

Submission to the Senate Inquiry into the Government's funding and administration of mental health services in Australia

Dr. John Burnett DPsy, BBS(Hons), MAPS

Introduction

I hold the degrees of Doctor of Psychology (Clinical Child, Adolescent and Family Psychology), and Bachelor of Behavioural Science (Honours), from the La Trobe University, Melbourne. I was registered as a psychologist with the Psychologists Registration Board of Victoria on 21 July 1999, and from 1 July 2010 I became eligible for an area of practice endorsement with the Psychology Board of Australia (PBA) that allows me to use the title of specialist practitioner in the practice of clinical psychology. I am a full member of the Australian Psychological Society (APS) and a full member of the APS College of Clinical Psychologists. This College maintains the highest standards for clinical psychology practice in Australia, standards which are also consistent with international standards for clinical practice. I have a Medicare Provider number and I am eligible to provide 'psychological therapy' items.

I have my private practice in the city of Sale in the Wellington Shire of the Gippsland Region of Victoria. The Gippsland Region stretches from the eastern edge of Melbourne to the far-eastern Victorian/New South Wales border. It has a unique combination of socioeconomic groups and demographic spreads, including urban/coastal areas, industrial centres and remote rural towns, and had an estimated population for 2010 of 266,000 (Victorian Population Bulletin, 2011). The Wellington Shire has an estimated population of 43,000.

I work with children and adolescent clients living in towns across the Wellington Shire and over 95% of these clients are referred to me under the "Better Access" initiative. In recognition of the above-referenced, unique combination of socioeconomic groups, I bulk bill (that is, no 'gap') parents/carers of all these "Better Access" clients. Therefore my hourly fee is the current bulk billing rate of \$119.80, a sum well below the recommended national fee (APS) of \$218.00. In my opinion, this bulk billing rate is not commensurate with the services that clinical psychologists provide, nor reflective of our qualifications which I am required to keep regularly updated through the continuing professional development (CPD) requirements of the PBA – requirements which are expensive and time-consuming to satisfy. Acceptable CPD activities where the content is related to clinical psychology can include - formal postgraduate education, workshops, seminars, lectures, journal reading, writing papers, receipt of supervision and peer consultation, and online training programs.

I am pleased to have the opportunity to make a submission to the Senate Inquiry, in particular to be able to comment on the following specific Terms of Reference: -

1. Changes to the Better Access Initiative regarding the rationalisation of general practitioner (GP) mental health services;
2. Changes to the Better Access Initiative regarding the rationalisation of allied health treatment sessions;
3. The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services (ATAPS) program;
4. Mental health workforce issues, including: -
 - 4.1 the two-tiered Medicare rebate system for psychologists.

Terms of reference (b) (i) - The rationalisation of general practitioner (GP) mental health services

The Australian Medical Association commented on 15 July 2011: -

“The Commonwealth has cut in half the rebate for GPs providing mental health care plans. Patients will be less able to access GP mental health care plans once the cuts take effect. While this is a problem right across the country it is particularly problematic for rural Australia. Rural patients are less likely to have access to alternative mental health options — especially options that they would be comfortable using. For many rural patients, the family doctor is the first and only port of call when facing mental health issues. The most recent Australian Institute of Health and Welfare report on mental health services in Australia found that regional areas have less than one third as many psychiatrists per capita as urban areas. The Commonwealth must stop funding its health reform program by cutting health services that are vital to regional Victoria. It is essential that the Government consult with General Practice at every stage of the health reform process. Otherwise, scarce health dollars will be wasted.”

The GP's who refer clients to me clearly care about mental illness. This is reflected in the overall quality of the Mental Health Care Plans forwarded to me with the referrals. The time taken to prepare these Plans should be appropriately recognised financially.

However as a viable alternative, I believe that removal of the currently required GP Mental Health Care Plan submission and 6-sessions review would free up funds for actual sessions. Referral should occur just like any other specialty. A referral letter reflecting the authorised Provider Number should be sufficient when accompanied by a signed K10 - Kessler Psychological Distress Scale (K10), or other evaluation, without the need for return to the GP for subsequent session reviews. A lesser Fee for Service regarding the preparation of the referral would then be appropriate. Of course psychologists should still be required to report to the referring GP, paediatrician or psychiatrist on progress with the referral. The psychologist should be allowed to see patients as he or she sees fit, but to ensure integrity, the psychologist must be required to liaise with the referring GP, paediatrician or psychiatrist and other necessary services in the best interests of the client.

