Increased access to evidence-based primary mental health care: will the implementation match the rhetoric?

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ABSTRACT

- There is clear evidence that coordinated systems of medical and psychological care ("collaborative care") are superior to single-provider-based treatment regimens.
- Although other general practice-based mental health schemes promoted collaborative care, the new Medicare Benefits Schedule payments revert largely to individual-provider service systems and fee-for-service rebates. Such systems have previously resulted in high out-of-pocket expenses, poor geographical and socioeconomic distribution of specialist services, and proliferation of individual-provider-based treatments rather than collaborative care.
- The new arrangements for broad access to psychological therapies should provide the financial basis for major structural reform. Unless this reform is closely monitored for equity of access, degree of out-of-pocket expenses, extent of development of evidence-based collaborative care structures, and impact on young people in the early phases of mental illness, we may waste this opportunity.
- The responsibility for achieving the best outcome does not lie only with governments. To date, the professions have not placed enough emphasis on systematically adopting evidence-based forms of collaborative care.

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> Dealing equally with health care for mental, substance-use, and general health conditions requires a fundamental change in how we as a society and health care system think about and respond to these problems and illnesses.[1]
>
> Harvey V Fineberg, President, Institute of Medicine, 2006.

For too long, the needs of those with common mental health problems have been marginalised by the society in which we live, the social systems we rely on and our traditional health care systems.[2-4] Once again, the need for coordinated national health and welfare services for people with mental health and substance misuse problems has been recognised by all Australian governments.[5] While a far-reaching and internationally recognised national mental health strategy was first developed in the early 1990s,[6] insufficient investment, lack of accountability, divided systems of government and changing health care demands resulted in a very patchy set of reforms.[2-4,7-9] Major geographical, economic and health system barriers to primary and specialist care persisted. There was insufficient development of systems to promote evidence-based psychological therapies, innovative early intervention programs, new e-health strategies, supported housing, community-based acute care and post-treatment recovery services.[2-4,7-12] Since 1996, the provision of services by specialist psychiatrists declined by 6.5%, while out-of-pocket costs to those receiving care increased by 48%.[13] Consequently, much of the work of providing mental health care has remained on the shoulders of general practitioners poorly supported by both public and privately funded specialist systems.[2-4]

> . . . it is equally clear that the last decade of achievements has not been enough to build an adequate system of mental health care. Reforms across the country are uneven and some jurisdictions remain way behind, having made relatively little progress over the ten years.[8]
>
> Christopher Pyne, Parliamentary Secretary to the Minister for Health and Ageing, 2005.

Fortunately, because of the leadership of the Prime Minister and the Premier of New South Wales, we now have a new whole-of-government mental health plan.[14] This plan is broadly consistent with community priorities.[1,2,15] It emphasises prevention and early intervention, and active management of those with comorbid alcohol or substance misuse. It recognises the private health and community sectors, builds sustainable partnerships with community service providers, and engages other relevant government bodies (employment, housing, education, social welfare and justice). The plan is backed by substantial new federal government resources ($1.9 billion new monies over 5 years) with possible commitments of up to $2 billion by state and territory governments.[4] It seeks to link general practice with better support from medical and non-medical mental health specialists.

Collaborative care

Effective delivery of improved mental health care depends not only on financial support for individual services, but also on administrative and resource support for the most relevant systems of care. For people with common anxiety and depressive disorders who present to primary medical services, the evidence has now made it clear that individualised medical care (or, more commonly, isolated, disorganised and episodic care) is less effective than well planned, integrated and multidisciplinary collaborative care (Box).[16-22] Collaborative care is typically described as:

> . . . a multifaceted intervention involving combinations of 3 distinct professionals working collaboratively within the primary care setting.[16]

Collaborative care not only improves depression outcomes at 6 months, but continues to show benefits for up to 5 years. As the authors of a recent meta-analysis noted:

> . . . sufficient evidence had emerged by 2000 to demonstrate the statistically significant benefit of collaborative care.[16]

Active promotion of collaborative care also needs to link with other strategies that promote early intervention to teenagers and young adults.[2] As over 75% of mental disorders commence before the age of 25 years, reducing the economic, geographical, attitudinal and service organisation barriers for adolescents and young adults is an essential first step.[23,24] That is, the system must move to active engagement with incident cases of disorder and, inevitably, provide a wider range of informational, e-health, psychological, social and medical interventions to people who present with earlier stages or less severe forms of illness.[23-26]

Collaborative care models for management of common mental health problems[16-22]

Collaborative care and other related enhanced or stepped-care models for the management of common mental health problems for people who present to primary care with anxiety or depression consist of:

- A structured and multifaceted approach based on chronic disease management principles; *and*,
- A greater role for non-medical specialists like case managers, nurse practitioners, clinical psychologists and other mental health specialists, including occupational therapists or social workers; *and*,
- Inclusion of some key organisational and professional components such as:
  - Clinician education
  - Dissemination and implementation of treatment or management guidelines
  - Use of case-screening procedures
  - Reconfiguration of roles within primary care
  - Earliest appropriate use of specialised psychological or psychiatric assessment or brief psychological interventions
  - Case management, reminder systems and other active follow-up schemes (telephone or e-health-based) to enhance continuity of care and adherence to treatments
  - Consultation–liaison or other methods of improving working relationships between primary and specialist/secondary services
  - Formal integration of services, including collocation and common clinical governance schemes
  - Support for patient education, self-monitoring and consumer-based decision tools ◆

Past research in Australian general practice has indicated that although people aged between 18 and 25 years have the highest rate of mental health problems, they are least likely to be recognised or treated.[27,28] Further, the rate of provision of evidence-based psychological therapies to young people is unacceptably low.[28] The federal government has responded to these specific problems by establishing "headspace", Australia's National Youth Mental Health Foundation (http://www.headspace.org.au/), to lead service-based reforms for young people with mental health and substance misuse problems; over $50 million are committed to the activities of headspace between 2006 and 2009.

