mothers with young babies or those with intellectual and development disability, are at a higher risk of mental illness but find it logistically difficult to attend appointments. Physical disabilities may impact on the ease of attending appointments. All of these groups could benefit from telepsychiatry consultations.

A further group that would benefit from the increased ability to access MBS funded telepsychiatry are doctors, nurses and other clinicians living in medium sized towns and cities (but not within a current telehealth eligible area) who currently feel forced to either accept psychiatric specialist treatment within what may be a small medical/clinical community, or put them off help seeking entirely because of privacy concerns.. Many clinicians face challenges such as depression and addiction and encouraging them to seek clinical care is essential to help prevent such problems escalating. The use of telehealth would assist clinicians practising in outer urban areas, as well as rural and remote areas, who are known to be a higher risk of poor general and specific mental health problems as well be the group most likely by work area to have had suicidal thoughts in the past year (beyondblue, 2013). In the 2013 *beyondblue* survey of the mental health of doctors and medical students, fear of lack of confidentiality/privacy is the biggest barrier, with 52.5% doctors saying it is a barrier to accessing treatment. Removing this barrier to enable access to specialists via telehealth will improve clinicians' confidence that their privacy will be protected and they can receive quality care.

The RANZCP would be pleased to discuss how this could work in practice to ensure that the right patients receive the most benefit. It is suggested that only patients as currently defined (e.g. those in rural areas) would continue to receive the 50% additional fee.

Patients with chronic conditions and disability

As data was unavailable on patients with physical and/or disability, an alternative way was determined to identify patients who are using psychiatry consultations who have higher needs, and who may find it difficult to access psychiatry through the usual channels – e.g. those with chronic conditions, intellectual disability, residential aged care residents, those who are refugees.

Data was therefore requested on the number of patients who have had a psychiatry consultation who have also consulted using item numbers 137 and 139 (children) and 701, 703, 705, and 707 (adults). These item numbers relate to health assessments for the following populations.

The category of people eligible for health assessments are:

- a) People aged 40 to 49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool
- b) People between the age of 45 and 49 (inclusive) who are at risk of developing a chronic disease
- c) People aged 75 years and older
- d) Permanent residents of a Residential Aged Care Facility
- e) People who have an intellectual disability
- f) Humanitarian entrants who are resident in Australia with access to Medicare services, including Refugees and Special Humanitarian Program and Protection Program entrants
- g) Former serving members of the Australian Defence Force including former members of permanent and reserve forces

Assessments are carried out either annually, or once in a lifetime. This means it is possible to calculate the proportion of people requiring these assessments who also consult with a psychiatrist over a one-year period.

The DHS data confirms that:

- In 2015-16 a total of 12,909 individual patients eligible for a health assessment, also consulted with a psychiatrist.
- In 2015-16 in total, 773,002 consultations were held for patients using item numbers 137 and 139 (children) and 701, 703, 705, and 707 (adults). This represents that nearly 2% of patients requiring health assessments, also required a psychiatrist consultation.

It is not possible to break down the type of patients within the group requiring health assessments (e.g. people with diabetes, at risk of developing chronic health, and those who are humanitarian entrants etc.) so this does not determine which group of patients has higher consultations with psychiatrists. However, Medicare data confirms that the vast majority of patients (87%) utilising these health assessments were over 75, which suggests that these are the primary users of these services. Further most assessments were billed as complex and took longer than 45 minutes or 60 minutes (items 705 and 707).

Key points: These data indicate that nearly 2% of people requiring health assessments also require a psychiatrist appointment. Whilst this is small, it is comparably higher than the 1.4% (AIHW data) of the total population who see a psychiatrist on an annual basis. Whilst this doesn't provide any specific support for promoting access to psychiatrists for these populations, it is still relevant that these populations have needs that are slightly higher than the general population and that any initiatives to increase access to psychiatrists (for example through telehealth) will have benefit without cost implications.

