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Blended mental healthcare Continue the momentum of telehealth

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Black Dog Institute

Summary

The COVID-19 pandemic has put further pressure on Australia's mental health system but continuing the shift to a blended mental health care model is a potential solution to improve accessibility and improve system efficiency.

- There is a gap in mental health service treatment in Australia, exacerbated by bushfires and
- COVID-19 Adapting to the public health restrictions during COVID-19 has demonstrated there is demand for digital and non-traditional mental health services
- Digital therapies can be clinically effective in reducing mental illness and suicide symptoms, are cost effective, and can improve the reach and efficiency of the mental health system
- Policy and regulations reform can assist addressing supply barriers to implementing a digitally blended mental health care model at scale

Recommendations

- **Fund** telehealth and blended care items as a permanent option for mental health consultations in the Medicare Benefits Scheme.
- **Continue** the shift toward a blended mental health care model by
  - integrating evidence-based digital services to increase flexibility and choice
  - addressing supply side barriers through policy and regulation
  - improving consumer information
  - ensuring equity of access

There is a mental health treatment gap in Australia

Recent major reviews have highlighted the mental health treatment gap – there is a difference between the number of people who need care and the number who receive care (1) (2). It is estimated that over 50% of Australians with mental illness do not receive treatment (3). This is reflected in the estimated annual economic cost of mental illness and suicide of around $180 billion (even prior to COVID-19), including reduced diminished health and life expectancy but excluding further costs of stigma and lower social participation (4). The upcoming final reports from the Productivity Commission and Royal Commission in Victoria will likely provide recommendations to governments to reduce the treatment gap and associated social costs, in part by increasing the use of digital technology (5) (6).

COVID-19 presents a unique opportunity

In Australia, the necessary COVID-19 physical distancing measures has resulted in a transition to a **blended mental health care model.** Temporary government measures, such as Medicare Benefits Scheme (MBS) funded telehealth consultations, are an opportunity to further explore the potential for complementing traditional face-to-face care with evidence-based digital therapies.

The pandemic has been a driver of **increased suicide risk** (7) and **increased demand for mental health services** , placing further pressure on the existing system. Traditional in-person care faces ongoing barriers to meeting demand including a limited workforce (ix), the location dependency of treatment, and out-of-pocket costs (10). Blended digital mental health care offers a future-focused solution, combining elements of face-to-face treatment and digital therapies. There is strong evidence that **digital solutions are clinically effective** in reducing mental illness (11) (12) (13) and the evidence for reducing suicide symptoms is growing (14) (15). Integrating these types of treatments are likely to improve the system architecture by increasing accessibility and consumer choice, improving system efficiency, promoting prevention and early intervention, and reducing costs (16). This should lead to better mental health outcomes that are independent of geographic location.

Digital technology should form part of the solution

With the right settings, there is **strong demand for the accessibility and convenience** of non-traditional forms of mental health care. For example, in April 2020, there were 5.8 million MBS- funded telehealth consultations across Australia, with around 90% of these via telephone and over 9% via video conference. As a category, mental health consultations had the highest ratio of just over 50% (17). One in six Australians (17%) used a Telehealth service in the previous four weeks, with persons with a mental health condition more likely to do so than those without a mental health condition (33% compared with 15%).

Other digital mental health services have also mobilised in recent years and have seen an increase in usage during the pandemic. ReachOut, a digital platform for mental health support for young people, saw visitation across services increase by 50% compared to the same period in 2019 (18). Black Dog Institute's myCompass service and HeadGear app saw increased use of over 35% for the March to June 2020 period when compared to the same period in 2019 (Black Dog Institute internal sources, 2020). This can be attributable to the effects of COVID-19 and associated social media advertising.

Digital therapies can be **clinically effective** in reducing mental illness symptoms. For example, online school-based technology has been proven effective in targeting substance abuse and other mental health issues like depression and anxiety (19). Self-guided interventions have been shown to be effective for reducing depression (20), anxiety (21), and suicide prevention (22), and can be helpful for low-income and low health literacy groups (23).

Digital therapies are also **cost effective**. Digitally delivered Cognitive Behavioural Therapy (iCBT) treatments are consistently cheaper than traditional methods due to the drastic decrease in time needed to consult with patients (24) (25), while also being just as effective as its face-to- face counterpart in reaching clinically significant improvements in patients (26).

However, there will always be the need for face-to-face mental health treatment, particularly when symptoms become more severe. Self-management tools improve system efficiency by allowing mental health professionals to focus on more severe cases and potentially avoid costly inpatient care (27).

Therefore, incorporating digital technology into the mental health system should aim for a **blended care model**, where face-to-face, digital, or the optimal use of both approaches are available based on consumer preference (28). This can involve combining the skill and training of a mental health professional with digital elements, which can help improve patient motivation and create longer term change (29) (30), while facilitating routine patient outcome monitoring. Video-conference-based psychotherapy can provide similar clinical results to face-to-face consultations, and as COVID-19 has demonstrated, are a feasible alternative when traditional methods are not possible (31) (32). This supports the Australian Government's preference for videoconferencing as the method of delivery for its temporary MBS measure during COVID-19 (33).

Recommended strategies for governments

1. Fund telehealth and blended care items as permanent options for mental health consultations in the Medicare Benefits Scheme. As a first step, the Commonwealth Government continuing the momentum of the COVID-19 related measure will maintain broad consumer access and choice, and allow for a thorough evaluation of costs, and the mental health and implementation outcomes over time. The next step includes providing new MBS items to allow for and encourage clinician-guided, blended care. Building on the momentum of current telehealth acceptability will help improve digital literacy and infrastructure and avoid costs of restarting digital reform in the future.

2. Continue the shift toward a blended mental health care model to improve the accessibility and efficiency of the system. In responses to the upcoming Productivity Commission Inquiry on Mental Health, and the Royal Commission into Victoria's Mental Health System, all governments should take actions to:

    a. integrate evidence-based digital services to increase flexibility and choice. This includes considering digital mental health technology in existing and new health and social services (including the multidisciplinary Adult Mental Health Centres trial), a focus on IT infrastructure, making the necessary MBS reforms, and providing workforce training for health and mental health professionals.

    b. address supply side barriers through policy and regulation. This includes Commonwealth and State Governments committing to and investing in a technology-enabled mental health strategy, changes to regional procurement policies, and clear quality assurance through regulations supporting the National Safety and Quality Digital Mental Health (NSQDMH) Standards. This also means providing a clear commercial and regulatory environment to promote innovation, large-scale implementation, and capital investment.

    c. improve consumer information. This includes differentiating the digital mental health tools that have a clinical evidence base with those that have not been tested. The platform where this is done should be widely promoted with clinicians and consumers.

    d. ensure equity of access. This includes targeted resources for vulnerable and minority groups, ensuring adequate broadband infrastructure in rural and remote areas, and reducing cost barriers to access through targeted subsidies for low-income or low health literacy groups. It also means providing appropriate cultural adaptions and translation of existing evidence-based digital programs into other languages to increase equity of access across CALD groups.

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