Recommendation

The reduction of the rebate for GPs providing mental health care plans requires re-evaluation in order to ensure that all (rural and non-rural) mental health patients receive the maximum mental health care that is possible. Alternatively, consideration should be given to authorising GPs to refer as is currently the practice of paediatricians and psychiatrists, and for which a fair, lesser Fee for Service would be appropriate.

Terms of Reference (b) (ii) - Changes to the Better Access Initiative regarding the rationalisation of allied health treatment sessions

Under the present Medicare system, rebates for consultations with allied health professionals are limited to 12 sessions each calendar year, or 18 sessions under exceptional circumstances. However, the new National Mental Health Reform – Better Access Initiative – Rationalisation of allied health treatment sessions measure (effective 1 November 2011), will limit allied mental health services to 10 sessions per patient, per calendar year. This limit is argued to be consistent with the intent of the Better Access initiative to address mild to moderate forms of mental illness.

What about severe forms of mental illness? In medicine, psychiatry and psychology, comorbidity refers to the presence of one or more disorders (or diseases) in addition to a primary disease or disorder and the interactive effect of such additional disorders or diseases. For example major depressive disorder is a very common comorbid disorder and the patient may simultaneously present with significant self-harm concerns and/or suicide ideation. Depression, anxiety, and organic disease have been found to be significantly correlated with longer hospital stay. Eating disorders such as anorexia nervosa and bulimia nervosa threaten both physical and psychological health. Besides the damaging physical effects that come from the acts of binge-eating, purging and starving the body, eating disorders contribute to psychological, emotional, and psychosocial problems. Comorbidity is also found to be high in drug addicts, both physiologically and psychologically.

The APS recently conducted a study of the nature and severity of disorders of the Better Access consumers who will actually be affected by these limits. The study demonstrated that of the 9,900 people who received between 11 and 18 sessions of treatment from psychologists under the Better Access initiative in 2010,

“ . . . 84% had a moderate to severe or severe disorder at the commencement of treatment by a psychologist, with nearly half (43%) having additional complexities such as a second ICD-10 mental health disorder, personality disorder or drug and alcohol abuse. The research shows that by the end of psychological treatment only 3% remained severely affected, while for 43% of people their disorders were effectively reduced to either no symptoms or only a mild presentation. The APS survey has demonstrated that the removal of these eight sessions of psychological treatment will have a dramatic impact on many thousands of people with serious mental health problems”.

Any cut to the present maximum of 18 permissible annual Medicare subsidised consultations directly undermines the most unique contribution of the psychologist to evidence-based and scientifically-informed mental health treatment. The most vulnerable population cohort will be those who cannot afford to fully pay for their remaining, necessary mental health treatment. (APS Matters – June 2011).

Recommendation

The application of the above-referenced limits directly minimises the distinct contribution of the clinical psychologist to specialist mental health care in Australia. I respectfully submit that the proposed imposition of these limits should be reassessed in an urgent sense.

Terms of Reference (c) - The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services (ATAPS) program

The Government has stated that people with serious mental health disorders who need more than 10 sessions of treatment should receive services through the specialised public mental health system, private psychiatrists, or the expanded Access to Allied Psychological Services (ATAPS) program. Each Victorian Division of General Practice acts as a fund holder for ATAPS. These Divisions engage allied health professionals (AHPs) who may be psychologists, appropriately experienced social workers, occupational therapists, and Aboriginal and Torres Strait Islander Mental Health Workers or mental health nurses, to provide **focussed psychological strategies** to disadvantaged groups.

Access to Allied Psychological Services (ATAPS) enables GPs under the Better Outcomes in Mental Health Care (BOiMHC) program to refer consumers to AHPs for short term, focussed psychological strategies primarily for high prevalence mental disorders such as anxiety and depression.