> Improving the quality of M/SU [mental health and substance use] health care . . . depends upon the effective collaboration of all mental, substance-use, general health care, and other human service providers in coordinating the care of their patients . . . Complementary actions are also needed from government agencies, purchasers, and accrediting bodies to promote the creation of these linkages.[1]

Recent reforms

Past efforts at major reform have been slowed by active professional resistance, with particular emphasis on retention of poorly coordinated fee-for-service systems. Independent analyses continue to indicate the extent to which individual-provider systems fail to deliver high-quality mental health care.[1] A fundamental shift in GP-based mental health care occurred in 2001 with the introduction of the Better Outcomes in Mental Health Care scheme (BOiMHC).[29] This innovative approach not only linked participating GPs with clinical psychologists, but also: specified the use of evidence-based psychological therapies; required and gave credentials to relevant programs of professional training; and promoted the use of relevant outcome measures. It sought to minimise the traditional barriers of large out-of-pocket expenses (through the use of locally negotiated service contracts between Divisions of General Practice and participating psychologists) and geographical disadvantage (through the organising and recruiting capacity of Divisions of General Practice in outer urban, rural and regional areas).

The positive community response to BOiMHC[2,3] and the feedback from the participants (GPs, psychologists and consumers)[29-31] were significant factors that supported the case for access to the subsequent Medicare-based scheme that commenced in November 2006. The new Medicare-based scheme now includes a suite of measures designed to increase access to appropriate and affordable forms of evidence-based psychological care,[32,33] and is expected to cost over $500 million in the first 5 years of operation. Specifically, by providing Medicare Benefits Schedule rebates for psychological services provided by a large number of clinical and other registered psychologists, social workers and occupational therapists, the Australian Government took a major step towards removing one of the most significant barriers to evidence-based care. Arguably, it is the most important and practical reform in Australian mental health care in the past 15 years.

Failings of the current Medicare-based system

> Individual practice may be an impediment to the delivery of high-quality M/SU [mental health and substance use] health care for multiple reasons . . . the ways in which M/SU and other health care providers are separated are more numerous and complex than is the case for other health care generally.[1]

Despite the successful promotion of collaborative care models through the BOiMHC scheme,[29-31] the new Medicare-based system does not overtly continue that process. Unfortunately, it largely reverts to traditional individual fee-for-service structures. Specifically, there are no requirements (or incentives) for collocation of services, recognised internationally as one of the most important practical measures for promoting collaboration.[1] There are no requirements for geographical distribution of services, despite the evidence of gross maldistribution of mental health specialist services in Australia[2-4,12] and the contribution of lack of mental health services to increased suicide rates in rural and regional communities.[10,11] Lack of access to appropriate forms of psychiatric and psychological care among Indigenous people, particularly those in rural and remote communities, has been a continuing feature of Australian mental health systems.[2]

Responding to considerable complaints by the professions, the previous mandatory requirements for ongoing professional education have been dropped. The three-step plan payment that promoted management of episodes of illness care rather than individual occasions of service will not continue. There are no practice-level or individual-provider incentives for treating patients in greatest need at low or no additional cost. There are no rewards for seeing younger people early in their illness. Assessment of the impact of the program is currently limited to periodic review of utilisation data. Currently available data indicate a very rapid uptake of both the GP care plan items (over 80 000 services

in March 2007) and the psychological services (over 100 000 in March 2007).[34] Current trends indicate that significant co-payments for services rather than bulk-billing by psychologists are standard practice. To date, it appears that most services are being provided to women aged 30–50 years.

No systematic study of the impact of the new scheme has been built into its design or implementation. As with other government programs, there is an unspecified commitment to ongoing program evaluation. There is no specific plan to build on previous national evaluation strategies, which indicated that increased treatment for depression in primary care was associated with falls in the number of completed suicides.[35] To date, the very rapid uptake of the new Medicare items for psychological services, as well as anecdotal feedback from referring GPs and psychiatrists, suggest that the initial beneficiaries of the scheme are largely those who were already receiving these expensive services. As the gap between the rebate for a session of 50 minutes or more delivered by a clinical psychologist ($110) or less-qualified professional ($75) and the recommended professional fee ($186) is still large,[36] it is likely that services delivered under this scheme will remain highly concentrated in communities with the capacity to pay. While the Australian Government has signalled its intention, through alternative mechanisms, to help those living in rural and regional areas ($51 million) and younger people ($15 million), the effects of such schemes may be rather limited by comparison with the Medicare-based services.

What needs to happen

> Mental, substance-use, and general illnesses are highly interrelated, especially with respect to chronic illness and injury. Improving care delivery and health outcomes for any one of the three depends upon improving care delivery and outcomes for the others.[1]

We urgently need general practice to be proactive and innovative in developing new service structures that deliver collaborative care, particularly to young people and those in greatest need. Relevant government bodies need to support service providers who embrace change and do not fall back on dislocated, isolated and expensive fee-for-service models. While the new Medicare schemes do provide GPs with greater specialist support, it is not yet clear whether they will benefit patients who do not already have access to care. The professions may well be content, but the community may be poorly served by a failure to support a genuine increase in widespread access to affordable and collaborative care.

Competing interests

Ian Hickie and Patrick McGorry are members of the headspace Consortium for the National Youth Mental Health Foundation.

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