Item number 14224: Electroconvulsive therapy (ECT)

Key issues: Currently ECT has only one item number to undertake the procedure. The MBS Schedule fee is very low at \$70.35. This is compounded because psychiatrists are unable to bill concurrent appointments for the assessment of the patient prior to and after the treatment under the MBS.

Key recommendation:

- Review and consider how MBS item 14224 can be amended to properly reflect changes in recent years in the complexity of ECT treatment and the increased financial and time demands associated with credentialing and maintaining the professional and legislative standards required for ECT practitioners.

Data received from the Department of Human Services confirmed that:

- In 2015-16 a total of 2,771 patients utilised ECT under the MBS. On average, each patient used 13.2 sessions during this period.
- In 2012-13 a total of 2,392 patients utilised ECT under the MBS. On average each patient used 12.2 sessions during this period.
- The bulk-billing rate for ECT is incredibly low at only 1% for patients in both 2012-13 and 2015-16 (compared to 33% for an average 306 consultation).
- In 2015-16 the average patient charge (excluding bulk bill) was \$91.96 (MBS fee = \$70.35). In 2012-13 the average patient charge (excluding bulk bill) was \$90.33.
- Publicly available data confirm that despite the low rebate, there has been an increase in the use of ECT from 97 services per 100,000 population in 2008 to 134 services per 100,000 population in 2014.

Data confirms that despite the low rebate and the increase in regulatory requirements, there has been an increase in the use of ECT since 2012, supporting its use as an evidence-based treatment that has positive outcomes for many patients. The low bulk-billing rate supports the RANZCP claims that the rebate for ECT is prohibitively low for any psychiatrist to bulk-bill. Despite this, psychiatrists are trying to keep costs for patients low by charging (on average) only \$20 more than the schedule fee with the costs for patients barely increasing over 3 years. To continue to deliver ECT requires an increased rebate, and to allow for remuneration of essential provision for pre-ECT assessment and post-ECT assessments. It is noted that in many facilities, particularly the post-ECT review will be undertaken by a different psychiatrist to that administering ECT. It is therefore necessary to separate out these consultations. It is not easy to pre-determine the time taken for each of these assessments as they will vary by patient, depending on whether the patient presents with complex initial issues, or if there are issues that arise during the course of the treatment. Reform of this item number is essential to allow psychiatrists to continue to deliver this evidence-based treatment at a reasonable cost for patients.

When compared to anaesthesia for ECT (item number 20104), the current fee for anaesthesia attracts 4 base units, plus one unit for time allowing for a total of 5 units. The MBS fee for one unit is \$19.80 so the total fee is \$99.00. If the patient is aged >70yrs, an additional unit can be applied, taking the fee to \$118.80. It is acknowledged that there is considerable skill required in providing safe anaesthetics for psychiatric patients, including those being treated involuntarily, and given the high level of comorbidity with physical ill health in those with a mental illness. However, given the time commitment for the

psychiatrist to deliver ECT, including the pre- and post- ECT preparation and monitoring, it seems inappropriate that the fee for the psychiatrist delivering ECT is currently significantly lower at \$70.35.

It is suggested that rebate of closer to \$396.00 is required to support the additional complexity and to encourage psychiatrists to engage in quality clinical practice for ECT. The RANZCP suggests that the Taskforce investigate comparative funding for ECT in public hospital settings as part of its work to address this issue.

Item number 310 – 319: Long-term consultations

Key issues: Whilst there is significant evidence supporting long-term intensive therapy, people requiring greater than 50 consultations per year are subject to financial discrimination which potentially impedes access to necessary treatment. Item 319 is not fit-for-purpose as it requires specific definitions to be met which identify a patient's mental illness, are discriminatory and have associated stigma. Use of item 316 has decreased, albeit steadily, over time. Use of item 319 has also decreased more significantly. This indicates that there is no 'overuse' of long-term psychiatry consultation numbers.

Key recommendation:

- Remove the limit on 50 sessions per year for consultation for item numbers 300 – 308 to ensure equitable access to long-term therapy. Subsequently remove items 310 – 319 only if the 50 session per year limit is removed for items 300 – 308.
- To amend the timed psychiatry consultations to incorporate consultations to better reflect actual patient consultations times, through including smaller time allocations (e.g. attendance of greater than 45 minutes but not more than 60 minutes, attendance of greater than 60 minutes but not more than 75 minutes, and attendance of greater than 75 minutes).