Focussed psychological strategies are specific mental health care management strategies, derived from evidence-based **psychological therapies** (please refer to * below) , that have been shown to integrate the best external evidence of clinical effectiveness with general practice clinical expertise. Focussed psychological strategies are: -

- Psycho-education (including motivational interviewing)
- Cognitive-behavioural therapy
- Relaxation strategies
- Skills training
- Interpersonal therapy

In contrast, under the Better Access Initiative, Medicare rebates are available for GPs to provide early intervention, assessment, treatment and management of patients with mental disorders as part of a GP Mental Health Care Plan (MHCP). To meet criteria for a GP MHCP a person must be suffering from a specified mental disorder. GPs can refer patients under the GP MHCP to a mental health care professional – for example a psychologist, general practitioner, psychiatrist,

psychiatric nurse or other community care provider. GPs refer patients under the GP MHCP to a clinical psychologist for **psychological therapies** which are more broadly defined than are focussed psychological strategies.

* **Psychological therapies** are appropriate for patients with more complex mental health problems and/or significant co-morbidities.

If access to ATAPS enables GPs under the (BOiMHC) program to refer consumers to AHPs for short term, focussed **psychological strategies**, what happens to the patients with more complex mental health problems and/or significant co-morbidities?

The Australian Government stated that Medicare Locals (as referred as primary health care organisations) will be independent organisations and not government bodies. The Government's reports, "A National and Hospitals Network for Australia's Future: Delivering better health and better hospitals" (May 2010, pgs 63-64) describes the role of Medicare Locals to "**better connect hospital, GP, allied health, aged care and Indigenous health services, making it easier for patients to get the treatment they need, including after hours**".

In their research titled "**Attracting psychiatrists to a rural area - 10 years on**" (Wilks C.M, Oakley Browne M., and Jenner B.L. *Rural and Remote Health* 8: 824. (Online), 2008, concluded : -

"In rural areas across Australia the recruitment and retention of adequate numbers of medical specialists, including psychiatrists, has been a long outstanding problem. Latrobe Regional Hospital (LRH) has not been exempt. Latrobe Regional Hospital provides public mental health services to a population of over 220 000 across the rural Gippsland region, with little or no access to local private psychiatrists".

I have searched and been unable to identify even **one** privately practicing psychiatrist in the Gippsland region. Thus, it is unrealistic to believe that psychiatrists providing psychotherapy is a realistic solution to meeting the needs of clients who require more than 10 sessions in rural Victoria.

The following is extracted from "**Questions from ATAPS Review Discussion Paper - What are the barriers to attracting workforce for ATAPS?**" (Community Services Section, Mental Health & Suicide Prevention Programs Branch, Mental Health & Workforce Division, Department of Health & Ageing - 2009)

"The lack of space for additional services in GPs' consulting rooms or elsewhere is a barrier for service providers. Likewise travel and the compensation for travel time is a barrier. The low volumes of patients in small communities may also be difficult to cater to and means the work is not sufficiently worthwhile from a provider's point of view. There is a general shortage of allied health providers in more distant outer metro and rural areas. This may mean that it is difficult to recruit the range of skills the community may need".

The new mental health budget package invests in mental health services for teenagers and young adults - services such as the Early Psychosis Prevention and Intervention Centre (EPPIC) and "Headspace" (the National Youth Mental Health Foundation which helps young people aged 12 to 25 years who are going through a tough time).

EPPIC is a program of Orygen Youth Health, funded by the Victorian Department of Human Services. EPPIC is an integrated and comprehensive psychiatric service located in Parkville, Melbourne, (220 kilometers from Sale) and which addresses the needs of people aged 15-24 with emerging psychotic disorders in the western and north-western regions of Melbourne. That is, this service is not appropriate for young people living in the Wellington Shire or other remote areas of the Gippsland region of Victoria.

The nearest established "Headspace" close to Sale is located in Morwell, a road distance of over 70 kilometers to the west. This facility is not easily reached by young people living in the Wellington Shire.

The Australian Government has committed to establishing Medicare Locals, a national network of primary health care organisations, from 1 July 2011. The establishment of Medicare Locals is to build upon the strengths of the current Divisions of General Practice Network to include a broader range of providers and activities. A key role for Medicare Locals will be undertaking local health planning, identifying gaps in services at the local level, examining opportunities for better targeting of services and establishing formal and informal linkages with the acute and aged care sectors.

The East Gippsland Division of General Practice has changed its name to the East Gippsland Primary Health Alliance. This Alliance covers a vast and diverse area of eastern Victoria. Its region extends from Rosedale and Sale to the west to the New South Wales border, encompassing East Gippsland and Wellington Shires. The district is rural and remote, with a population of more than 75,000 in a region covering approximately 32,000km². I have organised for a contract document regarding the engagement of psychologists by the East Gippsland Primary Health Alliance ATAPS to be forwarded to me by but will not receive this document for perusal or comment before the deadline for submission to the Senate Inquiry.

I have been advised by the Australian General Practice Network that "There is not a funded Medicare Local in Sale yet". I understand that that future Medicare Locals are planned to commence operation in January 2012 and July 2012. Therefore, I do not understand how moderate to severe clients are to be re-directed to the East Gippsland Primary Health Alliance ATAPS from 1st November when a fully funded Medicare Local is not yet operational, at least within a 60 kilometer radius of Sale to **". . . better connect hospital, GP, allied health, aged care and Indigenous health services, making it easier for patients to get the treatment they need, including after hours"**, let alone solve the problem of the dearth of private psychiatrists in the Gippsland region.

Conclusion

The Access to Allied Psychological Services (ATAPS) program looms inadequate for the provision of necessary longer-term care of patients with more complex mental health problems and/or significant co-morbidities. It is not apparent to me that this program will take over the care of people with severe and persistent mental illness currently being managed by the specialist mental health system.

Terms of Reference (e) - Mental health workforce issues, including: - (i) the two-tiered Medicare rebate system for psychologists

Highlighted under **Terms of Reference (c)** above, is the fact that GPs refer patients under the GP MHCP to a clinical psychologist for **psychological therapies** for patients with more complex mental health problems and/or significant co-morbidities.

Clinical psychology is the only mental health discipline, apart from psychiatrists, whose entire accredited training is specifically focused in the field of evidence-based assessment, case formulation, diagnosis and evaluated treatment of the full spectrum of lifespan mental health disorders across the full spectrum of complexity and severity. That is clinical psychologists have extensive training in assessing a range of psychological difficulties and determining the most appropriate form of help, as well as being trained in providing more than one type of therapy. For example, they provide expertise in the assessment, diagnosis and treatment of mental illness such as the complex conditions of chronic psychiatric disorders, anxiety, depression, suicidal behaviour and post-traumatic stress disorder.

Not only are clinical psychologists specialists in the assessment, diagnosis and treatment of psychological and mental health problems, they are also involved in designing and implementing a wide range of prevention and mental health promotion programs. They variously work with infants, children, adolescents, adults and older adults. Clinical psychologists work in private practice, hospitals, universities, general medical practices, community health centres and mental health services.

Clinical child psychology is a specialty of professional psychology which brings together the basic tenets of clinical psychology with a thorough background in child, adolescent and family development and developmental psychopathology. Clinical child and adolescent psychologists conduct scientific research and provide psychological services to infants, toddlers, children, and adolescents.

The research and practices of clinical child psychology are focused on understanding, preventing, diagnosing, and treating psychological, cognitive, emotional, developmental, behavioural, and family problems of children. Of particular importance to clinical child and adolescent psychologists is a scientific understanding of the basic psychological needs of children and adolescents and how the family and other social contexts influence socio-emotional adjustment, cognitive development, behavioural adaptation, and health status of children and adolescents.

The untold hours that a clinical child psychologist spends in researching treatment options, writing reports and advice, and working collaboratively with other

professionals, colleges, and primary schools are unable to be claimed under the current Medicare provisions.

Recommendation

I could not believe that psychiatrists would be in agreement to have their fees for service reduced to those of less qualified medical practitioners. I do not understand why it is proposed to have the fees for service for clinical psychologists, including those well qualified to work with children and adolescents, and who have the same training in mental health as psychiatrists, reduced to those of less qualified psychologists. I respectfully submit that the two-tiered Medicare rebate system for psychologists must be preserved to acknowledge the professional expertise and the contribution of the clinical psychologist in the area of mental health.

Summary

In summary, I strongly support a carefully considered review of the Government's funding and administration of mental health services in Australia. I trust that the above observations and recommendations assist the Senate Inquiry.

I record my gratitude to the Senate's Community Affairs Committee for reminding all parties participating in its inquiry that all witnesses must be able to give evidence freely to a parliamentary inquiry.