Data received from the DHS confirmed that:

- From between 1 July 2015 and 30 June 2016 (2015-16), 620 individuals received greater than 50 consultations per year. Of these, the vast majority (541) received fewer than 100 consultations per year. 59 patients received between 100-150, and 20 patients received between 150-200. No patients received greater than 200 consultations per year.
- In 2015-16, a total of 1584 individual patients had a consultation under item 319. Of these the vast majority (1242) required 0-50 consultations, 252 received 50-100 consultations, 65 received 100-150 consultations, and 25 received 150-200 consultations. No patients received greater than 200 consultations per year.
- In total, in 2015-16 only 962 patients in total received greater than 50 psychiatry consultations per year. Of these, the vast majority (793) received 50-100 consultations per year.

These data clearly supports the RANZCP position that psychiatrists are not 'overusing' these item numbers, and that long-term therapy sessions are being delivered in line with evidence based practice to the vulnerable patients who require it. It also means there are also unlikely to be significant cost

implications to implement the RANZCP recommendations, as presently the limitation on the number of consultations under 319 is 160 consultations per year, which very few patients are using.

There is a need to ensure access to intensive, ongoing outpatient treatment, which is not available in the public sector for complex, severe and/or chronic conditions that have not responded to briefer therapies and/or medication. There are a number of recent reviews noting the effectiveness of long term therapy for a number of severe conditions (National Health and Medical Research Council, 2012; Taylor et al., 2012; Fonagy, 2015; Bateman et al.). The National Health and Medical Research Council review noted that evidence for psychotherapy for patients diagnosed with Borderline Personality Disorder includes: improvements in patient's mental state and distressing symptoms, improved quality of life, decreased self-harm and other suicide related measures, decreased use of health care services and improved interpersonal functioning. This review also noted that for the psychological approaches shown to be effective in high quality clinical trials, the duration of treatment is for several years and at least one session per week is considered necessary.

Long-term psychotherapy can help these patients to dramatically reduce the amount of psychotropic medication prescribed, prevent relapse and counteract gradual deterioration in severe mental illness. It has an important curative as well as preventative role in the management of mental illness. It has been shown to be highly cost effective and to reduce disease burden. Ongoing intensive treatment serves to reduce more costly emergency department presentations and hospitalisations for complex, severe and/or chronic mental illness, and, through recovery, enable people to lead more enriching lives and contribute to the community. Further, long-term therapy not only benefits patients, but can have a positive impact for the families and children of adult patients – for example through being able to provide an environment facilitative of secure attachment for their children, and reducing the potential for transmission of multigenerational trauma and its psychological and emotional sequelae.

In general, the patients who benefit from long-term therapy suffer from severe personality disorders including borderline personality disorder (borderline psychosis), histories of childhood sexual abuse, severe trauma and post-traumatic disorders, substance use and addiction disorders, eating disorders, suicidal thoughts, homicidal thoughts, severe family violence, alcoholism, and treatment resistant depression. It particularly supports those who have responded less favourably to short-term interventions, which may include victims of sexual abuse or family violence who are among the most vulnerable in society.

As noted in its 2015 submission, the RANZCP considers it is preferable to discontinue item 319, provided the needs of these patients can be addressed under amended items 300-308. To be eligible for Medicare-funded intensive psychoanalytic treatment under item 319, a patient would have shown no or little response to appropriate psychiatric treatment and be asked to agree to a diagnosis of considerable impairment, which brings issues of associated stigma (Anaf and Jewell, 2007). These issues are of significant concern to the community and the profession. Further, those who are attempting to re-join the workforce or education will not be able to receive treatment under 319, both matters which the RANZCP considers discriminatory. The benefits of long-term treatment are not limited to specific diagnostic groups, and these criteria mean that many vulnerable patients with severe mental illness.

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